Aid for AIDS: How donor policies affect access to & quality of health care

APHA Annual Conference Panel
Global perspectives on access to AIDS treatment:
The role of trade agreements and the WHO
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by
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Many countries in Africa have ARVs but can’t take full advantage of them, because of inadequate:

- Workforce (management, clinical)
- Systems of care
- Support services – laboratory, pharmacy

Donor policies bear a major responsibility in creating and perpetuating these conditions (SAPs, donor funding patterns, “Centers of Excellence”)

Outline of talk

1. Structural Adjustment Programs (SAPs)

2. Current aid policies - may foster rapid expansion of care, but often cause
   • Contributes to internal brain drain
   • Spotty coverage & limited expansion
   • Inefficiencies and sustainability
   • Limited control by local MOHs

3. Other models
   - Pooling resources
   - Donor country management of donors
Flow of annual debt payments since 1986

$15 Billion

US Banks

European Banks

African Governments
“Government is not the solution to our problems. Government is the problem.”

Ronald Reagan,
Inaugural Address, 1981
Structural Adjustment Programs (SAPs) imposed by IMF, World Bank “Washington Consensus”

Austerity measures designed to reschedule unsustainable debt, conditional on

- Reducing government spending (education, health)
- Privatize the economy (water, oil…even health & education)
- Improve terms for foreign investment (e.g., reduced corporate taxes & capital restrictions)

TRIPs are part of the same neoliberal agenda
Structural Adjustment Programs

Slashed government spending
- Mass lay offs of government workers (mostly health and education)
- Salaries greatly eroded
- Curtailed maintenance and support of clinics, schools
- Ended subsidies for poor (food, transport, water, housing)

Privatize the economy
- Market regulation of prices (huge increases)
- “willingness to pay” ethic for social services

Improved terms for foreign investment
- Reduced taxation (and government income)
- Reduced or froze wages & curtailed labor unions
How have SAPs weakened national health systems?

- Inadequate workforce & decreased morale
- Poorly maintained and equipped health facilities
- Limited transport, communication
- User fees
- Inadequate medicines and supplies
Faltering health systems and immunization efforts

Figure B1.1 Immunization coverage 1980–2001, 3 doses DPT – global and by region (Source: WHO/UNICEF/World Bank 2002)
Current aid policies
Bush PEPFAR Initiative

- $15B in 16 countries over 5 years
- Requirements - preferences?
  - Purchase of FDA approved (branded) ARVs
    - $600 vs $140 per person per yr
    - No single 3-drug fixed dose combination
  - Want rapid increase of people on treatment
  - Dependence on NGOs for delivery
  - “Centers of Excellence”
“Centers of Excellence”

AIDS treatment – mostly by NGOs

Why?

• Speed up access to ARV treatment
• Provide quality care using experience of NGOs (staff, logistics, drug procurement)
• NGOs create innovative approaches to care
• Expatriates relieve workforce constraints
• Work closely with (and strengthen) public sector
Concerns about “Centers of Excellence”

1. Islands of improved quality of conditions, better salaries
2. Exacerbate internal brain drain
3. Resentment and jealousy outside “centers”
4. Coverage is limited: fast uptake but often reach capacity
5. Parallel systems of care create management confusion
6. Creation of complex, non-replicable systems (doctor dependency, branded drugs, complicated reporting, etc)
7. What happens when NGOs & donors leave?
Example - Mozambique Health Sector Capacity for AIDS treatment

- **Personnel and facilities**
  - ~650 doctors – 2400 professional nurses
  - ~1200 health facilities (hospitals, health centers, health posts)
  - Well functioning drug procurement and distribution system
  - ~500 doctors trained in HAART (3 week course)

- **Achievements: health coverage**
  - DPT3 immunization rate (at 1 yr) 88% urban, 60% total
  - Prenatal care attendance 95% urban, 76% total
  - Tuberculosis - under treatment ~30,000
    - completed treatment ~75%
MOH characteristics

- Slow, bureaucratic
- Dependent on a few key people (who travel all the time)
- Workforce expansion is a principal bottleneck -
  - limited by Ministries of Finance

BUT:

- Has broad health network – more capable of broad coverage for poor
- Sometimes best option for rapid access
- SWAP and common fund processes have been implemented to rationalize donor behavior
Mozambique management workforce

National level MOH staff for HAART rollout: (~45 sites, 35,000 in HAART)

- National director of medical care (MD, MPH)
- Deputy director - medical care (MD)
- HAART rollout coordinator (PhD)
- HAART rollout Expat advisor (MD)
- ~10 Expats (all of whom have project specific responsibilities)

Each province: One director (with no staff) for HAART roll out, malaria, TB
Donor-induced management burden – Mozambique (2005)

• Over 200 health NGOs
• Over 150 independent sites of operation
• 10-20 program categories
• Independent planning cycles, implementation
• Reliability dependent on donor policies
• “Neocolonization” – spheres of control by NGOs (also Uganda, Ethiopia, Kenya)
Too Much of a Good Thing

Between 2000 and 2002, aid agencies in rich countries committed to funding 1,371 different projects in Tanzania. That is a lot for a small government in a poor country to juggle. For example, Switzerland committed $29.7 million through just five projects, whereas Ireland offered roughly the same amount of total aid, but through 404 different projects.

The bars reflect the total aid each donor country gave to Tanzania. The cells within each bar reflect the number of different aid projects each country funded.
Donor assistance causes internal brain drain

Donor funding

Non Governmental Organizations (NGOs)
- high salaries, benefits
- good work conditions

Ministry of Health (MOH)
- low salaries

Local in-country organizations
- higher salaries

Nurses, Doctors, etc

Funds

“white follows green”

Trained technical staff flow to NGOs
Inadequate clinical workforce

- Principal limitation of expansion is low number of ARV providers (MDs are often part-time)
- NGOs often recruit the best providers
- Many trained providers but not allocated efficiently for HAART
- Limited number of ARV sites ("Centers of Excellence") means many trained providers in other facilities are unable to provide HAART
# Global Distribution of Health Workers in Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Doctors (per 100,000)</th>
<th>Nurses (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>2</td>
<td>59</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Mozambique</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Rwanda</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Uganda</td>
<td>8</td>
<td>61</td>
</tr>
<tr>
<td>Zambia</td>
<td>12</td>
<td>174</td>
</tr>
<tr>
<td>Kenya</td>
<td>14</td>
<td>114</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>16</td>
<td>72</td>
</tr>
<tr>
<td>South Africa</td>
<td>77</td>
<td>408</td>
</tr>
<tr>
<td>Brazil</td>
<td>115</td>
<td>384</td>
</tr>
<tr>
<td>Cuba</td>
<td>591</td>
<td>744</td>
</tr>
</tbody>
</table>

*Source: World Health Report, 2006*
Coverage, expansion, and support systems
NGO vs PHC model

1. NGOs usually work in a few highly resourced facilities (MOH or separate)
2. NGO centers often reach capacity quickly
3. Expansion requires work with systems, not just health facilities
Manica & Sofala Provinces, Central Mozambique

Basic information

~3,000,000 inhabitants
High HIV prevalence
  Sofala 26% (Beira up to 34%)
  Manica 20%
~400,000 PLWHA
~60,000 requiring HAART
Parallel systems created by donor projects

1. Separate recurrent maintenance costs - including vendors, processes

2. Separate systems of drug and laboratory procurement
   - difficult for central or provincial MOH to learn system
   - Separate sources of procurement (often more expensive)

3. Separate workforce recruiting and workforce management (often levels of workforce are not sustainable)
Provincial Health System
Starting ARV care at referral site

MOH support
Drugs, Lab, M&E

Provincial Health Center

ARV Care Sites -
Provincial Health System Expansion to District Centers

Provincial Health Center

MOH support
Drugs, Lab, M&E

ARV Care Sites

District Health Center

District Health Center

District Health Center

Health Post

Health Post

Health Post

Health Post

Health Post
Provincial Health System
Expansion to some Health Posts

MOH support
Drugs, Lab, M&E

Provincial Health Center

District Health Center

Health Post

District Health Center

Health Post

District Health Center

Health Post

District Health Center

Health Post

Health Post

Health Post

ARV Care Sites -
Provincial Health System Expansion to most Health Posts

MOH support
Drugs, Lab, M&E

Provincial Health Center

ARV Care Sites -
NGOs & Provincial Health System Coverage and system support

- MOH support
  - Drugs, Lab, M&E

- Provincial Health Center

- District Health Center

- Health Post

- NGO 1 support

- NGO 2 support

- ARV Care Sites
New patients on HAART per site - Chimoio & Beira (MOH sites) vs Machava and Chingassura (Sant'Egidio sites)

Coverage – NGO vs PHC
HIV Treatment Initiation 2003

<table>
<thead>
<tr>
<th>Facilities providing HAART</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ Registered</td>
<td>2,000</td>
</tr>
<tr>
<td>Pts in HAART</td>
<td>94 (0.2%)</td>
</tr>
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</table>
HIV Treatment Expansion 2004

<table>
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<tr>
<th>Facilities providing HAART</th>
<th>2</th>
</tr>
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<tbody>
<tr>
<td>HIV+ Registered</td>
<td>7,300</td>
</tr>
<tr>
<td>Pts in HAART</td>
<td>600 (1%)</td>
</tr>
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HIV Treatment Expansion 2005

<table>
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<tr>
<th>Facilities providing HAART</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ Registered</td>
<td>18,600</td>
</tr>
<tr>
<td>Pts in HAART</td>
<td>2500 (4%)</td>
</tr>
</tbody>
</table>
HIV Treatment Expansion Plan 2006

Facilities providing HAART: 17
HIV+ Registered: 36,000
Pts in HAART: 5,250 (9%)
HIV Treatment Expansion Plan 2007

Facilities providing HAART | 47
---|---
HIV+ Registered | 63,000
Pts in HAART | 13,000 (22%)
HIV Treatment Expansion Plan 2008

Facilities providing HAART: 53
HIV+ Registered: 100,000
Pts in HAART: 24,000 (40%)
DIAGNOSTIC CAPACITY
CD4s, hemograms, and chemistries

Current: 14
Proposed: +10
Sustainability questions

Donors and NGOs usually leave when funding ends

Manica Province, Mozambique

1994

1998 the yellow agencies had left

**Manica Province, Mozambique 1994**

**1998 the yellow agencies had left**
Alternative approach – integrate HAART into Primary Health Care

1. Owned by MOH - more investment, support by all in MOH
2. Often get slower initial uptake than “Centers of Excellence” -
3. More potential health facilities are typically involved
4. More coherent system of support - facilitating learning at all phases
Basket funding: Give most donor funds directly to MOH!

- Increase MOH workforce - to reverse internal brain drain
- Increase staff salaries (e.g., lunch allowances)
- Improve MOH systems
  - maintenance and rehabilitation of health facilities
  - purchase and distribution of drugs, laboratory tests
  - Monitoring and evaluation
  - Link HIV support to other services (Tb, malaria, ANC)
- NGOs and expatriates can provide technical assistance at behest of MOHs
What to do as expatriate health workers?

• Understand (and reduce?) salary inequalities
• Work within the national health system
• Follow national systems and guidelines
• Be sensitive to resentments that might be present
• Observe and document what you see
Living here, what can we do?

- Understand (and witness) the potentially detrimental aspects of US foreign policies
- Cancel poor country debt, combat “neoliberalism” & help rebuild the public sector overseas (Jubilee, Oxfam, Africa Action, Global Exchange, Intl Forum on Globalization)
- Work to change forms of international aid (Oxfam, Action Aid)
Thank you!
SOME EFFECTS OF DONOR ASSISTANCE IN 
THE HEALTH SECTOR

Generally Positive

• Principal support of many MOH programs (materials, transport, $)

• Support of local NGOs

• Support of (fashionable, innovative) services

• Trickle down
  – Per diems
  – Transport
  – Supports aid industry

• Faster initial HAART uptake
SOME EFFECTS OF DONOR ASSISTANCE IN THE HEALTH SECTOR

Generally Negative

• Inequities and resentment
• Human resource movement to funded programs
• Inefficiency, waste of money resources
• Weakening of public sector
• Less ability for large scale HAART coverage
What can be done?

Cancel poor country debt

Reverse structural adjustment programs
  • Invest in governments
  • advocate for living wages

Finance public HIV treatment and prevention programs, including purchase of generic drugs and recurrent costs