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Funding and scale-up of HIV / AIDS services in Zambia

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

POLICY BRIEF
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GLOBAL HIV/AIDS
INITIATIVES NETWORK

FUNDING AND SCALE-UP OF HIV/AIDS SERVICES IN ZAMBIA

In Zambia, approximately 14 per cent 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 (GHIs) has achieved a remarkable scale-up of HIV/AIDS services. These services aim to control the spread of HIV and provide treatment, care and support for people living with HIV/AIDS.

This policy brief describes the funding for HIV/AIDS in Zambia focusing on the President's Emergency Plan for AIDS relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank Multi Country AIDS program (MAP). It highlights the impact of this funding on scale-up of HIV/AIDS services and on non-HIV/AIDS services in Zambia.

Global Health Initiatives and funding for HIV/AIDS services

Zambia has benefited from high levels of external funding for HIV/AIDS control rising from US$6 in 2003 to US$10 per capita in 2006. During this period, the proportion of funding from external sources rose from 70% to 74%. The largest external funder was PEPFAR (50% of external funding) followed by the GFATM (16%) and the World Bank MAP program.

Table 1: Funding from GHIs between 2003 and 2007

Global Fund (round/amount committed/ year)	World Bank MAP (amount committed/year)	PEPFAR (amount committed/ year)
Round 1 $90M (2003)	$42M (2003)[1]	$82M (2004)
Round 4 $236M (2005)		$125M (2005)
Round 8 $144M (to be signed)		$147M (2006)
		$216M (2007)

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, HIV/AIDS service providers had little knowledge about levels and targets of disbursements and limited insights into the 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 conditions as an imposition of rigid financial restrictions and conditions that lacked appreciation of local realities whereas 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.

Some NGOs reported difficulties in accessing Global Fund and PEPFAR funds due to complicated disbursement mechanisms. Some argued that the World Bank-funded Community Response to AIDS (CRAIDS) projects had been more flexible in this regard. Several channels existed for disbursement of GHI funds at district level.

Scale-up of HIV/AIDS services

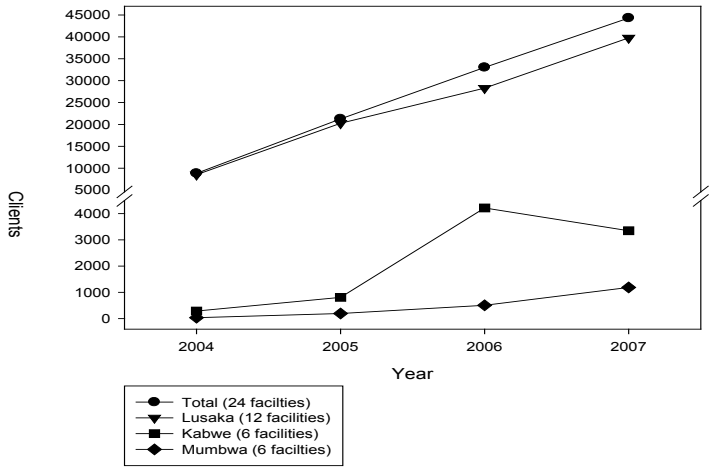
In the three districts included in the research (Lusaka, Kabwe and Mumbwa), there was evidence of rapid scale-up of HIV/AIDS services between 2004 and 2007 at district hospitals and sub-district

1 The World Bank MAP grant ceased in late 2008.

facilities. Mapping data suggested earlier roll out in urban areas, with only 39% of mapped and surveyed facilities in rural Mumbwa providing antiretroviral therapy (ART) in mid 2008 compared to 80% in Kabwe and 89% in Lusaka.

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 differences were found, with ART roll-out only starting in rural Mumbwa in 2006.

Figure 1:Trends in number of clients on ART by district, 2004-07



There was a large increase in voluntary counselling and testing (VCT) between 2004 and 2007, with numbers of clients rising threefold and annual coverage rates increasing 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 services occurred between 2004 and 2007. Around 20-25% of women who were tested for HIV at antenatal care (ANC) clinics tested positive and treatment rates were 94% or higher across the three districts.

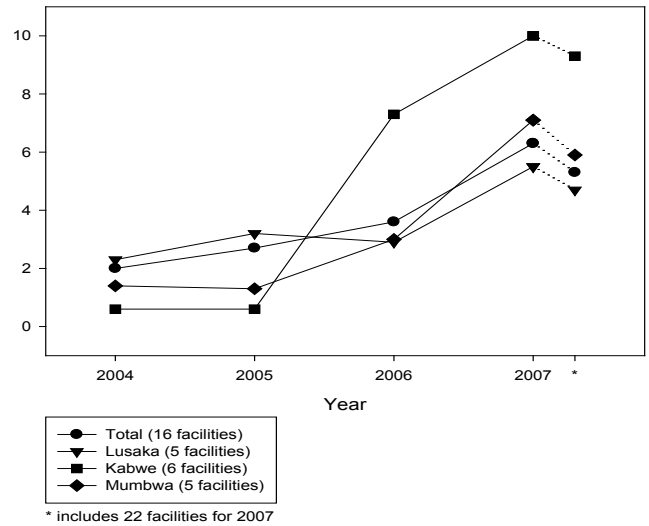
Most facilities provided a broad range of AIDS care and support services to communities, including home-based care, food and nutrition support, income generation activities and education interventions. GHIs were credited for their support to these activities.

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 ANC 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.

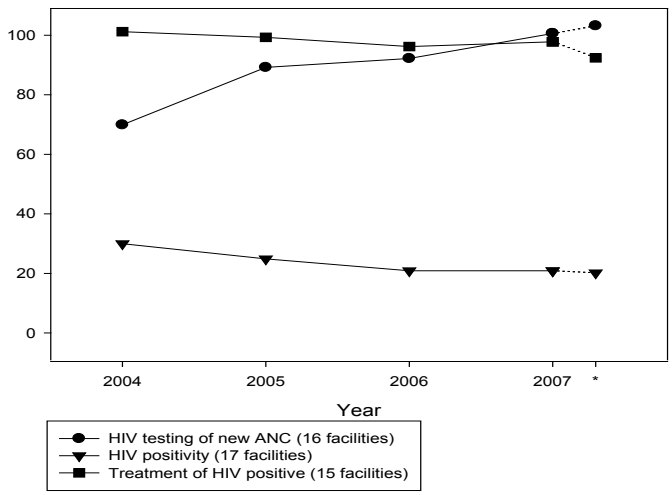
National level key informants had a more negative view of the effects of GHIs on non-HIV priorities, which they attributed to inadequate resources allocated to non-HIV diseases relative to HIV allocations.

Figure 2: HIV testing coverage by district, 2004-07



* includes 22 facilities for 2007

Figure 3: PMTCT Coverage: percentage of women attending antenatal clinic who were tested, percentage who were HIV positive, and percentage of HIV test positives who received treatment, 2004-07



* includes 27, 26 and 28 facilities, respectively, for 2007

Recommendations

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. 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.

Monitoring HIV scale-up

- 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 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, and strengthening the expansion of fixed facilities and quality improvement measures implemented where necessary.

Non HIV priorities

- 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.

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

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

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

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