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Tracking global HIV / AIDS initiatives and their effects on the health system in Zambia.

Global HIV/AIDS Initiatives Network
Royal College of Surgeons in Ireland

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POLICY BRIEF
OCTOBER 2009

GLOBAL HIV/AIDS
INITIATIVES NETWORK

TRACKING GLOBAL HIV/AIDS INITIATIVES AND THEIR EFFECTS ON THE HEALTH SYSTEM IN ZAMBIA

Over 20 years into the HIV pandemic, Zambia - like other countries in sub-Saharan Africa, continues to experience the greatest burden of this disease. Approximately 14% of adults aged 15-49 are estimated to be HIV positive and over 800,000 children have been orphaned by AIDS. Since 2000, the Zambian Government, in collaboration with support from Global Health Initiatives has achieved a remarkable scale-up of HIV/AIDS services. These services aim to control the spread of the disease and provide treatment, care and support for people living with HIV/AIDS.

This policy brief shows the impact of three global health initiatives - the World Bank Multi Country AIDS program (MAP), the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) and the President's Emergency Plan For AIDS Relief (PEPFAR)- at national and sub-national levels in Zambia[1], including the effects on scale up of focal (HIV/AIDS) and non-focal health services, human resources for health, coordination and governance.

Global Health Initiatives and funding for HIV/AIDS services

Most funding for HIV/AIDS services in Zambia comes from three GHIs - GFATM, World Bank MAP[2] and PEPFAR. Each of the three GHIs provided funding to HIV/AIDS specific activities, using different strategies for involving government and other country stakeholders in agreeing these activities. Despite these differences, service providers had limited knowledge about the funding disbursements and effects of the individual GHIs on the health system.

Respondents had divided views about the funding conditionalities that governed the disbursement and management of GHI funds. Some viewed these conditions as an imposition of rigid financial restrictions and conditions that lacked appreciation of local realities. Others viewed GHI accountability mechanisms as justifiable conditions for ensuring programme effectiveness and for preventing the misuse of funds. District implementers also reported that they were able to find ways to reallocate money to suit their needs.

Recommendations on funding

- All contributors of funds (GHIs, other donors and Government) should share information on the locations and levels of disbursement and expenditure with relevant national stakeholders, through the National AIDS Council (NAC). This will require all funding agencies to collect and then share end-expenditure data.
- All donors, including GHIs, should make it a condition that all recipients of their funding report expenditure data to National Health and HIV Accounts exercises.
- The cooperating partners, including GHIs, should support Government in drafting an integrated funding plan, based on agreed national HIV/AIDS priorities, which will identify funding gaps for donors to fill and enable greater long-term predictability of funding.

1 Selected districts were Lusaka and Kabwe (urban) and Kabwe (rural)
2 Funding from the World Bank MAP grant ceased in late 2008

Scale-up of HIV/AIDS services

In the three districts included in the research, there was evidence of rapid scale-up of HIV/AIDS services between 2004 and 2007 at district hospitals and sub-district facilities. Mapping data suggested earlier roll out in urban areas, with only 39% of mapped and surveyed facilities in rural Mumbwa providing Antiretroviral Treatment (ART) in mid-2008 compared to 80% in Kabwe and 89% in Lusaka. This is consistent with NAC data.

GHIN facility-based estimates showed a rise in ART coverage in the facility catchment populations from 10.5% in 2004 to 47.2% in 2007. Rural versus urban difference were found, with ART roll-out only starting in rural Mumbwa in 2006 and still at a lower level in 2007.

There was a large increase in voluntary counselling and testing (VCT) between 2004 and 2007: numbers of clients rose threefold and annual coverage rates rose from 2.0% to 6.3% of the adult population. Rural health facilities in Mumbwa achieved similar VCT coverage rates to urban facilities.

Rapid scale-up of prevention of mother to child transmission of HIV (PMTCT) services occurred between 2004 and 2007. Around 20-25% of women who were tested for HIV at ANC clinics tested positive and treatment rates were 94% or higher across the three districts.

Most facilities provided a broad range of AIDS care and support services to communities, including home-based care, food and nutrition support, income generation activities and education interventions. GHIs were credited for their support to these activities.

Recommendations on scale-up of HIV services

- Regular district monitoring and measurement of facility HIV service delivery and coverage should take place, under the direction of the relevant national authorities. Information on facility, sub-district and district performance should be shared with the District AIDS Task Force (DATF) and the relevant national managers.

- Service delivery monitoring data should be disaggregated by age, sex, distance from health facilities and where possible by socio-economic status of service users.

- High and low performance should be the subject of audits so that lessons can be learned and appropriate corrective action can be taken, including the establishment of outreach services, the strengthening and expansion of fixed facilities and quality improvement measures implemented where necessary.

Effects of scale-up on non-HIV services

The research found no clear attributable evidence that linked HIV scale-up to negative effects on non-HIV services at the district level. Between 2004 and 2007, population coverage and the numbers of persons benefiting from other priority services were sustained. These included antenatal clinic and family planning registration, childhood immunisations and outpatient attendance. There was some evidence of more frequent stock-outs of non-HIV compared to HIV related drugs.

National level key informants had a more negative view of the effects of GHIs on non-HIV priorities, which they attributed to inadequate resources allocated to non-HIV diseases relative to HIV allocations.

Recommendations on non-HIV services

- Monitoring, analysis and responses to non-HIV priority service delivery and coverage levels should be instituted, as outlined in the above recommendations on HIV scale-up.

- Mechanisms for auditing quality of care of HIV and non-HIV services need to be implemented.

- Lessons learned on ensuring good stock control and other quality improvement measures should be transferred from HIV to non HIV/AIDS priority services.

Human resources for HIV/AIDS programs

The increase in HIV/AIDS service provision in Zambia has imposed tremendous strain on health workers because there has been no corresponding increase in clinical staff and the already weak human resource system has been weakened further. Findings showed stagnation in staff numbers, deteriorating clinical health worker densities (ratios of clinical staff to population sizes), heavy and increasing workloads and big and growing disparities between districts, notably rural versus urban facilities.

Between 2004 and 2007, the number of doctors in 27 surveyed facilities remained the same, the numbers of nurses and medical assistants fell and there was a moderate increase in HIV counsellors, lab technicians and pharmacists. By 2007, clinical staff numbers in rural Mumbwa had fallen, staff densities had fallen yet further and OPD workload had increased by 31% across the three districts.

While GHIs funded health worker training, they did not fund the training of new health workers. National and district level informants reported that PEPFAR funded NGOs were attracting staff away from the public sector to work on GHI funded projects. The GHIN study was not able to confirm and quantify government to NGO migration.

More health workers received training in HIV than in non-HIV services such as malaria and maternal health, although training in child health was not far behind HIV. More health workers received incentives for delivering HIV than non-HIV services. Most staff were delivering both types of services and HIV scale-up was additional work. There were no significant differences between urban and rural health workers with regard to receipt of financial incentives.

Results confirmed that the Zambia Health Worker Retention Scheme up to 2007 had not succeeded in increasing the available staff, especially in rural Mumbwa.

Recommendations on human resources

- Support should be given to facilities/districts to accurately record health worker numbers, inflow and outflow; and to monitor health worker density (ratio of staff to population) and workload.
- The human resource information system needs to be updated on a regular basis and used to inform implementation of the Human Resources for Health Strategic Plan.
- All three GHIs should provide long term investments towards the training of new health workers, in line with the government Human Resources for Health Strategic Plan and the National Training Plan.
- The operational effectiveness of the Zambia Health Worker Retention Scheme should be reviewed and revised where necessary. The scheme should be actively supported by GHIs and other donors.

Coordination and governance

While NAC had made progress in the implementation of the National HIV/AIDS Strategic Framework 2006-2010, its coordination responsibilities were being overwhelmed by the complexity of the stakeholder and funding environment, funding shortages and a lack of effective mechanisms for engaging across government ministries.

Coordination was not seen to be a priority area for funding by the Global Fund or PEPFAR, whilst the World Bank had given funding to support NAC secretariat at the national level.

The DATFs and Community AIDS Task Forces (CATFs) were credited with beginning to improve district level coordination. However, the absence of a legal mandate for all service providers to register with DATFs proved a major impediment to district level coordination. Government had not sufficiently defined the roles of different intersectoral and sectoral sub-national bodies.

In many cases, PEPFAR recipient organisations did not cooperate with sub-national coordination mechanisms. However, some NGOs were seen to be actively contributing to district level coordination.

Whilst GHIs have come along way towards ensuring the projects they fund use the National AIDS Report Forms (NARF) and the Health Management Information System (HMIS) format, they continue to demand additional indicators and reports which have placed an additional burden on facility and district staff. Delays in reports from the MoH have encouraged GHIs to maintain separate reporting formats because they needed to report promptly for the funds they had disbursed.

Recommendations on coordination

- NAC requires processes to ensure effective communication and flow of information between national, provincial and district levels.
- There needs to be greater clarity on the divisions of roles and responsibilities at all levels – between: AIDS coordination mechanisms (NAC, PATFs and DATFs) and the MoH, the MoH and the other sector ministries, and CSOs and public sector managers.

- Government needs to formalise the positions of DACAs and PACAs (district and provincial AIDS advisors) in line with the recommendations in the Joint Mid-Term Review of the National AIDS Strategic Framework 2006-2010.

- Government and the cooperating partners (including GHIs) need to build the capacity of DATFs as the main coordination body at the district level and provide funding to make them effective.

- All potential service providers wishing to operate in the district should be obliged to sign an MoU with NAC/PATFs and DATFs, to contribute to and align with district plans.

Recommendations on reporting and health information systems

- All stakeholders should work to operationalise and improve a unitary integrated health information system. GHIs should avoid and where possible eliminate the addition of agency-specific indicators and reporting requirements.

- GHIs should avoid and where possible eliminate the addition of agency-specific indicators and reporting requirements.

- Government and the cooperating partners, including GHIs, should invest in capacity-building of facility and district managers to undertake analysis, supervision and quality control of facility records. Support and incentives should be given to district staff to analyse data and take action (e.g. to act on differential coverage levels at sub-district level).

- Health Information quality control systems, such as Lot Quality Assurance, should be implemented at facility and district levels.

- Support and incentives should be given to district staff to analyse data and take action (e.g. to act on differential coverage levels at sub-district level).

- Support from higher levels should include summary findings that would enable facilities, sub-districts and districts to see how they were performing relative to others at their level.

About the research

This policy brief is based on research conducted from 2007-2009 by the Frontiers Development and Research Group, Zambia, supported by researchers from the Royal College of Surgeons in Ireland (RCSI). Funding for field work was from the Open Society Institute. The study is part of the Global HIV/AIDS Initiatives Network (GHIN), a network of researchers in 22 countries that has been exploring the effects of three global HIV/AIDS initiatives on country health systems: the Global Fund, PEPFAR and the World Bank. Coordination of the Network is carried out by RCSI and the London School of Hygiene and Tropical Medicine (LSHTM). The GHIN Network is funded by Irish Aid and Danida.

Qualitative and quantitative research methods were used to collect baseline data in early 2007 and follow-up data in mid 2008; including document review, facility surveys and in-depth interviews with national and sub-national stakeholders. Structured interviews with facility managers and providers of health services were also administered. The research took place in two urban districts – Lusaka and Kabwe – and one rural district, Mumbwa.

More detailed policy briefs on the following themes from the study can be found at www.ghinet.org

- HIV/AIDS funding and scale-up of services in Zambia
- Global HIV/AIDS initiatives and human resources for health in Zambia
- Global HIV/AIDS initiatives and coordination, reporting and evaluation of HIV/AIDS programmes

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