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The named contributors alone are responsible for the views expressed in this publication.

Introduction: Civil society and the Maximizing Positive Synergies project

Communities and civil society are at the heart of strong, accountable health systems—at the grassroots level, they represent the end users of health services; they are also engaged in implementation, service delivery, planning and priority setting, advocacy, and monitoring and evaluation (M&E). The crucial contributions of empowered and informed civil society in stimulating community demand, expanding access to health services, extending coverage for marginalized populations, protecting and promoting rights-based approaches to health, and strengthening health systems governance precede and contributed greatly to the recent launch of new Global Health Initiatives (GHIs). Indeed, civil society challenges to governments, United Nations (UN) institutions, and other actors to accelerate responses to priority diseases, helped catalyze the creation of recent GHIs, and have directly shaped GHI policies and practices. Some GHIs have innovated further through their policies and their national and global architecture, systematizing expanded roles for civil society as partners alongside national governments, bilateral donors, and multilateral institutions.

For example, the origin of the Global Fund and PEPFAR can be traced to strong national and global advocacy targeting governments and other partners from the North and South. In addition, civil society built a groundswell of support for a comprehensive response to HIV in developed and developing countries, including antiretroviral treatment (ART)—effectively rescinding narrow interpretations of sustainability and cost effectiveness.

However the direct involvement of communities in GHI-funded service delivery as well as in advocacy and priority setting, particularly in the context of the response to HIV, has given rise to new expectations of meaningful engagement of civil society in health policy and service delivery.

Against this backdrop of dynamic involvement of civil society in the creation of GHIs and in the oversight and implementation of GHI-funded programmes, political and technical debates have intensified over the impact of disease-specific initiatives' investments on health systems.

The Maximizing Positive Synergies Project (MPS) was initiated by the World Health Organization (WHO) in order to expand the evidence base regarding positive and negative interactions between GHIs and health systems, and to generate new learning about models of GHI-funded programme implementation that leverage opportunities for synergies and prevent or mitigate unintended negative interactions.

As a critical partner in governance, advocacy and community-based health service delivery, civil society engagement is needed in order to determine how best to leverage positive synergies between health systems and GHIs. Likewise, grassroots civil society engagement is crucial for ensuring ownership of research outcomes aimed at building consensus around evidence-based

guidelines for maximizing positive synergies. Therefore WHO's MPS project was structured with a consortium of civil society organizations (CSOs) working in collaboration with academic researchers. In the first phase of research, partners in the civil society consortium have generated country case summaries from original research in Kenya, Malawi, Uganda and Zambia. This report describes the approach and framework of the civil society research partners, methods, and outcomes of the research, as well as the implications for policy change.

The consortium is coordinated by Health GAP (Global Access Project), and is led by indigenous CSOs working as lead country partners in Uganda, Zambia, Kenya and Malawi. In collaboration with Health GAP and the Global AIDS Alliance, the four organizations—Treatment Advocacy and Literacy Campaign, Zambia; Uganda Community Based Association for Child Welfare (UCOBAC); GROOTS Kenya; and REACH Trust Malawi—completed country research, data analysis, and implementation and dissemination efforts from November 2008 until the present.

Research questions

Building on the overarching research question of the MPS project, the civil society consortium posited the following research question: "What are the right roles of civil society in optimizing the interactions between global health initiatives and national health systems, in order to capitalize on positive synergies and minimize negative impacts?"

Related research questions addressed by the country teams included:

- How has civil society participation influenced the interaction between GHIs and country health systems? What have been the benefits of this influence?
- In what ways have civil society modified GHIs to increase their responsiveness to country/consumer needs and contextual specifications?
- What reforms and actions should GHIs take to be more responsive to grassroots civil society priorities and health needs?
- How can CSOs work with governments and/or GHIs to navigate implementation roadblocks? What are CSOs doing already?
- What priority health issues identified by front-line CSOs are not being addressed by GHIs, or are being impacted GHIs (positively or negatively)?

Framework and approach

There is broad consensus among diverse groups that civil society represents an important participant in exploiting positive synergies and must be engaged in the work of health systems strengthening in order to increase absorptive capacity; provide local expertise; and create enabling socio-political and legal environments that promote the right to health. Nonetheless, barriers at the country- and GHI-level continue to prevent civil society from acting as equal partners in the planning, implementation, oversight and evaluation of GHI-funded programmes. These barriers include marginalization of civil society participants in national decision-making bodies; weak accountability of civil society representatives in capitals to their constituencies at

community level; lack of transparent mechanisms to participate in some GHI planning and implementation efforts, and lack of resources among civil society representatives to participate in relevant preparatory and planning meetings organized by government and donor partners.

WHO describes six essential building blocks needed for strong health systems—financing; governance; health workforce; health information; service delivery; and medical products, vaccines and technologies. Although not explicit in WHO’s model, civil society and communities cut across each building block, engaging in distinct activities in each category.

Building on the WHO model, civil society research teams elaborated a description of civil society engagement in health systems, emphasizing the functions of civil society that contribute to community mobilization for comprehensive primary health care services. These areas of civil society expertise include evidence- and needs-based advocacy, implementation, grassroots community experience regarding what works, service delivery for excluded populations, the ability to identify gaps and challenges, and the provision of independent oversight and monitoring (see Figure 1).

Figure 1



However civil society and community-based organizations—for a range of reasons—are often ill-equipped to contribute in these areas. The concept of ‘community systems strengthening’ (CSS) has been identified as a key means for strengthening the individual and network capacity of CSOs. It has been described as the provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities (Low-Beer et al 2007; International HIV/AIDS Alliance, 2009).

Increasing the strength and resilience of communities requires multiple interdependent features, including an enabling legal and socio-political environment, access to predictable and sufficient funding for core activities, and capacity building in priority areas (see Figure 2).

Figure 2



Strong community systems in turn can support advocacy that optimizes GHIs at the global and national level, and contributes to expressions of demand to GHIs that better reflect community priorities (see Figure 3). These interdependent elements can help advance a common drive toward comprehensive primary health care.

This approach by the civil society consortium—of communities at the centre of thriving health systems, and of health systems strengthening and community systems strengthening as interdependent efforts—complements the conceptual framework of the MPS academic consortium, which highlights the roles and contributions of civil society along with the contextual factors that impact their strength and success (Atun et al 2006).

Figure 3



In the tradition of community-led participatory research, the consortium partners are actively promoting adoption of their Positive Synergies-related findings by in-country GHIs—through country requests to GHIs and through reforming GHI policies at the headquarters level.

Methods used

The consortium relied on qualitative data collection methods using a standardized questionnaire administered during focus group discussions and key informant interviews.

A range of stakeholders operating at multiple levels in the health system were interviewed in each country by multidisciplinary research teams. Key informants included representatives of implementing agencies, community health workers, grassroots advocates, health professionals and experts, local health officials, patient groups, nongovernmental organization (NGO) implementers, and GHI representatives. Country data were coded and analyzed for key themes and sub themes. Country partners also conducted reviews of relevant literature.

Civil society researchers explicitly sought informants from grassroots communities, in order to provide a 'bottom-up' perspective on the research questions.

Civil society consortium research countries were selected based on a range of criteria, including:

- Substantial GHI funding as a percentage of national health spending
- Existing civil society partnership
- Existing engagement of civil society with GHI structures
- Epidemiological factors (prevalence of HIV and other priority diseases)

Existing evidence

The consortium took into consideration the evidence base regarding the impact of civil society on policy formulation, service delivery, and demand creation and on the importance of community system strengthening for further advancement of civil society roles.

The voice of CSOs is critical in examining how GHIs should be used to improve health outcomes for priority diseases and to address fundamental health system weaknesses. In some reported cases, civil society has already been able to help guide GHI priorities to meet community needs, both in terms of priority diseases and the greater community health needs. In Kenya, civil society has advocated for GHI allocation of resources to increase access to desperately needed pediatric formulations of antiretrovirals. Civil society's intimate knowledge of the local key determinants of health and disease has also led to the creation of innovative and cross-cutting health programming. For example, grassroots organizations in Western Kenya have instituted a programme to protect widows' property and inheritance rights and have pushed GHIs to fund micro-agriculture programmes and pay school fees for orphans and vulnerable children. The

positive effect of housing security and education on HIV prevention and other health outcomes has been well documented. [1,2,3]

Evidence shows that GHIs are investing significant funding through civil society groups, ranging from indigenous community-based groups to large NGOs. CSOs have played a key role in connecting communities to health care services, and helping patients navigate the health system [4] as well as implementing health programming—especially where the health sector is weak, such as in rural areas.[5,6] For these reasons, nearly 20% of Global Fund grant money for the seventh funding round was channeled through NGOs.[7] CSOs play an even larger implementation role for PEPFAR. According to 2005 data, more than 40% of funding for prime partners and almost 70% of funding for sub-recipients, was granted to NGOs or faith-based organizations (FBOs).[8] Civil society has had a strong track record as an effective recipient of GHI funds and has out-performed government recipients in some cases.[9,10]

Civil society has several advantages as complementary partners to governments including focusing on sustainable long-term strategies;[11] monitoring for good governance and ensuring that emerging community health issues are reported;[12] ability to deliver care to marginalized groups;[13] ability to increase absorptive capacity;[14] ability to advocate for evidence-based

1 Leaver, C.A., Bargh, G., Dunn, J.R., and Hwang, S.W. The effects of housing status on health-related outcomes in people living with HIV: A systematic review of the literature. *AIDS & Behavior*, 11 (6)/Supp. 2: S85-S100

2 Hargreaves JR, Morison LA, Kim JC et al. The association between school attendance, HIV infection and sexual behavior among young people in rural South Africa. *Journal of Epidemiology and Community Health*, 62(2):113-119. 2008.

3 Duflo E, Pascaline D, Kremer M et al. Education and HIV/AIDS prevention: Evidence from a randomized intervention in Western Kenya. World Bank Policy Research Working Paper 4024. 2006.

4 Medicins San Frontiers, Achieving and Sustaining Universal Access to Antiretrovirals in Rural Areas: The Primary Health Care Approach to HIV Services in Lusikisiki, East Cape, 1-19 (2006). (<http://www.equinetafrica.org/bibl/docs/MEDaids.pdf>)

5 Patcharanarumol, W. Global health initiatives and health system: Experiences of Thailand. Presentation in Geneva, 29 May 2008.

6 Amazigo, U. Defeating River Blindness and strengthening health systems in Africa. Presentation in Geneva. May 2008.

7 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Progress Report 2006. (http://www.theglobalfund.org/en/funds_raised/reports/; accessed 30 August 2008.)

8 PEPFAR. All countries: Partner and sub-partner counts by local status, organization type and program area (FY 2005). (<http://www.state.gov/s/gac/progress/other/data/partners/60363.htm> ; accessed 30 August 2008.)

9 Global Fund and Int'l HIV/AIDS Alliance, Civil Society Success on the Ground: Community System Strengthening and Dual-track Financing: Nine Illustrative Case Studies (2008).

10 Radelet S and Siddiqi B. Global Fund grant programs: An analysis of evaluation scores. *The Lancet*. 369(9575): 1807-1813. 2007.

11 UNAIDS. The “three ones” in action: Where we are and where we go from here. (http://data.unaids.org/publications/irc-pub06/jc935-3onesinaction_en.pdf; accessed 30 August, 2008).

12 UNDP. Governance for human development. UNDP Strategy Paper. February 2000.

13 Hannah Brown, Community workers key to improving Africa's primary care, 370 *Lancet* 115-17 (Sept. 29, 2007) (<http://download.thelancet.com/pdfs/journals/lancet/PIIS0140a673607614937.pdf>)

14 Global Fund for AIDS, Tuberculosis and Malaria. Investing in impact: Mid-year results report 2006.

health policy reforms;[15] and expertise in providing patient follow-up and outreach services in scaling up quality antiretroviral treatment programmes.[16] Acceptance of GHI programming by target communities is crucial to the success of the programme.[17,18]

Priority areas for GHI involvement in health systems strengthening include funding the pre-service training of additional health workers; overall increases in health worker salaries and harmonization of public sector and GHI-funded health professional salaries; strengthening procurement and supply chains for medicines and other medical supplies; assuring adequate supplies of essential medical equipment, improving medical records and other health information systems, and updating standards of care and practice to improve existing (and expanded) disease programme outcomes.

GHIs may also help increase the capacity of civil society-led advocacy organizations as well as community-based implementers and community health worker (CHW) groups. In particular, CHWs may serve to link the formal health sector and GHIs with the community, stimulate community demand and uptake for health services, extend the reach of health screenings, increase community education on topics such as ART and prevention literacy, and provide community-based treatment.[19] All these activities serve to reduce the patient burden on over-stretched health professionals. CHWs have been shown to improve HIV treatment outcomes.[20] However, CHWs are not being used to their full potential. GHIs can help CHWs reach their potential by providing accreditation and training, salary support, and health care supplies and transportation. Additionally, GHIs may facilitate strengthening linkages between CHWs and the formal health sector.

Limitations of civil society consortium research

The initial outcomes of the first phase of civil society consortium research is subject to several limitations. Importantly, the extremely short timeline under which the research was conducted cut short opportunities for further data collection and analysis. In particular, time constraints made elaborating evidence-based models for civil society involvement in successful leveraging of positive synergies difficult.

15 Szekeres G. The next 5 years of global HIV/AIDS policy: Critical gaps and strategies for effective responses. *AIDS*. 22: S9-17. 2008.

16 Weidle, P. J. et al., Adherence to antiretroviral therapy in a home-based AIDS care programme in rural Uganda, *Lancet* 368:1587-94. 2006.

17 Hsu, L. Building democratic governance and HIV-resilient societies. UNDP. January 2004.

18 Bhan A et al. Grand challenges in global health: Engaging civil society organizations in biomedical research in developing countries. *PLoS Medicine*. 4(9):e272. 2007

19 Nyirenda L., Nkhonjera P. and Simwaka B., Sustainability of community home based care activities: case of four districts in Malawi. Geneva Health Forum, 2008.

20 Farmer P et al. Community-based approaches to HIV treatment in resource-poor settings. *The Lancet*. 358(9279): 404-409. 2001.

The findings are also restricted to a limited number of countries, from only two regions in Africa, although the findings are consistent with contemporary civil society led research on similar topics.[21]

In addition, many respondents reported a lack of information about the operations of GHIs at the national and community level. This complicated data collection. It also presents an easily realized opportunity for synergy—in order to increase ‘GHI literacy’, GHI structures in-country should disseminate materials and programmes to the public, establishing offices at population centres that provide information on applications, implementation, M&E, and to receive community information and feedback.

Kenya: Maximizing positive synergies in Kenya Health Gap (Global Access Project)

GROOTS KENYA *

Abstract

Global Health Initiatives (GHIs) have supported substantial investments in malaria, tuberculosis and HIV in Kenya. Civil society-led research was conducted to determine opportunities for positive synergies between health systems and priority disease investments, with a focus on determining civil society and grassroots community priorities for GHI investments, and on developing findings that can be adapted to inform country planning processes and expressions of demand to GHIs. The research revealed positive impact by GHIs on the health system, for example in expanding health worker training and in improving health information systems. However, research also identified unintended negative consequences, such as internal 'brain drain' of health workers in the public sector moving to nongovernmental organization (NGO)-funded projects. Significant opportunities to maximize positive synergies have been missed in Kenya, in particular in the area of production and retention of additional professional health workers, modernizing and equipping health infrastructure, and training, compensating and recognizing community health workers. These findings are based on field surveys of more than 1400 health professionals, programme implementers, grassroots health activists, GHI representatives, Kenyan health experts, community health workers, people living with HIV, and Kenyan Government Officials for the World Health Organization's (WHO) project on Maximizing Positive Synergies (MPS). The research was conducted between November 2008 and March 2009 and the conclusions have been validated by more than 8000 people from every province across Kenya.

Background and problem context

Development assistance for high profile GHIs addressing specific priority diseases has greatly increased in recent years. Some of the best-known initiatives are the Global Fund and PEPFAR. The Global Fund is a multilateral funding mechanism launched in 2003 after a successful activist campaign that pushed for a vehicle to scale up AIDS treatment. Donors contribute to the Global Fund, and country-convened coordinating bodies (comprising state- and non-state health actors) apply for funds. The Global Fund has committed US\$ 15.6 billion to programmes in 140 countries.

In 2003, after a successful activist effort, the U.S. government launched PEPFAR and provided US\$18.8 billion to fight AIDS by the beginning of 2009. In 2008, U.S. Congress, with the support of now-President Obama, greatly expanded PEPFAR for its second five years, enlarging it to US\$48 billion and

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expanding it to cover HIV/AIDS, TB, malaria, and nutrition programmes as well as substantial new investments in health workforce and health systems. In 2009, the programme was expanded and extended yet again, with the White House increasing its pledge to \$60 billion over six years, to cover additional support for maternal and child health and health systems strengthening. Advocates plan to work to increase this sum even further.

GHI investments in priority diseases have exposed critical weaknesses in the broader fabric of resource-constrained health systems. The approach to health services GHIs have adopted in some cases, has led to the unintentional effect of further eroding the capacity of health systems to address more generalized health needs. In response to these challenges, there must be a concerted stakeholder effort to strengthen overall health systems - particularly infrastructure, human resources, supply chain management, health information systems, health financing and coordination between donors and the public health sector.

However, an evidence base is lacking regarding how best to maximize positive synergies between GHIs and health system strengthening efforts. To facilitate the development of such an evidence base, WHO has commissioned a project on MPS; the civil society track is coordinated by Health GAP (Global Access Project), with lead project partners GROOTS-Kenya, UCOBAC-Uganda, Treatment Advocacy and Literacy Campaign-Zambia, REACH Trust Malawi and Global AIDS Alliance in the U.S.

The work is proceeding in two phases. Phase one involved data collection and analysis and generating a country-specific platform of recommendations. Phase two, which is ongoing, consists of monitoring implementation of the country platforms and WHO guidelines. The second phase also includes country-led efforts to gain endorsement, adoption and implementation of civil society recommendations by the GHIs.

Kenya statistics

Indicator	Value	Year
Population	39,020,000	2009
GDP per capita, PPP (constant 2005 international \$)	1,600.00	2008
Birth rate (per thousand)	37.89	2008
Death rate (per thousand)	10.3	2008
Infant mortality rate (per 1000 live births)	54.7	2009
Life expectancy at birth (years)	57.86	2009
male	57.49	
female	58.24	
Total fertility rate (per mother)	4.56	2003
Estimated adult HIV (15-49) prevalence (%)	6.7	2003
People living with HIV/AIDS (thousands)	1,200,000	2003
Death from HIV / AIDS	150,000	
Major infectious diseases		
Food / water borne diseases	Bacterial diarrhea, protozoa diarrhea, hepatitis A, typhoid fever	
Vectorborne disease	Malaria, Rift Valley fever	
Waterborne disease	Schistosomiasis	

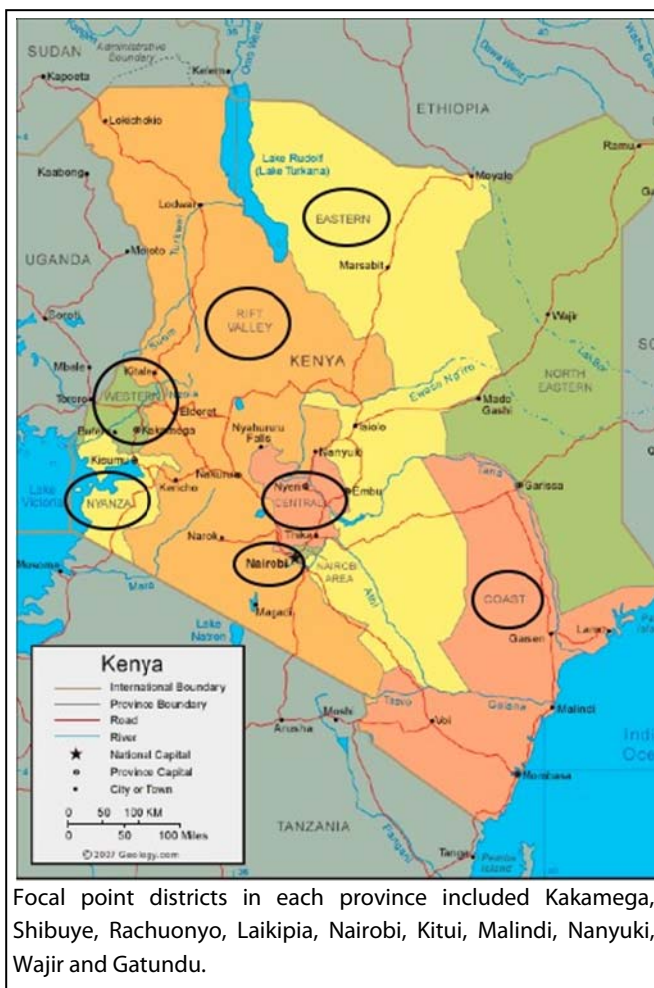
Study objectives

- Develop an evidence base and country-specific recommendations from the perspective of civil society to inform GHI policies and programmes in Kenya and beyond;
- Produce practical tools to facilitate implementation of WHO normative guidance by civil society and other stakeholders at country level;
- Apply civil society recommendations to GHI planning and application processes at the individual country level in real time, synthesizing country survey data to create detailed country-specific platforms of policy and programme recommendations;
- Increase direct engagement by civil society with GHIs at the national and international level in areas such as priority setting and programming, monitoring and accountability, accessing funding, transparency and responsiveness to community-based organizations (CBOs);
- Provide civil society input for WHO technical and policy guidance, while evaluating and contributing to the work of the MSP project's academic and government implementer consortiums;

Research team composition

Research teams comprised representatives of GROOTS Kenya and Health GAP. GROOTS Kenya is a network of more than 2000 CBOs and self-help groups in Kenya. GROOTS Kenya was founded in 1995 and works to increase and promote the involvement of grassroots women in key development and policy decision-making forums. The organization has long-term experience in building the capacity of grassroots communities to face the challenge of HIV and AIDS through activities, including the creation of an alliance of community health workers and promoting home-based care. GROOTS Kenya affiliate partners are active in six out of eight provinces in Kenya: Western, Nyanza, Eastern, Rift Valley, Nairobi and Central.

Health GAP (Global Access Project) is a policy and advocacy organization that has worked to end the AIDS pandemic since 1999. The group initially focused on removing US and World Trade Organization (WTO) policy barriers to country efforts to access affordable generic medications, followed by campaigns to increase global investment in AIDS treatment, care and prevention, which contributed to the launch and programme design of the Global Fund, as well as PEPFAR I and PEPFAR II. Health GAP has worked since its inception to promote grassroots voices in policy-making.



Training research teams

At the launch of the study, GROOTS Kenya organized an induction meeting with 30 grassroots women leaders from six provinces to orient them to the project and train them in the study methodology. To promote community awareness on the study, the women leaders also organized mobilization meetings, where each region selected two leaders to join a core team of research assistants to spearhead the study. A team of 20 leaders was trained for two days to understand the research methods, and test and validate the survey tools.

Study design and methodology

The study used a cross-sectional design. In Kenya, GROOTS and Health GAP have conducted action-oriented research in and around 10 areas between November 2008 and March 2009, including Nairobi, Kakamega, Kitui, Nanyuki, Kendu Bay, Limuru, Nakuru and Gatundu, Malindi and in Wajir. A broad range of 1438 stakeholders were interviewed, including implementing agencies, community health workers, local grassroots advocates, health professionals and experts, local health officials, patient groups and people living with HIV/AIDS (PLWHA), orphans and vulnerable children (OVC) and youth, and representatives of GHIs.

A multivariate qualitative approach was used. This included key informant interviews using a standardized, validated questionnaire; semi-structured focus group discussions; consultations; remotely administered questionnaires; a literature review; field visits and participant observation accompanied by appreciative enquiry. Focus group discussions were used especially among people working in similar situations, for instance community health workers, PLWHA, orphans and health programme implementers. Individual interviews focused on health professionals, government officials and national health activists. GROOTS Kenya used consultative meetings among various health planners and policy makers to seek clarification on different policies developed by the Global Fund and PEPFAR and also to gather their recommendations.

The research team analysed the data and sought peer review by Kenyan experts and civil society groups, and then organized a series of national validation meetings.

Before compiling findings and recommendations, a draft report was shared with research respondents for validation. Following validation and feedback meetings, more than 8000 diverse stakeholders across the country have endorsed the recommendations. (*Specific survey reports from each district will be available online at www.healthgap.org and www.groots.org/members/kenya/htm when field notes are completed.*)

Dates, settings and sampling

The study was conducted in 32 districts in all eight provinces of Kenya. 1-6 districts were selected from each province. Data collection took place between November 2008 and March 2009.

Focus groups discussion participants were selected from the available CBOs, support groups of PLWHA, self-help groups and other village groups responding to health issues, as well as referral hospitals and private and nongovernmental organizations implementing health programmes. In-depth interviews were held with health activists, civil society leaders, implementing agencies, local government officials, health professionals and representatives GHIs.

Survey participants were identified using purposive and snowball sampling. GROOTS Kenya focal point regions in various provinces formed the entry point for the researchers. Local GROOTS leaders from these regions identified the desired population depending on their involvement in health issues and understanding of the GHIs.

Research instruments

At the beginning of the research, GROOTS Kenya, with technical support from Health GAP and the MPS civil society team, developed the research questionnaire, and then piloted it in one of the target regions to review, revise and validate the research questions for civil society organizations (CSOs).

Survey participants

	Community Health Workers	People living with HIV/ AIDS	Orphans & Vulnerable Children	* Health Professionals	Program Implementers	Health Advocates
Total no.	735	300	105	147	91	60
Female	622	230	38	67	27	38
Male	113	70	67	80	64	22
Urban	263	141	31	65	38	49
Rural	472	159	74	82	53	11

Challenges

In some regions people had very little information about GHIs, limiting the ability of some participants to take part in the survey. More importantly, GHIs do not always operate with the degree of transparency that would facilitate meaningful civil society engagement in policy and programming discussions. As a result of the low rates of 'GHI literacy,' research teams incorporated educational sessions into the group interviews to build awareness about GHIs and help participants contribute effectively.

High demand for information regarding PEPFAR and Global Fund

Respondents of all types were hungry for written materials and opportunities to hear more about how to contribute to PEPFAR and Global Fund programmes and policies. This was a challenge since most of the available documents are technical in nature and not optimized for CBOs.

Results

1. Poor Infrastructure, supply chain and information systems:

- a) Widespread shortages of essential medical equipment were found at many health facilities across the country. Health professionals lack the medical equipment they need to safely and effectively meet GHI and national health targets as well as patient needs.
- b) Facilities were often in need of renovation or expansion, and some lacked electricity or clean water and sanitation, resulting in sometimes severe hospital-related illnesses. GHI policies prohibiting new construction were repeatedly identified as barriers to care.
- c) In rural areas, distance from health facilities, expense of transport and lack of ambulance service constitute major impediments to health.

- d) Inadequate medical record-keeping between facilities results in poor disease tracking, patients lost to follow-up, waste and duplication of labour, misdiagnosis and cases of patients receiving treatment at multiple sites.
- e) Poor supply chain management for medical supplies, ranging from gloves to essential medicines, was found at many levels. Commonly needed drugs were too-frequently missing or out of stock—especially at public dispensaries, but often reported available (at marked-up prices) at private chemists nearby.
- f) Standardized formularies for lower-level public facilities are set at the national level by KEMSA (Kenya Medical Supplies Agency) without accommodating local requests for more locally appropriate medicines. Unneeded medicines are wasted, while needed drugs are not available. Delays in medical supply delivery were frequently reported, especially from public sector supply chains.

2. Inadequate Human Resources for Health:

Extensive health workforce shortages were identified in every district surveyed across the country, and were exceptionally desperate in rural areas. Even in facilities where GHIs had taken steps to post additional health workers, staff shortages and crushing workloads were evident. In addition to shortages of doctors and nurses, dire shortages of lab technicians, dentists, pharmacists and other health auxiliaries were also identified. Dedicated health workers spoke of departing for “greener pastures” due to poor working conditions, low or unpaid wages, unrelentingly long hours and years without leave.

- a) Health professionals reported inadequate technical and professional development support, as well as scarce opportunities to conduct research in academic or community settings.
- b) Health workers at all levels reported artificial staff shortages due to uncoordinated GHI-sponsored trainings and seminars, often held at great distances from their posted facility.
- c) Wages were found to be insufficient to retain health professionals across the board. Respondents also reported that GHIs have perpetuated internal brain drain with salary disparities. Further, salaries for nurses were reported to be lower in rural areas than urban areas - thus cementing low rates of rural health coverage.

3. Community health workers are unrecognized:

- a) Community health workers (CHWs) remain the one of the largest resources available to rapidly and effectively respond to health needs. In spite of significant recent improvements, CHWs and their referrals continue to be inadequately recognized by formal health systems. CHWs are very often poorly supported and equipped, and the vast majority of them are almost entirely uncompensated.

- b) Almost all CHWs receive inadequate ongoing training and health professional supervision. According to WHO, best-practice use of CHWs within a health system requires adequate professional supervision, compensation, and a functional referral system.

4. Narrowly defined disease prevention strategies:

- a) Rates of new infection are unacceptably high, and current strategies that focus narrowly on categories of behavior can overlook structural causes that increase risk of disease.
- b) Inadequate human rights education and enforcement results in poor health services and outcomes, and creates greater risk of infection for vulnerable populations.
- c) Gender based violence (GBV) - particularly sexual violence - is a major contributor to the transmission of HIV and of sexually transmitted infections (STIs) - particularly among young girls. GBV is not a GHI programme focus.
- d) Stigma associated with HIV discourages people from using VCT centres for fear of being identified as HIV-positive.
- e) While poverty is recognized as a leading risk factor for illness, the practice of disinheritance and asset stripping of widows and OVCs is particularly devastating economically, with victims too often forced to resort to unsafe activities to earn a living.
- f) A lack of drug treatment programmes in spite of demand, and policies against effective harm reduction programmes, are contributing to growth of the epidemic in regions facing injecting drug user (IDU)-related epidemics.

5. Outmoded treatment standards:

- a) Powerful new AIDS medications with greatly reduced side effects have been developed in recent years. First-line AIDS regimens in Kenya are now less effective and significantly more toxic than these safer, more powerful drugs. However, the new medicines have more patent protections and will be more costly in the short-term until generic competition reduces costs.
- b) Increases in AIDS-related opportunistic infections (OIs) and antiretroviral (ARV) side effects were noted across most areas. Emerging health issues increased incidences of cancer, diabetes, hypertension, and AIDS-related dementia.
- c) In most (but not all) locations, PLWHA are finding unaffordable and unreliable supplies of medicines to treat or prevent HIV-related OIs - in spite of new U.S. legal requirements for PEPFAR to support access to free medicines to treat and prevent OIs.
- d) Insufficient treatment literacy amongst PLWHAs and health workers leaves simple-to-treat illnesses misdiagnosed and can lead to increased drug resistance.
- e) Respondents reported limited availability of pediatric ARVs across the country.

6. Planning and priority setting:

- a) While acknowledging some welcome efforts to decentralize health planning, health workers and patients, including PLWHA at community level reported inadequate involvement in priority setting, and that current programmes did not accurately reflect changing needs and priorities at the community level.
- b) National and GHI-funded health programmes are poorly coordinated, hampered by duplication, bureaucratic inefficiencies, high administrative costs, and misalignment between proposals and activities.
- c) Layers of overlapping bureaucracy, poor coordination and lack of transparency and accountability within public and GHI-sponsored programmes create lengthy roadblocks and disbursement delays for programmes funded by the Global Fund, especially for CBOs. Unpredictable funding flows and unexplained loss of financing even for successful local programmes have plagued GHI-supported programmes, again in particular for those supported by the Global Fund.
- d) Large international NGOs have long-established administrative infrastructures that provide advantages over local CBOs in accessing funds. However, a high percentage of GHI funding being awarded to these organizations is spent on international administration - maintaining their advantage, rather than being spent to assist targeted beneficiaries and grassroots communities. While positive steps have been taken by GHIs, PEPFAR in particular continues to fund larger international NGOs, which subcontract to local organizations.

7. Inadequate malaria control is intensifying the epidemic:

- a) Surveys found that unpredictable GHI funding, in particular from the Global Fund, meant that insecticide treated mosquito nets distribution programmes unexpectedly ended while community need and demand for the nets remained strong.
- b) Inadequate use of artemisinin-based combination therapy (ACT) for malaria treatment results in more complex courses of treatment and can contribute to increased occurrence of drug-resistant malaria.
- c) Health professionals reported emergence of malaria cases in Nairobi province - an area not typically covered by anti-malaria initiatives.
- d) Some GHI recipients are limiting distribution of insecticide-treated bed nets only to children 0-5 years of age.
- e) GHIs such as the US President's Malaria Initiative (PMI) have signed costly contracts with a private U.S. company holding a patent monopoly on a high-tech indoor insecticide product. The company requires unnecessarily high levels of educational qualifications for indoor spraying workers. This is not cost effective and does not maximize coverage.

8. Tuberculosis not fully tracked or monitored:

- a) Low levels of TB treatment and prevention awareness were found in communities and among health workers.
- b) Too few hospitals and doctors in Kenya treat multidrug-resistant tuberculosis (MDR-TB). The lack of accessible services within local communities leads to untreated cases and increased contagion, and to the spread of MDR TB.
- c) Health facilities without isolation wards for contagious patients – as well as crowded conditions in urban areas - can contribute to the spread of tuberculosis.
- d) Poor availability of medical equipment, laboratories and weak referral networks leave too many cases of tuberculosis undetected. Additionally, disease tracking systems are inadequate to detect and contain emerging outbreaks.

9. Disease initiatives depend on primary care systems for success:

- a) AIDS, tuberculosis and malaria are intricate parts of overall public health, and cannot be addressed in isolation.
- b) **Water and sanitation:** Communities - and even medical facilities - suffer from a lack of clean water and adequate sanitation. Cases of typhoid, cholera and bilharzias were found across many areas. This exacerbates health conditions for people living with HIV/AIDS, TB and malaria as well as other public health threats.
- c) **Maternal and Child Health:** expectant mothers were reported as being unable to afford hospital birth services and/or transport to hospitals, and therefore significantly more likely to deliver at home without prevention of mother-to-child transmission (PMTCT) services. A lack of public education on the value of PMTCT services impacted service uptake.
- d) **Disabilities:** many medical facilities are not accessible for people with physical handicaps.
- e) **Slum dwellers:** Overcrowding and poor sanitation in densely populated slum areas multiplies vulnerability to many forms of disease, including outbreaks of tuberculosis.
- f) **Shelter:** Crowded, inadequate housing was found to push young people to leave their families and seek refuge with strangers and peers, increasing the risk of gender-based violence, early marriage and unsafe sex.

10. Orphans and Vulnerable Children (OVC):

- a) Orphans who fall ill are sometimes sent home from school, rather than to medical care, because of inability to pay for services.

- b) Orphans without extended family support receive a greater degree of support from GHIs, including funds to cover monthly living expenses, but orphans living with elderly family members face greater hardship in making ends meet.
- c) OVC programmes focus on slums, but services are needed in less dense areas including estates and rural areas.
- d) Some GHI-supported programmes require OVCs to achieve prohibitively high marks in school to qualify for benefits.
- e) School-related costs prohibit many youth from attending, leaving them more vulnerable to infection.

Discussion and Conclusions

Infrastructure

At many health facilities across Kenya, widespread shortages of essential medical equipment and supplies make it difficult for health professionals to safely and effectively meet GHI and national health targets, and patient needs. Facilities were found to be often in need of renovation or expansion, and some lacked electricity or clean water and sanitation, resulting in sometimes severe hospital-related illnesses. GHI policies prohibiting new construction were repeatedly identified as barriers to care. This problem was particularly acute in rural areas, where GHI support was less common: distance from health facilities, expense of transport and lack of ambulance service constitute major impediments to health.

GHIs should ensure that facilities meet or exceed existing Government of Kenya staffing and equipment standards, including reliable supplies of clean water and electricity, and sustaining an essential package of medical equipment (including CD4 and x-ray machines) and supplies at public and GHI-supported facilities. GHIs should fund the creation, renovation and/or construction, and staffing of new public medical facilities and mobile clinics to reach underserved areas, including incentive pay for health staff. Additionally, GHIs should fund transportation so that all patients can access health facilities in both rural and slum areas, including motorized and on-foot ambulance services to meet international standards requiring that health facilities be reachable within one hour by foot or affordable transport.

Health information systems

Inadequate medical record-keeping between facilities was also shown to be a significant problem in the communities surveyed. Poor information systems result in poor disease tracking: patients are lost to follow-up; labour is wasted or duplicated; misdiagnosis is not uncommon and cases of patients receiving treatment at multiple sites were documented. GHIs should fund and sustain a unified electronic medical records and health information system, integrated with an automated inventory and supply system for all public and GHI-supported facilities. The national electronic health information system should include, but extend beyond, AIDS, TB and malaria.

Medical products, vaccines and technologies

Supply chain management for medical supplies is poor at public facilities, a problem that has not been significantly alleviated since the advent of GHI support. Shortages in equipment and essential medicines were found at many levels. Commonly needed drugs were too frequently missing or out of stock – especially at public dispensaries, but often reported available (at marked up prices) at private chemists nearby. Delays in medical supply were frequently reported, especially in the public sector. Existing GHI-sponsored pilots of automated electronic inventory systems should be expanded to the national level and incorporated in national health management information systems.

In spite of recent PEPFAR policy changes, respondents continue to report availability of ARVs but not medicines to treat and prevent OIs. In addition, the dramatic improvements being seen in wealthier nations due to adoption of newer, less toxic ARV regimens and improved standards of care are not being seen in the context of ongoing treatment rollout in Kenya. However, the severe side effects and toxicities resulting from outdated regimens are being widely experienced by survey participants in growing numbers—with attendant treatment failures and declines in adherence. To maximize overall system-wide benefits while sustainably meeting programme targets and goals, GHIs should support and establish routine ongoing reviews and updates of national treatment standards of care and practice for HIV, tuberculosis as well as other public health threats—including payment and provision of new generic forms of updated ARVs and comprehensive treatment and prevention of HIV-related opportunistic infections and co-morbidities.

Health workforce

Extensive health workforce shortages were identified in every district surveyed across the country, and were exceptionally desperate in rural areas. Even in facilities where GHIs had taken steps to post additional health workers, staff shortages and crushing workloads were evident. In addition to shortages of doctors and nurses, dire shortages of lab technicians, dentists, pharmacists and other health auxiliaries were also identified. Health professionals reported inadequate technical and professional development support, as well as scarce opportunities to conduct research in academic or community settings.

Health workers at all levels reported artificial staff shortages due to uncoordinated GHI-sponsored trainings and seminars, often held at great distances from their posted facility. Wages were found insufficient to retain health professionals across the board.

Respondents also reported that GHIs have perpetuated internal brain drain with salary disparities. Further, salaries for nurses were reported to be lower in rural areas than urban areas - thus cementing low rates of rural health coverage. Positive synergies in this area will require increased GHI funding for production, training, support and retention of health professionals and for improving the capacity and quality of medical practice and medical and nursing training institutions. Specifically, GHIs should increase funding and work with the government to meet Kenya's national health workforce posting requirements, including an aggressive programme to train, support and retain at least 2.3 doctors, nurses and midwives per 1000 country residents (with a target that these workers graduate or be in the educational pipeline within five years), to achieve

significant new investments in production and retention of health professionals, and to increase the production capacity and quality of medical training institutions.

GHIs should further support health workforce production and retention measures to achieve 1.8 health auxiliaries per 1000 residents, including pharmacists, lab technicians other trained paraprofessionals. Training opportunities funded by GHIs should include improved opportunities for continuing medical education, research opportunities and peer reviews, and updated medical training methods and curricula. GHI-sponsored trainings should be coordinated, recorded by national medical accreditation bodies, and contribute to career advancement. Finally, training opportunities should occur closer to the district level wherever possible, rather than requiring lengthy travel that leaves duties unfulfilled at local clinics;

Above all, salaries adequate to retain health professionals, and harmonized *increases* in wages between public and non-state health sectors, are critical if the gains from GHI interventions are to be translated into permanent improvements in health system infrastructure. Recruitment codes of conduct to lessen internal and external brain drain should be adopted for GHIs, NGO-GHI funding recipients and donors.

GHIs should actively work to reform macroeconomic policies that discourage sufficient public sector employment levels and prohibit wage levels sufficient to retain health professionals.

Community health workers (CHWs) are additional health workers who are available to rapidly and effectively respond to health needs. Despite significant recent improvements, CHWs and their referrals continue to be inadequately recognized by formal health systems. CHWs are very often poorly supported and equipped, and the vast majority work almost entirely without compensation. GHIs and the Government of Kenya should fully implement the Ministry of Health's Community Health Guidelines and establish an accreditation programme to train and support CHWs, with a target of ensuring coverage of at least one accredited CHW for every 20 households. An additional full-time salaried health extension worker should oversee every group of 25 CHWs, as per national guidelines. GHIs should ensure compensation to full-time CHWs, including adequate wages that are harmonized and provided to accredited CHWs and CHW community organizations. Government and GHIs should provide grants for community organizations to support income generating activities and to strengthen existing CBOs, and provide a pension support system for accredited CHWs. GHIs should adopt and promote internationally recognized best practices as established by WHO's Task Shifting Guidelines, including requirements that recipients provide and support remuneration for CHWs, appropriate ascending career and training opportunities for CHWs, adequate equipment for CHWs - including regularly replenished medical kits - CHW transportation, nutrition support for patients, and ongoing professional oversight and case review on a regular basis.

Financing

Unpredictable funding flows and unexplained loss of financing even for successful local programmes have plagued GHI-supported programmes, in particular those supported by the Global Fund in Kenya. Large international NGOs have long-established administrative infrastructures that provide advantages over local community-based organizations in accessing funds. However, a high percentage of GHI funding being awarded to these organizations is spent on international administration—maintaining their advantage, rather than being spent to assist

targeted beneficiaries and grassroots communities. While positive steps have been taken by GHIs, PEPFAR in particular continues to fund larger international NGOs, which subcontract to local organizations.

Leadership and governance

Despite welcome efforts to decentralize health planning, health workers and patients, including PLWHA at community level reported minimal to non-existent involvement in priority setting, and that current programmes did not accurately reflect changing needs at the community level. Layers of overlapping bureaucracy, poor coordination and lack of transparency and accountability within public and GHI-sponsored programmes has created lengthy roadblocks and disbursement delays for programmes funded by the Global Fund, especially for CBOs. There is great need to streamline, simplify and harmonize existing parallel planning systems at the national, provincial and district and sub-district levels into a coordinated system accessible to the public via independent 'Eyes and Ears Committees' in population centres, with one joint administrative office in Nairobi overseeing satellite offices in each provincial population centre. The satellite offices should perform local needs assessments and patient satisfaction surveys, monitor local health system performance, identify health system gaps, and ensure timely responses to emerging health issues and disease outbreaks. Satellite offices should ensure that all local health actors have the most current information to access GHI funds *and* services, and can also support community and local government efforts to host local health education training sessions. These findings should also be used as a basis for grant reprogramming. Senior GHI policy makers should attend public meetings in different population centres of the country to provide information and receive feedback and input to and from current and potential implementers and other stakeholders.

Service delivery

It is widely acknowledged that disease-specific interventions ultimately depend on primary care systems for their long-term success. AIDS, tuberculosis and malaria are intricate parts of overall public health, and cannot be addressed in isolation. Many communities - and medical facilities - suffer from lack of clean water and adequate sanitation. Cases of typhoid, cholera and bilharzias were found across many areas. This exacerbates health conditions for PLWHA, TB and malaria as well as other public health threats. Moreover, expectant mothers were reported to be unable to afford hospital birth services and/or transport to hospitals, and therefore significantly more likely to deliver at home without PMTCT services. A lack of public education on the value of PMTCT services impacted service uptake. Overcrowding and poor sanitation in densely populated slum areas multiplies vulnerability to many forms of disease, including outbreaks of tuberculosis. Positive synergies between GHI programmes and primary care settings are tied closely to meeting GHI policy targets. GHIs should fund clean water and sanitation projects for communities. GHIs should develop and implement a plan with the government to achieve universal coverage of full PMTCT services within five years, including increased public education and outreach, support for trained professional midwives, publicized free in-hospital deliveries, and free transportation for expectant mothers to medical care. Increased coordination between family planning and HIV/AIDS programmes is needed. GHIs should support increased services that are responsive to the needs of people living with physical disabilities, and fund transportation and renovation to increase

accessibility of health facilities. Slum upgrade programmes urgently require expansion; GHI resources should be used, along with existing programmes, to provide adequate shelter for families, and incorporate disease control in their planning design and implementation to reduce incidence of TB, cholera and other diseases.

The national response to OVCs should be expanded with GHI resources; GHIs should negotiate operating agreements with medical providers, and provide health insurance cards to OVCs attesting that GHIs will reimburse necessary medical care. Greater social and economic support is needed for family caregivers taking care of OVCs. GHIs should support increased access to the highest standard of care for children with HIV, including increased coverage of generic pediatric formulations of anti-AIDS medications. Programmes that pay levies relating to basic education should be expanded and supported with GHI funds; simultaneously, funding should support a national transition over time to move away from imposition of user fees for essential health and education services. Finally, GHIs should invest in community networks in urban, peri-urban and rural areas that provide safety nets for vulnerable youth and children including recreational centres with arts and sports programmes, life skills education and income generating activities.

Prevention efforts should take a comprehensive and holistic approach, tackling structural issues that drive increased risk of disease. For example, GHI-sponsored efforts like the Partnership for an HIV-Free Generation should include a major new focus on efforts to address the structural causes of disease such as poverty, stigma, gender-based violence and poor education and enforcement of economic and other human rights. GHIs should fund establishment of gender violence prevention and recovery centres at the community level and strengthen existing community initiatives. GHIs should increase support for income generating projects and socioeconomic empowerment programmes including sustainable local agriculture for PLWHAs and OVCs and their families and communities. GHIs should fund comprehensive in-patient and outpatient drug treatment rehabilitation programmes, and support availability of clean injection equipment to keep active drugs users safe and in communication with health workers until they are willing to be enrolled in drug treatment programmes. GHIs should support the establishment of a 'community human rights corps' in every region of grassroots educators, based out of existing grassroots human rights and prevention organizations where possible, who are adequately compensated to work full-time providing education and advocacy services such as: educating health providers and the public on the human right to health in general, and the specific services patients should expect and demand; monitoring the status of new widows and involving local authorities in protecting inheritance and property rights; monitoring other threats against full enjoyment of economic and human rights; educating men, families, youth and community groups to promote gender equality and protect against violence and exploitation of women and children; and educating and training vulnerable populations on economic empowerment and microfinance opportunities.

Finally, health systems should be strengthened in order to scale up the response to TB and malaria in Kenya, specifically through using GHI funds to implement an aggressive, comprehensive plan of action to fully control malaria in the country in the next 10 years, with greatly scaled-up treatment and prevention, indoor and outdoor mosquito control, and distribution of insecticide treated bednets and window screens to all Kenyan residents of all ages. GHIs should fund increased coverage with more effective combination ACT malaria therapies and should train CHWs to conduct indoor residual spray programmes with cost effective off-patent insecticides. GHIs should support the government to train professional health workers and provide MDR-TB medication at all national, provincial and district hospitals. In addition, GHIs should fund regular disease surveys and education programmes to increase awareness of tuberculosis control among the public as well as all cadre of professional and community health workers. GHIs should upgrade more facilities to ensure effective TB control, including support for the purchase and maintenance of medical equipment and supplies.

Malawi: Maximizing positive synergies between health systems and Global Health Initiatives

Civil society findings from Malawi

Tchaka Ndhlovu and Lot Nyirenda²¹

Abstract

Global Health Initiatives (GHIs) are indispensable in countries such as Malawi, where there is a heavy disease burden and less than 10% of health centres are able to deliver the basic package of essential health services. This study was conducted to identify successful strategies for strengthening health systems while achieving disease specific outcomes through GHIs with a particular focus on strengthening the role of civil society. Data were collected during semi-structured interviews and focus group discussions among civil society stakeholders at the primary, secondary, and tertiary levels of the health care system. The study found that GHIs have been successful in addressing priority diseases in Malawi, increasing coverage of antiretroviral therapy (ART), voluntary counselling and testing (VCT), and prevention of mother-to-child transmission (PMTCT), for example. GHIs have also helped to strengthen the health system, contributing to the recruitment, training, and retention of health workers and increasing the availability of essential medicines, supplies, and equipment. However, GHIs have not been fully optimized due to operational challenges such as insufficient and/or unpredictable funding flows, difficulties among civil society organizations (CSOs) in applying for funds, and potential conflicts of interest among grant recipients. Increased efficiencies and resources are needed to address structural problems such as weak supply chains, poor transportation infrastructure, and the shortage of health care workers.

1.0 Background

Malawians suffer a heavy disease burden against a background of poverty, particularly among rural communities. The poor are particularly disadvantaged when accessing health care due to geographical isolation, economic barriers, and weak health systems. As a consequence, the health indicators in Malawi are poor (see Table 1). Less than half of the country's workforce is employed, and the average monthly income is US\$ 35. The poor rely on subsistence farming, which is vulnerable to climate. Nutritional insecurity is common, exacerbated by the HIV/AIDS pandemic. While most Malawians have access to safe drinking water, constraints remain on access to basic education and health care.

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The public sector is the largest provider of health services in Malawi, operating at primary, secondary and tertiary levels; however a recent assessment revealed that “less than 10% of health centres in Malawi are capable of delivering the [Essential Health Package] due to the poor state of infrastructure and critical shortages of staff” [1]. The health system in Malawi also includes non-professional health workers functioning at the community level, including Health Surveillance Assistants (HSAs) and community volunteers. Several major non-profit organizations are also delivering services in the health system, such as the Christian Health Association of Malawi (CHAM), which is responsible for 35% of services delivered in the formal health sector [1].

GHIs such as the Global Fund and PEPFAR have responded with funding to priority diseases such as HIV. GHIs have the ability to mobilise huge amounts of resources within a short period of time, and to address priority diseases in a manner that responds to health systems weaknesses as well. Global attention and resources devoted to disease-specific health initiatives create opportunities for successful strategies to strengthen health systems while achieving disease specific outcomes. This study set out to understand how positive synergies between GHIs and health systems can be maximized in Malawi. To achieve this, we focused on each level of the health care system: primary, secondary and tertiary.

1.1 Study Objectives

1. To build the evidence base regarding the interactions between GHIs and the national health system.
2. To identify best practices for maximizing positive synergies between investments in and outcomes for disease-specific programmes and health systems strengthening.

2.0 Methodology

The study used a cross sectional, qualitative design; data were collected during semi-structured interviews and focus group discussions.

2.1 Setting

The study was implemented in two districts from each of the three regions of Malawi: Phalombe and Blantyre districts from the Southern Region, Lilongwe and Kasungu districts from the Centre, and Mzimba and Rumphi from the North. Selection of study districts was influenced by multiple factors including: the presence of community based organizations (CBOs) and support groups for people living with HIV/AIDS (PLWHA), disease burden, and the availability of referral hospitals. The data collection took place from January to March 2009.

2.2 Training and team composition

A research team comprising eleven members was formed, led by REACH Trust. One member was drawn from the National Organisation of Nurses and Midwives, one from the National Association of People Living with HIV/AIDS, and one from the Malawi Health Equity Network. This composition allowed different perspectives to emerge during the analysis and interpretation of the data. The team was trained for three days and later split into two groups. Data collection was followed by a debriefing meeting where research teams shared field experiences and compared findings.

2.3 Sampling

Purposive sampling was used to recruit participants. In-depth interviews were held with civil society members, PLWHA, traditional leaders, government officials and health workers. Focus group discussions (FGDs) were conducted with PLWHA, CBO volunteers and health workers. For purposes of planning, the study team made a deliberate effort to include male and female respondents and set out to conduct at least seven FGDs with CBO volunteers and PLWHA from each district. Sample size was otherwise determined by conducting FGDs and in-depth interviews until a point of saturation was reached where no new information was generated.

2.4 Data collection

Data collection tools included FGDs and in-depth, semi-structured interviews using a standardized questionnaire developed and validated by the civil society consortium for the Positive Synergies project. Questionnaire topics include the effects of GHIs on multiple aspects of the health system, the roles and contributions of civil society, and health care priorities of the respondent and his/her community. The Malawi team adapted the questions to the local context. For instance, to enhance understanding by respondents, especially community volunteers and PLWHA, the team presented questions about the Global Fund through the activities of the National AIDS Commission (NAC), since in Malawi, most funds from Global Fund grants are channelled through the NAC.

2.5 Data analysis

The research team coded the data and identified themes and sub themes as well as areas of contradiction among respondents. Data analysis was ongoing throughout the study. A debriefing meeting was held immediately after data collection was complete. Three meetings were held to disseminate findings, which also served as data validation workshops. The first two workshops were attended by members of civil society. The last meeting included stakeholders outwith civil society, such as government officials from the Ministry of Health (MOH), donor organisations such as the UK Department for International Development (DFID), and WHO Malawi staff, as well as members of civil society. The meetings provided different perspectives, clarified results and suggested areas for further investigation.

3.0 Results

3.1 Sample demographics

Most respondents were female. For example, amongst PLWHA and CBO volunteers, females composed 62% of respondents. A total of 41 FGDs were conducted with PLWHA, CBO volunteers, HSAs and nurses. One hundred and twenty-two in-depth interviews were conducted with health professionals, HSAs, government officials and members of civil society (Table 1). Age range for respondents was 20-65, with most PLWHA and CBO volunteer respondents being small-scale farmers.

Table 1: Respondents in FGDs and In-depth interviews

FGDs conducted (average of 8 respondents per group)	
Category of respondents	Number of FGDs
People living with HIV/AIDS	23
CBO volunteers	8
Health Surveillance Assistants	4
Nurses	6
Total Respondents in all FGDs.: 451	Total FGDs:: 41
In-depth interviews conducted	
Category of respondents	Number of in-depth interviews
Health professionals*	70
Health Surveillance Assistants	32
Government/District Assembly Officials	8
Civil Society Officials	12
Respondents in all in-depth interviews	122
Total number of all respondents in FGDs and in-depth interviews	573

* Professional health workers include all formally trained health workers excluding HSAs, auxiliary nurses, patient attendants, hospital administrators and other support staff.

3.2 GHI impact on key components of the health system

3.2.1 Health workforce

In the area of the health workforce, respondents perceived that GHI funding had increased training opportunities for non-professional and professional health workers, especially in delivery of ART. However, these training opportunities, funded with grants from the Global Fund, were reported to favour health workers in urban facilities and those working at the headquarters of the MOH.

The Round 5 Global Fund grant has been used to fund a portion of Malawi's Emergency Human Resources for Health Plan, including a 52% salary increase for professional health workers and expansion of student hostels at the University of Malawi's Colleges of Medicine and Nursing. These investments were reported to have had a positive impact on overall health worker production and retention. However, respondents also indicated that nurses were displeased by the salary incentives, as they were extended equally for auxiliary nurses as well as nurses, although auxiliary nurses are not professionally trained.

Most workers reported receiving short-term trainings and post-basic training as part of career development; the majority of workers described HIV service components as being funded by the

Global Fund and PEPFAR. The bulk of health personnel reported that in-service training was irregular.

Every health worker reported that staffing levels were inadequate. A majority of health workers interviewed [2] stated that they could provide better services if they were provided with more equipment and supplies, adequate staffing levels, better salaries and more physical space. Some health workers said that the nursing department had the major shortage in staffing levels; other professional health workers perceived that their own cadres were suffering the brunt of staffing shortages.

One research team member, a nurse, delivered a baby at a health facility where she was conducting her interviews—a dramatic testament to the severity of staffing shortages. At the time of her visit, there was only one nurse at the hospital who could not cope with a full labour ward. As noted by an official from the Nurses Organisation of Malawi during a workshop to disseminate and discuss findings: “The vacancy rate for nurses is 76% in Malawi. How do you expect one elderly nurse to supervise 1000 patients at Kamuzu Central Hospital at night?”

Another general observation was that rural health centres with vast catchment areas were served by just one or two health workers. One medical doctor at a health referral hospital observed that, “It is risky to work at this facility due to a shortage of staff and equipment. There is need to increase the number of staff at least by half the number that is [currently] available.”

It was reported that there is a high staff turnover in the majority of health facilities that researchers visited. Most health workers, however, mentioned that staff turnover was not as acute as in recent years. This supports the findings of a recent study conducted by the Nurses Organization of Malawi that showed a downward trend in migration of health workers, especially nurses, to other countries [3]. Health workers cited financial incentives as the main reason for the reduction of staffing turnover. In the past, most health workers migrated to other countries or facilities due to poor salaries and working environment. It was also highlighted during the dissemination workshops that most health workers leaving the public health sector join the NGO sector, including NGOs funded by GHIs. Stakeholders viewed this “internal brain drain” as a negative impact of GHIs on the health workforce.

Resources from the Global Fund have also been used to recruit 5469 new HSAs—community health workers—under a contract from October 2007 to October 2011. This use of GHI funding to expand the supply of community health workers was reported to be positive. However, the HSAs recruited using GHI funding were reported to have been deployed to their posts before they were trained [4].

It was reported that the reliance of NGOs and other implementers on voluntary community health workers was leading to high turnover among that core health worker cadre. For example, most programmes implemented by CBOs and funded by the Global Fund and PEPFAR rely on community volunteers. In addition, voluntary work was reported to be less attractive to men. Other studies [5] have shown that men would rather engage in remunerative work, as breadwinners, than perform voluntary work.

3.2.2 Medical products, vaccines and technologies

Civil society respondents reported that GHI funding had improved the availability of essential medicines and supplies and equipment such as computers, vehicles and microscopes. However, health workers acknowledged that protective wear, gloves and gumboots are mostly out of stock. In worst-case scenarios, health workers 'protect' themselves using plastic bags, for example during the delivery of babies. Respondents reported widespread delays in the refilling of medical supplies due to deep-seated bureaucracy within the Central Medical Stores. Inadequate transport was also cited as undermining referrals from one level of the health system to another, especially from health centres based in rural areas to district hospitals. Respondents reported that many children die of malaria due to poor referral systems.

3.2.3 Service delivery

Respondents reported that GHIs have resulted in the scale-up of a range of services including ART, PMTCT programmes, counselling and testing, HIV prevention and treatment literacy campaigns, and provision of start-up loans for income-generating activities and nutritional supplements given to PLWHA.

Respondents perceived that GHIs had, in rare cases, resulted in the skewing of the delivery of health services towards HIV/AIDS—one example reported was the closure of some health facilities on specific days to see only ART patients.

3.2.4 Civil society

Insufficient, erratic and/or unpredictable funding provided to CBOs by GHIs was a widespread concern, and has made sustained delivery of services difficult. For example, training for community health workers has been interrupted in some cases. In another example, money from the Global Fund was partly used to pay school fees for orphans and other vulnerable children in secondary schools. In 2009, the money for school fees has been cut by more than 50%. This has led to some students being withdrawn from school due to non-payment of school fees.

Several additional challenges were identified relating to the flow of funds to country implementers, including difficult grant application procedures and unexplained delays in review of proposals. Respondents also perceived that funding decisions favoured service delivery by civil society rather than civil society advocacy. Civil society also reported that sub-grants provided by the NAC are too small, especially for CBOs. Civil society respondents were concerned that the current Global Fund grant implementation structure consolidates power with a sole primary implementing agency (or Principal Recipient) and may result in conflict of interest or corruption. For example NAC is the Principal Recipient and is also responsible for running the Secretariat through which other implementers submit their proposals for funding from the Global Fund.

Civil society respondents also reported a lack of capacity to develop proposals to GHIs, a lack of transparency in recruitment of CCM representatives from their sector, and poor communication between the NAC and civil society.

4.0 Study limitations

While we aimed to sample a group representative of the Malawi population, the results may not represent all views held. However, the qualitative approach employed allowed the research team to understand the contexts within which funding for health programmes, especially HIV programmes, takes place. The study was also prone to selection bias, as most PLWHA interviewed were members of National Association of People Living with HIV/AIDS of Malawi (NAPHAM). Due to HIV stigma, the research team was only able to interview people who were members of NAPHAM and openly living with HIV/AIDS. However, most NAPHAM support groups faced challenges similar to those faced by other CBOs in the country. Strategic bias was another constraint, as the study dealt with resources, especially financial; hence there was room for people to falsify information in anticipation of getting financial support. The team, however, explained clearly the objectives of the study to minimize that bias. Finally, the study took place within a short period of time, which might have led the research team to overlook some important findings, especially as qualitative research is an iterative process. The research team responded to the limited period of time by performing continuous analysis of the data. Given the amount of data collected and overall merits of the research design, we assume the impact of these limitations to be minimal.

5.0 Discussion and conclusion

5.1 Discussion

The study showed that the advent of GHIs has led to an increase in funding for health care, which in turn has led to an increase in quality and quantity of some health care services. Funding from the GHIs has increased the coverage of ART; in some limited cases ART scale-up was perceived as draining resources from already overstretched health systems, for example through the hiring of health workers away from public sector posts to work for GHI-funded NGOs.

However, growing ART treatment coverage was also perceived as strengthening the health care delivery system along many dimensions. It has saved the lives of health care workers, thereby maintaining the size of the health care workforce. It has also reduced the bed occupancy rate due to reduced admissions. Fewer and fewer HIV patients are admitted to public hospitals. As a result, health care workers can now devote more person-hours to equally important conditions such as child and maternal health. GHI funding was also reported as contributing to other aspects of health systems strengthening, such as more recent system-wide investment, using GHI funds, in improving professional health worker retention and funding and deploying a formally recognized cadre of non-professional health worker, the HSA.

Regarding the critical area of the health workforce, our findings indicate that simultaneous and proportionate investments by GHIs are needed in producing and retaining additional health workers in order to promote synergies between ART scale-up and health systems strengthening in Malawi. Caring for carer programmes targeting HIV-positive health workers should also be promoted and funded by GHIs; a core aspect of health systems strengthening is ensuring access to health care for health workers [6]. Selection of health workers for training should be competitive. There is also a need to adequately train HSAs recruited with Global Fund resources. Salary incentives from Global Fund resources and other donors have enabled the health sector to retain health workers. This is especially true for nurses. The drawback however is that the incentive is

small and heavily taxed. The salary incentives should be further increased, and this increase should not be taxable.

In order to retain and promote community-based health service delivery—and ensure compensation for care labour particularly among women—GHI funding should be used to pay community health workers.

One of the major challenges reported for civil society and CBOs is access to resources from the Global Fund, due to time-consuming and complicated procedures and the lack of capacity among civil society to develop technically sound proposals. To alleviate this challenge, the Global Fund should simplify its procedures and focus its communications to civil society on opportunities to use its funding mechanisms.

There is also a need for capacity building of CBOs in order to strengthen community-based elements of the national health system, for example the provision of community home-based care. CBOs also strongly suggested that funding for their activities should not be channelled through district assemblies, in order to increase transparency and streamline access to resources. Support groups working under NAPHAM suggested that their funding should be directed through NAPHAM headquarters while other CBOs suggested that, in funding matters, they should deal directly with NAC, without the involvement of the district assemblies. Malawi should increase the size of its requests to the Global Fund for grants to CBOs in order to enhance their potential for positive impact. Recruitment of an additional non-governmental Principal Recipient—especially to manage funds meant for civil society and CBOs—would enhance transparency, accountability, and performance. Finally, NAC and stakeholders should work together to improve their communications.

Funding from the Global Fund has been used to acquire equipment and other supplies. However, the health care delivery system still lacks basic equipment and materials. The Global Fund needs to invest more resources for acquisition of equipment and materials in order to strengthen the health sector. The Global Fund needs to shift its funding paradigm from short-term investment to long-term investment such as health infrastructure development.

5.2 Conclusion

GHIs are indispensable in countries such as Malawi, which are characterized by extremely weak health care delivery systems. This is especially true given the fact that GHIs have the ability to raise substantial amounts of resources within a short period of time because of their strong advocacy base. However, additional concerted efforts should be made to expand GHI investments in programmes that maximize synergies between health systems and disease specific investments, with a particular focus on strengthening the role of civil society and in investing in production and retention of health workers. Such an effort does not entail diverting funding from GHIs. On the contrary, it calls for additional GHI investments in priority areas, such as the health workforce, where health systems weaknesses are undermining disease-specific outcomes, and where resources from GHIs have the potential to deliver significant benefits in health outcomes for entire communities.

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Uganda: Civil society, Global Health Initiatives and health systems in maximizing positive synergies

Alice Kayongo²², Asia Russell²³

Abstract

Global Health Initiatives (GHIs), in particular the Global Fund and PEPFAR, have committed significant amounts of additional funding to Uganda's response to priority diseases. These increased investments have resulted in pronounced benefits. However, major weaknesses in Uganda's health system that impede access to health services and that undermine the success of disease-specific programmes have up to now not been substantially addressed with GHI funding. Using semi-structured interviews with key informants and focus group discussions we completed a qualitative assessment of civil society perspectives and roles in maximizing synergies between priority disease funding and health systems strengthening efforts, of health issues warranting increased prioritization through GHI-funded programmes, and of the impact of civil society in planning and implementation of GHI-funded programmes.

Results from data gathered by civil society research teams in four regions and six districts of Uganda indicate an urgent need to implement GHI-funded programmes in a manner that addresses chronic weaknesses in the health system—in order to improve the outcomes and impact of AIDS, tuberculosis and malaria programmes and to improve health outcomes for communities overall.

These findings provide a bottom-up assessment of the impact of GHIs on the health system, the extent to which GHI investments reflect the priorities of communities, and views as to how GHIs can better leverage civil society capacity in programme implementation, advocacy and oversight. Achieving the policy recommendations on GHI funding emanating from this study will require evidence-based civil society advocacy. Therefore, the outcomes from this project will constitute the basis for a national civil society campaign in Uganda. Civil society will apply these findings to revitalized efforts to inform and shape national and local community-led campaigns to expand the investments and improve the policies of GHIs in priority health systems strengthening areas. This will include using these outcomes to inform participation in current opportunities to impact the nature of GHI investment in Uganda, such as the ongoing Global Fund Round 9 proposal development process.

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²³ Health GAP (Global Access Project)

Background

Civil society sector

In Uganda as everywhere, civil society organizations (CSOs) are not homogenous. Their constituencies, interests, methods of work and objectives are diverse. Many of the most established CSOs engaged in health policy and service delivery are based in urban areas, with token presence in the rural countryside. The majority of CSOs in rural areas are smaller community-based organizations (CBOs) and self-help groups. The bulk of CSOs are involved in service delivery activities and relatively non-controversial areas. They are becoming stronger and more vocal in the areas of governance, accountability, democratization and human rights.

The character and role of most CSOs in Uganda is influenced by four major factors; the availability of funds and interests of donors, the space available for civil society actors given political history and the contemporary political environment, socio-economic conditions prevalent in the country, and the character and objectives of organizational leadership. The Government of Uganda increasingly involves CSOs in the processes of health policy formulation and implementation. However the selection of the CSOs that participate in these processes is random and the capacity of CSOs to have significant impact through these processes is limited.

CSOs are largely constrained by lack of funds and sufficient expertise to engage the state on technical matters. Several CSOs in the country are dependent on external donor funding and the interests of donors often determine their objectives and causes. This weakens social bases CSOs may have and can result in CSOs that are not accountable to the communities they aim to serve. Additionally they are constrained by capacity issues to comprehensively and sustainably carry out programmes in relevant sectors countrywide.

In spite of these limitations, CSOs are playing an increasingly important role in monitoring national and local programmes and expenditures at national and district levels—particularly Poverty Alleviation Funds (funds targeted for monitoring of government programmes at the district level) and health sector funds, including GHI expenditures that are channeled through the health sector.

In terms of the national response to HIV within and outside of the formal health system, CSOs have historically played a role alongside government. Early and effective civil society involvement has contributed to Uganda's successes in addressing HIV, and in establishing models for multi-stakeholder engagement in HIV treatment, prevention and care that are replicable and scalable.

Because of the relatively more substantial amounts of funding committed through the Global Fund and PEPFAR in Uganda, the existing research focusing on their systems effects, and their established multi-stakeholder governance and implementation models, we chose to focus specifically on the Global Fund and PEPFAR, and not to include additional GHIs such as the Global Alliance for Vaccination and Immunization (GAVI) in this initial assessment.

Interviewing grassroots CSOs—those who are most identified with underserved populations and ultimate beneficiaries of GHI-funded programmes—was a particular emphasis of this research. Grassroots civil society is a sub-set of the sector of civil society in Uganda that has important potential impact in stimulating demand, improving linkages between patients and health care services, and advocating for more responsive and accountable GHIs and health programmes.

Data was collected from key informants and focus group discussions in six districts (Hoima, Pader, Luwero, Kampala, Bugiri and Tororo) in four regions of Uganda (Northern, Central, Eastern and Mid-western). Tororo, Kampala, and Bugiri districts were selected on the basis that they receive substantial amounts of GHI funding, while Hoima, Luwero and Pader currently receive relatively less GHI funding, helping to create opportunities for comparison.

Features of the health system in Uganda

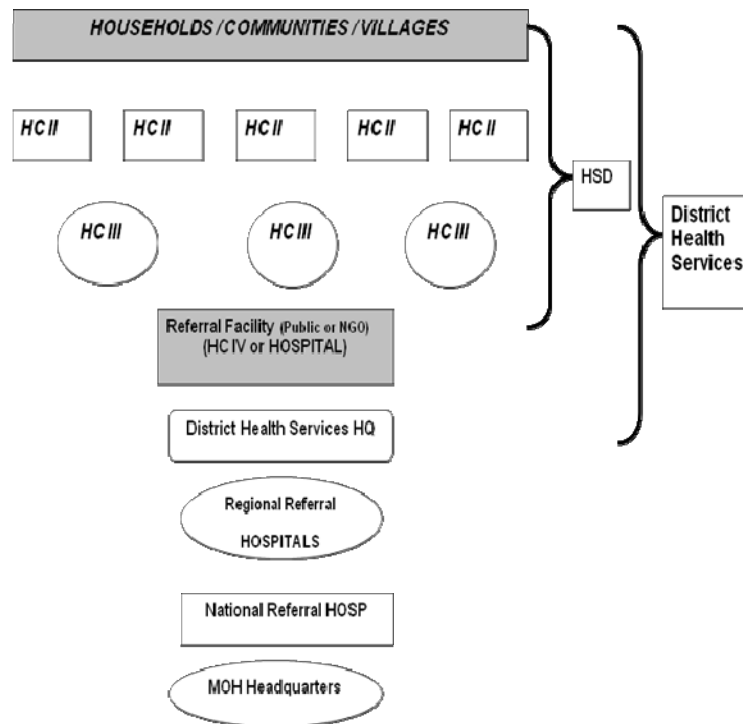
Uganda's health care is organized through: public sector, private not-for-profit (including faith-based organizations [FBOs] and mission hospitals), private medical practices, and community health workers/promoters as well as traditional and complementary medicine. The Uganda health care delivery systems took on a decentralized framework following national decentralization in 1995 (see Figure 1). This framework includes the following levels:

1. **Ministry of Health (MOH) and other national-level institutions**—functions include policy formulation, standard-setting, quality assurance, resource mobilization, capacity development, training and technical support, provision of nationally coordinated services, e.g. epidemic control, coordination of health research, monitoring and evaluation (M&E) of overall sector performance.
2. **National Referral Hospitals** (serving more than 27 million people); Of the 102 hospitals in Uganda, two are national public referral hospitals, 11 are regional, and 43 are general – totaling 56 public hospitals. Forty-two are private not-for-profit hospitals and four are private for-profit health practitioner hospitals.
3. **Regional Referral Hospitals** (serving two million people); In addition to the services offered at general hospitals (see below), regional referral hospitals should offer specialist services such as psychiatry, ear, nose and throat (ENT), radiology, pathology, ophthalmology, higher level surgical and medical services, including teaching and research.
4. **District Health Services/General hospital** (district level, serving 500,000 people): functions include; health service delivery; recruitment and management of personnel for District Health Services; passing by-laws related to health, and planning, budgeting, additional resource mobilization and allocation for health services. District Health Services are responsible for all health structures in the district except the Regional Referral Hospitals (where they exist).
5. **Health Sub-District or Health Centre IV** (county level—serving 100,000 people): This is where leadership of the Health Sub-District (HSD) is located. It is a functional subdivision of the district health system that should bring health care closer to the people, allow for the identification of local priorities, involve communities in the planning and management of health services and increase responsiveness to local

need. Its functions are primarily: provision of basic preventive, curative and rehabilitative care in the immediate catchments; provision of secondary level referral services for the HSD including life-saving medical, surgical and obstetrical emergency care such as blood transfusion, caesarean section, and other medical and surgical emergency interventions.

6. **Health Centre III** (sub-country level—serving 20,000 people): Offers continuous basic preventive, promotive and curative care and provides support supervision of the community and HC II facilities under its jurisdiction. There should be provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county.
7. **Health Centre II** (parish level—serving 5,000 people): This represents the first level of interface between the formal health sector and the communities. Health Centre II provides only ambulatory services, except in strategic locations (e.g. poor access to HC III or HC IV) where interim strategy maternity services are provided. An Enrolled Comprehensive Nurse is key to the provision of comprehensive services and for linkages with Village Health Teams (VHTs).
8. **Health Centre I** (Village Health Team—serving 1,000 people): Functions include facilitating the process of community mobilization and empowerment for health action. Each Village Health Team is comprised of 9-10 people selected by the village local council level I. One-third of VHT members must be women, to ensure their active participation in local health activities.

Figure 1 (used from presentation by Dr Francis Runumi, "The Ugandan Health System," Network-TUFH Conference 2007, Kampala)



Uganda’s health policy is operationalized through the Health Sector Strategic Plan (HSSP), which identifies problems and weaknesses within the health sector, and outlines solutions to address these. However, implementation is constrained by major inadequacies, mostly in resources. A majority of health centres do not provide the level of care articulated in this idealized health system structure. This is due to a combination of factors, for example resource constraints, inadequate human resources for health and poor infrastructure. Other challenges include:

- Inadequate health work force in terms of numbers and skills at all levels of service delivery;
- Leadership, management, specialist and other important skills are in short supply at all levels of health service delivery. Capacity building is curtailed by high levels of health worker attrition;
- A low health sector budget leaves many goals unfulfilled, health worker posts unfilled, and quality plans unimplemented;
- Low investment in training; poor recruitment and retention of staff; inequitable deployment of staff; rising out-migration of health workers; demoralization due to work overload is common primarily due to restrictions on recruitment and low salary packages. .

Objectives and Methodology

The governance structures of the GHIs researched in this study typically require meaningful involvement of civil society at the national and global levels. Therefore the expansion of these initiatives has provided significant opportunities for civil society to impact on the development of health policy and priorities, programme implementation, national and global accountability, and monitoring and evaluation (M&E).

This civil society-led research project in six districts in Uganda was carried out as part of a WHO-supported project on maximizing positive synergies (MPS) between global health initiatives and health systems strengthening. Civil society research teams administered questionnaires and completed analysis of qualitative data using a standard methodology in four countries (Zambia, Malawi, Uganda and Kenya).

The research questions developed for this research project aim to determine the following:

- The right roles for civil society in optimizing positive synergies between global health initiatives and country health systems, in order to capitalize on positive synergies and minimize negative impacts;
- How civil society's participation has influenced the interface between global health initiatives and health systems, and the benefits of this influence; and
- In what ways civil society has impacted global health initiatives in order to increase their responsiveness to country needs.

Although these overall research objectives were common to each country, in Uganda particular contextual considerations regarding the GHIs were also explored. These include:

- The impact on civil society of the 2005 suspension of a Round 1 Global Fund HIV grant due to allegations of corruption and mismanagement by government and non-government actors; the termination of Global Fund Round 2 tuberculosis and malaria grants in 2006 due to poor performance following from the Round 1 suspension, and subsequent attempts to prosecute cases of alleged wrongdoing and to recover stolen funds;
- The impact on civil society of recent changes to national GHI governance and funding structures, such as restructuring of the country coordinating mechanism (CCM) and the establishment of the Civil Society Fund (CSF). The CSF is designed to channel GHI and bilateral donor funding earmarked for programmes implemented by civil society.

Study design and personnel

The study employed qualitative data collection methods using a standardized questionnaire administered through focus group discussions and key informant interviews. The study collected information about positive and negative effects of GHIs in Uganda, how GHIs could interact more effectively with civil society, civil society impact on GHI-funded programmes, and the health systems strengthening priorities that GHIs should address.

We used 18 data collectors and 2 data entry personnel. All were Ugandan nationals. The site survey manager was a Ugandan public health specialist with a social work background, experienced in carrying out qualitative data collection in the health sector in Uganda. The data collection team was comprised of social workers and grassroots experts including people living with HIV (PLWHA). They were paired in teams of two to ensure quality data collection. Commencement of research was preceded by training in Kampala in the use of the survey tool, the context for the research project, and the nature and type of GHIs to be studied.

Selection criteria

At district level, health professionals were sampled from all levels of the health system. Nongovernmental organization (NGO) and CBO implementers, health advocates and policy makers were purposively selected based on their prior interaction with GHI-funded programmes. Government officials were sampled from relevant local government departments including social services, health and finance departments. Community health workers (CHWs) were sampled based on NGO, CBO and government facilities they were attached to. Emphasis was placed on recruitment and participation of local and grassroots civil society representatives.

Sample size

124 key informant interviews and 14 focus group discussions were conducted to obtain data. Data was collected from 42 health facilities including public, private and mission facilities (key informant and focus group discussion conducted); 50 NGOs and CBOs (including key informant and focus group discussion); 15 advocates who were either independent or attached to an institution; 28 policy makers at national and district levels; and three planners.

Data management

Interviews were conducted in pairs to ensure quality data collection. Data entry was independently carried out by two different people to ensure quality control, while content analysis of the data was conducted from the beginning and throughout the study.

Ethical considerations

Opinions were collected from respondents and information gathered was confidential, therefore participation conferred no risks for informants. There was adherence to the laws of data collection in Uganda. Approval of this study was obtained from the Uganda National Council of Science and Technology. Consent forms were designed to inform respondents about possible risks and benefits of participation, time involvement, use of information to be obtained and subject rights. These consent forms were signed by respondents where they agreed to the content.

Interviews were conducted with key informants including: health advocates and policy makers, government officials, GHI representatives, NGO and CBO implementers, community health workers, professional health workers, and CCM representatives. Government officials included District Health Officers, District HIV, malaria and tuberculosis focal persons, District Chief Accounting Officers, District Hospital Administrators, Parliamentarians, health officers at the Ministry of Finance, and MOH officials.

Data collection was supplemented by reviews of relevant documents including approved Global Fund grant proposals, grant performance reports, Global Fund disbursement requests, reports from the Office of the Inspector General of the Global Fund, and PEPFAR Country Operations Plans and Uganda country reports.

Results

Civil society has observed significant positive effects from GHI-funded efforts to scale-up the response to HIV, tuberculosis and malaria. These effects included increased availability of essential services such as HIV testing and treatment, decreased sickness and death, increased availability of essential commodities such as antiretroviral medicines (ARVs), increased training opportunities for health workers, increased resources to address health priorities and an overwhelming demand for those resources.

Reported negative effects ranged from direct effects caused by additional resources to indirect effects emanating from existing system weaknesses that were exposed or exacerbated by efforts to scale-up. These include poor management of GHI funding, poor coordination with local priority setting processes, corruption and diversion of funds, unexplained and sudden interruptions and delays in disbursement of Global Fund funding, closure of beneficial GHI programmes, increased workload on an already overstretched health workforce, interruptions in essential commodities, such as medicines for opportunistic infections (OIs), the perception that government has 'stepped back' because of the increased availability of external resources, the perception that civil society with expertise and commitment had been bypassed in favor of 'briefcase NGOs' without competence or a track record in service provision in a given district.

"People are on treatment, in a way it has helped strengthen health systems, because we have improved labs, monitoring systems, and we are recruiting more staff. It has improved family based support; it has reduced stigma and improved the productivity of society. But there is lack of coordination—that is you find one district with a clinic with a ton of medicines, and another with nothing. There are too many conditions, administering the funding takes up so much time, and the accountability requirements people don't necessarily know how to meet. There has also been corruption."

-PWA activist and NGO employee, Kampala District

At district and village levels, civil society reported inadequate opportunities to impact priority setting and GHI proposal development. While there is some passive information sharing about the existence of GHI funding opportunities, there is insufficient support, such as basic capacity building for proposal writing and grant management, to translate that awareness into action.

CSOs play a critical role in Uganda in implementing care, support, and prevention programmes at all levels of the health system. As a complement to government, respondents emphasized that civil society has greater awareness of health needs of communities at the grassroots level and displays a high degree of commitment in delivery of preventative and curative services. Respondents also reported CSO gaps in capacity such as in proposal writing, M&E and programme oversight that have resulted in weaknesses in programme implementation.

The urgent need for additional health workers including doctors, nurses, lab technicians and pharmacists, as well as community health workers, was overwhelmingly cited as a priority that should be addressed with GHI-funded programmes. Increased remuneration for health workers, improved health worker housing, and the need for improved health facility infrastructure such as the provision of electricity, safe water, and sufficient space were consistently reported as health

system weaknesses that are undermining the impact of GHI-funded programmes. Lack of equipment such as x-ray machines, CD4 count machines, and other essential laboratory equipment were routinely reported as priorities GHI-funded programmes should address.

“There needs to be funding for training of more staff, and producing more staff and recruitment. There needs to be more infrastructure. The rooms are small, even the medical store. We don’t have a laboratory room, we are improvising. The health centres should have a good referral system. We don’t have a good communication and referral system network—a person in obstructed labor, she can’t be referred. There is no mortuary in the whole of Pader. There is no water source for the health centres; we don’t have lights!”

—Focus group discussion with CHWs and nurses, Pader District

“There are supposed to be four enrolled nurses at this health center IV but there is only one. The doctor has not started yet, and the former doctor was here only twice a week from morning until mid-day but he was supposed to be a resident doctor. We are a Health Center IV. We need more than this.”

—Nurse, Health Center IV, Nankhoma, Bugiri District

Although GHI funding has invested significant amounts of funding in procurement of essential medicines in Uganda, respondents highlights weaknesses in procurement and supply chain management that still result in stock-outs, procurement of unnecessary medicines or medicines that are about to expire.

Health priorities associated with primary health care initiatives, such as providing access to water and sanitation and nutrition were consistently cited as an important area for investment by GHIs. This funding would have the effect of strengthening priority disease programmes while benefiting larger communities.

Other priority diseases and conditions respondents felt GHIs should invest in included neglected tropical diseases such as sleeping sickness, elephantitis, schistosomiasis, onchocerciasis; outbreaks of cholera and hepatitis E and other infectious diseases, non-communicable diseases such as diabetes; and other conditions such as cervical cancer.

Among respondents in Kampala, civil society was reported to have had some impact on the implementation structure, planning and oversight of GHIs in Uganda, for example through their work on the Global Fund CCM. However, outside of Kampala, respondents reported that civil society’s impact on all levels of GHI-funded programme implementation has been minimal.

“I think the most obvious result (of civil society involvement) is that there is an open policy dialogue. On how to spend money, on the distribution of resources, that is a major achievement. People are seated at the table—of course it needs to be exploited and taken advantage of but that's huge in itself.”

—Ministry of Health official, Kampala District

Discussion

Civil society has a significant capacity to impact the planning and implementation of GHIs, in order to ensure rapid scale-up of quality programmes, increase accountability in implementation to community priorities, and to strengthen community ownership over programmes. However this capacity has not been sufficiently leveraged in Uganda. This is due to several general factors such as technical weaknesses and gaps in areas such as grant administration and proposal writing. However, many respondents described demoralization among civil society at the national and local levels once corruption and mismanagement were uncovered in Global Fund-funded programmes, which has contributed to cynicism and reluctance to renew involvement.

In the case of the Global Fund, this has likely contributed both to civil society's relatively limited engagement in GHI governance as well as the poor performance of Global Fund supported programmes—at current writing, the Global Fund is disbursing only minimal amounts of funding to Uganda due to ongoing implementation issues. However respondents felt that stronger public independent civil society outcry over this situation is needed for resolution.

This research also revealed disconnects between investments of the GHIs and the priorities identified by the grassroots—for example, despite the universally cited need for additional health workers and for health worker salary increases, GHI programmes in Uganda are not yet in any substantial way investing in these areas.

Although health commitments have been increasing over the past five years, there is urgent need for additional funding from GHIs, as well as increased investments from the Government of Uganda in response to the priority diseases and health systems strengthening.

Conclusions and recommendations

The approach of purposefully maximizing synergies between priority disease initiatives and efforts to scale-up access to comprehensive primary health care services holds promise as a model for effective health development financing. Enhancing the synergies between priority disease-specific outcomes and improvements in health outcomes overall is critical to achieving existing global commitments, such as the Millennium Development Goals (MDGs).

GHIs are delivering tangible benefits but there are significant missed opportunities for positive synergies between GHIs and health systems strengthening. Given civil society's experience in identifying health priorities and advocating based on community needs, civil society must play a significant role in leveraging those opportunities. Recommendations based on the findings of this research include:

Addressing health system priorities

Addressing the well-established weaknesses of health systems in Uganda should become a significant aspect of all new GHI requests. Opportunities to reprogramme existing grants should also be explored in order to improve performance and impact. These priorities include:

- Improving retention, increasing production, increasing salary support, and ensuring equitable deployment of professional and non-professional health workers, in order to reach minimum target concentrations of health workers needed to achieve basic health outcomes;
- Equipping community health workers with ongoing on-site training and materials needed to perform a range of essential health promoting as well as preventative, curative and supportive services that respond to the health needs of communities; GHI funding should also be used to pay community health workers in order to reduce turnover and increase motivation and credibility within their communities;
- Increasing the capacity and reliability of procurement and supply chain management systems to reduce stock outs, needless expiration of medicines, and to ensure regular supplies of relevant medicines and equipment;
- Rehabilitating and improving infrastructure of all health facilities for example through ensuring access to safe water and electricity and expanding physical space; and
- Increasing equity in access to services by expanding coverage in rural and underserved areas through the creation of equipped mobile health clinics and the creation of reliable referral networks and transportation between health facilities.

Programme planning and monitoring

At the national level, GHIs should significantly alter their planning processes and communication structures, to ensure a meaningful degree of civil society involvement and consultation at all stages of proposal preparation and programme implementation. Once GHI funding is approved, regular and transparent flow of information about the size of programme budgets and programme results must be communicated to CSOs at local, district and national levels, as well as to the public in general, in order to facilitate appropriate programme monitoring, oversight and advocacy. This process should not rely only on CSOs that are already engaged in service delivery or monitoring efforts, but should include relevant additional CSO stakeholders.

Civil society involvement

Implementation of GHI-funded programmes in Uganda should rely directly on civil society, for example through establishment of a civil society Principal Recipient. Implementation structures that create excessive bureaucracy and delays should be eliminated. In addition, civil society capacity to deliver services, assess grassroots health priorities, write proposals, and monitor the impact and results of programmes should be strengthened through direct GHI funding.

Addressing basic health and social priorities

Access to food, the need for safe water and sanitation, access to education, and access to housing are all fundamental priorities that directly affect communities heavily impacted by HIV, tuberculosis and malaria. Addressing these priorities should be integrated into requests for GHI funding, in order to maximize positive synergies.

Zambia: Civil society perspectives on maximizing positive Synergies between health systems and Global Health Initiatives

The Treatment Advocacy & Literacy Campaign (TALC), Lusaka²⁴

Introduction

Zambia faces the dual burdens of poor health indicators and a weak health system. The country is home to some of the highest rates of infant and maternal mortality, and its HIV prevalence rate ranks among the highest in the world. Meanwhile, access to health services is severely limited, especially in rural areas, due to the lack of health facilities and a crippling shortage of health care workers. Zambia has benefited from a large influx of donor assistance for health, generating marked progress in areas such as access to antiretrovirals (ARVs), infant mortality, and malaria morbidity and mortality. Yet ongoing health challenges demand additional resources and greater impact from existing funds. This paper summarizes the key findings of a research study designed to assess the impacts of external financing provided through Global Health Initiatives (GHIs), specifically the Global Fund and PEPFAR, on Zambia's health system. The study focuses on civil society perspectives on GHIs and the health system, including the roles that civil society stakeholders play in maximizing positive synergies between the two.

1. Background and context

Zambia is a country with a high disease burden compounded by high poverty rates. Health services are offered by public, mission-based, private, and nongovernmental providers as well as by traditional healers. The government of Zambia operates health facilities at the national, provincial, and district levels. According to the Ministry of Health (MOH), Zambia's poor health indicators are exacerbated by a severe shortage of health care workers, inadequate funding, lack of geographic coverage, and crumbling health facilities and equipment, among other factors [1].

Currently, donor funds constitute 50 % of health expenditures. Much of these resources flow through a number of GHIs operating in Zambia, including public-private partnerships such as the Global Fund and the Global Alliance for Vaccines and Immunization (GAVI); bilateral programmes such as PEPFAR; and private foundations such as the Bill and Melinda Gates Foundation. GHIs have made significant contributions of financial and technical support to the Zambian health system (see Table 2). However, there are reasons to believe that GHIs have not yet achieved their full potential in addressing key health systems constraints.

²⁴ The preparation of this report was led by Felix Mwanza, Programmes Manager, TALC.

2. Study objectives

The purpose of the study is to engage civil society experts and stakeholders in Zambia to examine the relationships, both positive and negative, between GHIs and health systems. The study aims to address the following questions:

1. What are the key civil society perspectives on the relationship between health systems and GHIs?
2. What recommendations can be made for maximizing positive synergies between health systems and GHIs, including with respect to the contributions of civil society?

3. Study design and methodology

Data was collected through a series of key informant interviews and semi-structured focus groups using a standard set of questions developed by the Civil Society Consortium of the World Health Organization (WHO)-led initiative, Maximizing Positive Synergies (MPS) between health systems and Global Health Initiatives. Interviews and focus group discussions were conducted in English, Lozi, and Bemba.

In order to obtain informed consent for participation, all survey participants received an explanation about the research project, an overview regarding the questionnaire, and information regarding how the data would be used. In addition, participants were advised about the confidentiality of their interview/focus group participation and that information provided by individual research participants would be kept confidential, unless appropriate permission were obtained. Finally researchers sought verbal permission to make written notes of interviews/focus group discussions.

The study was carried out in four of Zambia's nine provinces, covering a total of 15 districts: Lusaka and Kafue districts in Lusaka province; Kaoma, Mongu, and Senanga districts in the Western province; Kapiri Mposhi and Kabwe in Central province; and Ndola, Kitwe, Mufulira, Chingola, Chililabombwe, Luanshya and Masaiti in the Copperbelt province. The provinces were chosen in order to obtain a representative sampling of respondents from both rural and urban areas. In addition, the four selected provinces reflect the country's highest HIV prevalence rates, ranging from 15% in the largely rural Western province to 21% in Lusaka province [2].

The majority of survey respondents were civil society stakeholders engaged in AIDS-related service delivery, education, and advocacy. A range of civil society perspectives was sought; respondents included people working at the grassroots, community-based, regional and national levels. Participant types consisted of patient groups (people living with HIV, survivors of tuberculosis and malaria), volunteers, paid and unpaid community health workers, social workers, faith-based organizations (FBOs), civil society organization (CSO) staff, and professional health workers.

In order to obtain a complete picture of the relationships between GHIs and health systems, both governmental and nongovernmental recipients/implementers of GHI funding were included in the survey. These included district-level representatives (health workers and administrators) of the MOH, sub-and sub-sub-recipients of Global Fund and PEPFAR funding. In addition, semi-structured interviews were conducted with national-level governmental representatives and

technical agencies that participate in policy framing, decision making, and implementation, including members of the donor community, the MOH, the National AIDS Council, and the WHO.

Finally, the research team reviewed relevant policy and planning documents including:

- National AIDS Strategic Framework 2006 - 2010
- Midterm Health Strategic Plan Evaluation
- Fifth National Development Plan
- National AIDS Council Strategic Plan
- Joint Assistance Agreement for Zambia
- National Compact for the International Health Partnership and Related Initiatives (IHP+)
- National Budget
- Global Fund grants, disbursement reports, grant score cards
- PEPFAR country operation plans and country reports

5. Results

GHIs have generated positive disease-specific outcomes, easing the burden on the health system and strengthening health care infrastructure

Respondents credited GHIs with improving the health of people in Zambia. For instance, the significant investments in HIV have contributed to increasing the number of people accessing treatment from a mere 5000 in 2004 to well over 200 000 in 2008. The HIV prevalence is reported to be declining from a high of 17.5% in 2006 to 14.3% in 2008, a possible indication that existing prevention interventions are effective, including efforts to delay sexual debut among young people and to discourage early marriages, intergenerational sex, and multiple concurrent sexual partners. There are equally significant improvements in reducing under-five mortality rates, as well as declines in malaria morbidity and mortality [3].

GHIs have also made contributions to improving the health infrastructure and capacity of health care workers. For example, the Zambia Prevention Care and Treatment Partnership (ZPCT) and the Centre for Infectious Disease Research in Zambia (CIDRZ), both United States Agency for International Development (USAID)-funded projects, not only implement activities but also ensure that they procure equipment such as CD4 count machines, necessary medicines such as ARVs and reagents for various tests in clinics. They have also contributed to the renovation of selected laboratories in the health facilities in which they work, and they train staff in various technical areas including prevention of mother-to-child transmission (PMTCT), paediatric HIV treatment, tuberculosis treatment and others. Renovations of a laboratory, for instance, and skills building for staff were reported to have an overall positive effect on health system strengthening as it enhances people's well being.

GHI-funded programmes have resulted in these important achievements, which have an indirect effect of strengthening the overall health system. For instance, successfully treating people living with HIV/AIDS (PLWHA) and those with malaria indirectly reduces the number of people that would require health services, since they will experience fewer opportunistic infections, decongesting health facilities to provide services to other people [4].

Zambia's most recent Global Fund proposal focuses on health systems strengthening priorities, particularly the country's need for additional health workers. While it is still too early for this Round 8 grant to show results, this new investment represents an important opportunity for GHI funding to be used in a way that strengthens overall health systems.

GHIs have not been fully leveraged to strengthen health systems

Although GHIs have indeed generated positive outcomes including with respect to health systems strengthening, a number of factors indicate that they have not been fully leveraged toward this end. In general, respondents do not perceive GHIs as a resource for helping to overcome the infrastructure and human resource challenges that the health sector is facing.

Across the board, this is in part the result of a lack of easily accessible information about GHIs.

Hence, GHIs' contributions to health systems strengthening may not be visible, even if they have explicit strategies targeting health systems, as do the Global Fund and PEPFAR. Many respondents, especially at the grassroots and community levels, reported having very limited knowledge about the Global Fund and PEPFAR and virtually no specific knowledge about how GHIs operate and what services and activities they fund. In addition, many were not aware of the source of funding for various health services/programmes in their community. Similarly, respondents from the MOH said that since large amounts of GHI funding are channelled through NGOs, it is difficult to estimate the overall health financing in the country. Focus group participants consistently stated a need for more transparency and oversight in order to monitor expenditures at the national and district levels, inform the public about how money is being spent, and evaluate the people-level impact on health.

In addition to a perceived lack of information, civil society respondents also cited a lack of coordination among organizations that receive and use Global Fund money. While participants appreciated the networking among the government line ministries and NGOs who are the Principle Recipients of Global Fund financing (Ministry of Finance, the MOH, the Churches Health Association of Zambia-CHAZ, and the Zambia National AIDS Network-ZNAN), they noted that there is little-to-no coordination among sub- and sub-sub-recipients. As a result it is not clear which organization is covering which HIV, tuberculosis and malaria thematic areas, which organizations are covering which geographic areas and which organizations are implementing activities responding to the special needs of different groups, such as people with disabilities. This lack of coordination may have contributed to duplication of activities by organizations, particularly in terms of geographical distribution of resources. Money may have gone persistently to the same provinces through the same organizations, rather than being more equitably distributed in order to maximise impact.

Among national government representatives and technical agencies, respondents complained that GHIs have not adhered to the principles of national alignment and harmonization. In theory,

they are guided by the Joint Assistance Strategy and the Zambia Aid Policy and Strategy of 2005, which draw heavily on the Paris Declaration for Aid Effectiveness, making them a part of the Sector Wide Approach (SWAp) to health. Respondents noted that the GHIs have not signed a memorandum of understanding with the Zambian government, which would commit them to harmonizing their support to the health sector. Similarly, the fact that some GHIs are not contributing to basket funding or on-budget earmarked funding was taken as an indication that they are not aligned with the government's costed health plan.

While government respondents cited this as a negative impact of GHIs, civil society respondents cautioned that alignment with national plans and donor harmonization do not inherently indicate broad-based country ownership. National plans do not necessarily represent civil society or community priorities, as planning processes have typically lacked transparency and participation by a representative group of stakeholders. Likewise, efforts led by external development partners and international financial institutions to coordinate and harmonize support, such as development of the health SWAp and the IHP+ compact are not perceived to be any more transparent to or welcoming of civil society perspectives.

The lack of standardized proposal processes, procurement systems and financial disbursement mechanisms among GHIs is a source of frustration among national-level policy makers and is taken as further evidence that resources are not being optimized. Even within GHIs, such as the Global Fund, multiple proposals must be submitted and separate contracts signed with differing reporting timelines and mechanisms [5].

GHIs are an important source of funding that allow CSOs to fill critical gaps in the health system

Respondents reported that civil society stakeholders and organizations at all levels have moved to fill gaps in the health system that are beyond the scope or capacity of public health institutions. Regardless of whether they receive funding from GHIs (or any external support), civil society respondents consistently articulated their roles in addressing needs that have remained unmet due to severe shortages in health care workers, chronic underfunding of the health sector, and the unique needs of marginalized and hard-to-reach populations. In addition, direct outreach at the community and household levels, peer education, and public education and awareness campaigns increase uptake of services at public health facilities. Hence, CSOs that have been able to access funds through GHIs cited the positive impact of being able to reach more people with critical information and services. For example:

- **Voluntary Counselling and Testing (VCT):** While public health institutions do provide this service, staff shortages make it impossible to do so in a comprehensive manner. CSOs conduct sensitization campaigns critical to increase uptake of VCT services, particularly at the community level and among under-served or marginalized populations such as young people, prisoners, and men who have sex with men. Additionally, community-based and mobile services equipped with well-trained counsellors and testing kits bring services as close to people as possible, especially in rural communities where people find it difficult to walk long distances to health facilities for HIV testing.

- **Home Based and Palliative Care:** These services are important to ensure the well-being and comfort of PLWHA who are bed ridden and need support from close family members and community health workers. As these services cannot be performed by the public health care system, it is a role that civil society has taken on, with support from GHIs.
- **Stigma and Discrimination Reduction Activities:** In order to scale-up coverage of HIV-related health services, there is a need to reduce stigma and discrimination that frequently deter people from doing so. Civil society organizations are better placed to carry out stigma and discrimination reduction activities at the community level. The involvement of PLWHA in these programmes has increasingly encouraged people to be more open about their HIV status. Models such as the ARV Community Education and Referral Programme implemented by the International HIV/AIDS Alliance have demonstrated that training PLWHA as Treatment Adherence Support Workers and integrating them in health facilities and ART centres not only reduces stigma but also increases the possibility of people accessing and adhering to treatment.
- **Care and Support to Orphans and Vulnerable Children (OVCs):** One of the distressing effects of HIV is its contribution to increasing the number of orphans and vulnerable children in Zambia. It is estimated that there are approximately one million children who are now OVCs. Civil society with support from GHIs such as PEPFAR and the Global Fund has taken up the challenge of providing not only nutritional, education and material support, but also health and counselling services to enable these children to live balanced and better lives.
- **Door-to-Door Sensitization:** Civil society organizations carry out sensitization activities that health facilities cannot do on a daily basis. These sensitization activities provide information to the community. People can use this information to take action and change their behaviour. These efforts also stimulate demand for essential services from the formal and informal health sector.
- **Establishing support groups for PLWHA:** GHI funding has enabled CSOs to help establish support groups for PLWHA and in some cases, provide training and capacity building to help sustain such groups.

Respondents reported that access to GHI funding, particularly for grassroots and community based groups is limited

Participants in the research commonly noted that there is a need for increased transparency in how local communities are informed about the availability of Global Fund resources. Although participants acknowledged that ZNAN and CHAZ have made efforts to inform the public about the availability of funds through print media, many complained that print media is not accessible to smaller and rural based community- and faith-based organizations. Lack of information from sub- and sub-sub-recipients is even greater, as these organizations rarely advertise the availability of funds that implementers at the grassroots level can access.

In relation to PEPFAR, most community-based respondents did not understand PEPFAR funding processes and did not know where PEPFAR offices were located in Zambia. Participants highlighted the fact that calls for funding are not open to communities at grassroots level, and there is a widespread assumption that PEPFAR funds are only available for large international NGOs that are able to create large consortia of implementing partners. Furthermore, PEPFAR is perceived to have many complex rules and regulations with limited explanation available on how to follow them.

Operational weaknesses limit capacity building and sustainability amongst CSOs

In relation to the Global Fund, participants reported inadequate and erratic funding to CSOs. For example, both CHAZ and ZNAN, the organizations providing civil society with funding to implement activities do not sign long-term contracts with sub-recipients, often opting for quarterly agreements. Participants also reported delayed disbursement of funds from Principal Recipients to implementing partners; in most cases money is delayed by up to two months in a quarter before it reaches the implementing partner. Not only does this interfere with the ability of the organizations to implement activities, it also hinders the ability of organizations to plan their activities and deliver them in a rational way.

Funders disbursing GHI resources do not fully support the administrative costs of civil society organizations. ZNAN, for instance, imposes a 15% administrative cost that also includes paying salaries for programme staff, conducting monitoring and evaluation (M&E) activities and purchasing stationery and all the necessary equipment needed by the organizations to implement activities. According to respondents, this deduction affects the quality of services that organizations can plan and implement.

According to participants, Global Fund funding was not being used in Zambia to support effective monitoring of activities by those implementing them. Since funding is often received late and M&E budgets are not directly supported, implementing partners simply spend what they receive with minimal follow-up and monitoring to learn how to change what is not working and to design new programmes based on evidence.

With respect to PEPFAR, local Zambian NGOs are often sub-recipients of funds from large international organizations. Being sub-recipients of GHI funding does not necessarily assist capacity building for local organizations, because most of the money they receive is for programme implementation rather than infrastructure development, skills upgrading, and equipment purchases that would contribute to sustaining these local organizations. In addition,

PEPFAR was seen to focus more on achieving statistical results, paying relatively less attention to the complexity of quality programme implementation that brings about sustainable change.

After discussing both the strengths and weaknesses of PEPFAR and the Global Fund, participants were asked whether they have participated in or have been able to influence change in the behaviour of these two GHIs. Respondents reported that civil society in Zambia has not yet been able to change the behaviour of these initiatives. Participants however acknowledged that during the country proposal development for the Global Fund's 8th funding Round, there was significant effort by civil society to influence how Global Fund money is managed. For example, the International HIV/AIDS Alliance and the Treatment Advocacy and Literacy Campaign (TALC) conducted consultations with civil society to contribute to developing ideas for a proposal on community systems strengthening. It is hoped that the recommendations that were made, which contributed to the Round 8 proposal and were assessed by the Global Fund Technical Review Panel as a Category One—or highest rated—proposal, will be implemented by the Principal Recipients. Critical to the recommendations were issues relating to equity of fund disbursement, taking into account geographic coverage and special groups of Zambian society.

6. Conclusion

Our findings take stock of salient emerging issues associated with the GHIs, recognizing that, while GHIs present huge opportunities for securing funding and alleviating resource constraints, they have also imposed unintended consequences on health systems and structures, as argued by officials from the Zambian government. We also found that, despite a great need in the country, GHIs had not yet been used to fully address health systems constraints in Zambia, although a recent Round 8 Global Fund grant focusing on health systems strengthening and community systems strengthening could indicate a new trend to do so.

GHIs should do more in Zambia to help strengthen the general health system by supporting infrastructure development and staff development through additional workforce production, retention, recruitment and support for remuneration.

In the same vein, civil society involvement in programme implementation at community level should be encouraged, especially in settings where public health institutions lack capacity. More accessible, transparent and accountable mechanisms from GHIs should be put in place at local, national and global levels to facilitate and catalyze such involvement. GHIs can play a significant role in helping realize shared health goals in Zambia and in supporting civil society implementers who make up a key component of the health system in Zambia.

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Conclusion: From learning to action on civil society and maximizing positive synergies

The civil society consortium's research has resulted in new learning regarding civil society's perspectives and civil society's impact on interactions between GHI-funded programmes and health systems. The next phase of activity for the research partners in the consortium is application of findings concerning positive synergies through country-led efforts to gain endorsement, adoption and implementation of civil society recommendations by the GHIs.

As learning organizations, GHIs' policies and practices at country and global levels are in flux—for the sake of research, they are 'moving targets.' For example, during the course of the maximizing positive synergies (MPS) project, the Global Fund began implementing a new funding opportunity for countries—the 'National Strategy Application' (NSA), which will eventually allow countries to request 'disease specific' Global Fund funding for an overall health sector plan. Likewise, PEPFAR is initiating its five-year 'Partnership Frameworks,' designed to increase funding predictability, while reducing some conditions associated with U.S. bilateral funding. PEPFAR is also implementing a new law requiring that it directly fund the pre-service training and hiring of 140 000 additional professional health workers. This dynamic policy environment poses exciting challenges for identifying research findings that are timely and relevant.

However, the civil society consortium country partners have pursued efforts to apply outcomes of their initial findings in real time, creating an incremental and iterative process that accelerates the interface between research findings and application to health system and GHI policy environments.

For example, findings by the Uganda research team that civil society's access to funding from the Global Fund was delayed by unnecessarily bureaucratic implementation structures contributed to a renewed effort to advocate for political space for a civil society 'Principal Recipient' alongside the existing government Principal Recipient. Pursuit of this process, in turn, created new opportunities for additional research with key informants.

And in Kenya, findings described by the research team have helped formulate a platform defining a comprehensive set of widely shared priorities for GHI investment. This platform, describing opportunities for GHIs to address wider health systems weaknesses, has been used to inform the currently ongoing update and review of the Kenya Strategic National AIDS Plan, as part of Kenya's application to the Global Fund's 'first learning wave' on NSAs.

Future Research

While outcomes from civil society partner research are illuminating, there are also important data gaps that indicate additional directions for future study.

1. More extrapolation from what works

In some countries, GHI funding has been used successfully not merely to strengthen health systems, but to implement ambitious and innovative plans that attempt to tackle significant and lasting health systems challenges, such as increasing overall professional health worker density and addressing social determinants of health such as nutrition, education, and advancing the rights of women and girls.

Such efforts are expensive and technically complex, and can trigger resistance from many actors, for example from Ministries of Finance inasmuch as they increase recurrent expenditures, e.g. for health worker salaries. What assortment of factors, including demand expressed from civil society, contributes to success in planning and implementation of such bold initiatives? How can those factors be urgently replicated in an array of environments and contexts? How can GHIs change their policies in order to help catalyze such funding requests?

2. Research in contexts of exclusion

In the four countries where initial research was conducted, civil society faces various challenges to effective advocacy, implementation, and oversight. However, minority populations within those countries, as well as civil society in general in other countries, face other more severe restrictions and exclusion—for example that faced by marginalized groups such as men who have sex with men or injecting drug users.

In many countries receiving GHI funding, HIV infection is concentrated in excluded populations, as are other priority health issues, such as multi-drug resistant tuberculosis, mental health issues, and sexually transmitted infections.

Additional civil society-designed and led research is needed in such contexts, to define innovative efforts to engage vulnerable and marginalized groups as authentic partners, as well as the policy and advocacy GHIs should be promoting in order to overcome such exclusion.

3. Refining and strengthening 'real time action learning' approaches

The civil society consortium developed and implemented a model of research in the service of action. This model features the application of preliminary findings in real time to country-level opportunities for reform of GHIs.

As an innovative approach that joins up elements of research as well as policy analysis and advocacy, it warrants further modification and refinement, particularly in varied country and regional contexts.

4. Expanding concepts of civil society involvement—from governance to partnership

Although GHIs have helped to advance new standards of civil society involvement in health service delivery and governance, constituencies focused on health systems strengthening often do not embrace a model of the health system that fully integrates civil society involvement at all stages. In particular, such constituencies often neglect community system strengthening, an undertaking that can extend and enhance the interconnectivity and complementarity of community-based health activities and those of the formal health sector. Likewise, there are many missed opportunities to value and act on the insight and input of affected communities—in advocacy, in policy formulation, and in oversight of health service delivery.

The civil society consortium has developed a conceptual framework that describes civil society functions in the health system, and inputs required for civil society success in those functions. Additional work is needed to disseminate and strengthen this model, and to challenge new health systems initiatives to build on and strengthen the minimum standard for civil society involvement that has been established by GHIs, rather than undermining or diluting it.

5. Addressing gender within the context of GHIs and health systems strengthening

Gender inequality plays a pivotal role in attainment of health—the disproportionate risk of women and girls to HIV infection illustrates this starkly. Gender inequalities often manifest themselves in unequal access to services; the concentration of women in lower-status, unpaid roles within the health workforce; and the lack of programmes and policies that address the unique needs of women, girls, and sexual minorities such as sexual and reproductive health services and programming to tackle gender-based violence. Women made up the vast majority of community health workers, volunteers, and home-based caregivers interviewed in Kenya, Malawi, Zambia and Uganda. However, more action-oriented research is needed to describe the extent and impact to which the burden of (usually unpaid) care labour and support falls on women and girls, particularly where health systems are weak. More participatory research is needed to build the evidence base and guidance for ensuring positive synergies between health systems and GHIs are exploited in order to eliminate gender inequalities in achieving the right to health.

6. Adapting the concept of “maximizing positive synergies” to accelerate progress in achieving the three health Millennium Development Goals (MDGs)

The MPS initiative seeks to build the evidence base to help resolve tensions between disease-specific and systems-wide approaches to public health. Similarly, applying the MPS model to examine the interplay within and among health priorities related to children, women, and priority diseases, can build consensus and generate guidelines for maximizing positive synergies in achieving the three health MDGs

Key Acronyms²⁵

AIDS (SIDA)	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARVs	Antiretrovirals
CBO	Community-based organization
CCM	Country coordinating mechanism
CDC	U.S. Center for Disease control
CHW	Community health worker
CSO	Civil society organization
DFID	U.K. Department for International Development
DOTS	Directly Observed Treatment, short-course
FBO	Faith-based organization
GAVI	Global Alliance for Vaccines and Immunization
GHI	Global health initiative
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
GDP	Gross domestic product
HIPC Initiative	Heavily Indebted Poor Countries Initiative
HIV	Human immunodeficiency virus
HMIS	Health management information system
IDU	Injecting drug user
ILO	International Labour Organization
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MOH	Ministry of Health
MPS	Maximizing Positive Synergies
NACP	National AIDS Control Programme

²⁵ All other abbreviations are spelled out in full in individual country case studies.

NGO	Nongovernmental organization
ODA	Official Development Assistance
OIs	Opportunistic infections
OVC	Orphans and vulnerable children
PEI	Polio Eradication Initiative
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
SWAp	Sector Wide Strategic Approach
SYSRA	Systemic Rapid Assessment Toolkit
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization
WHO NHA	WHO National Health Accounts
WHO SIS	WHO Statistical Information System (WHOSIS)
WHO WMR	WHO World Malaria Report
World Bank MAP	Multi-Country HIV/AIDS Program

