Global Health Initiatives: Context, Challenges and Opportunities, with Particular Reference to Africa

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Outline of Presentation

• Trends in burden of ill-health in the era of Primary Health Care - 1980 to 2004 – with special emphasis on Africa’s health situation
• Impact of globalisation, health sector reform and HIV/AIDS on poverty, health systems and human resources for health
• The changing donor funding architecture and the emergence of Global Health ‘Partnerships’
• Categories, purposes and features of GHPs
• Impact of GHPs on country health systems
• Conclusions
AFRICA’S CRISIS

Mortality 1 - 4 year olds

Territory size shows the proportion of all deaths of children aged over 1 year and under 5 years old, that occurred there in 2002.
AFRICA’S CRISIS

TB cases

 Territory size shows the proportion of worldwide tuberculosis cases found there.
Life expectancy trends in Southern Africa
Despite successes, growing inequalities in global health

Figure 1: Life expectancy at birth by region, 1970–1975 and 2000–2005

What are the key 'Basic Causes' of Africa’s Health Crisis?

HIV/AIDS

Increasing poverty and inequality worsened by inequitable globalisation

and selective PHC and inappropriate health sector “reform”

….. result in slow progress and reversals.
Global HIV prevalence

- 40 million people around the world live with HIV - more than the population of Poland.

- Nearly two-thirds of them live in Sub-Saharan Africa, where in the two hardest hit countries HIV prevalence is almost 40%.
External debt


- Africa spends more on debt servicing each year than on health and education
Unfair Trade (1)

- “..drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations”
  
  (G8 Communiqué, Genoa, July 22, 2001)

- BUT… many developing countries have destroyed domestic economic sectors, such as textiles and clothing in Zambia (Jeter 2002) and poultry in Ghana (Atarah 2005), by lowering trade barriers and accepting the resulting social dislocations as the price of global integration
The result... unequal growth of wealth between countries

GDP per capita in the poorest and the richest countries, 1960-62 and 2000-02
(in constant 1995 US$, simple averages)

Source: Based on a sample of 94 countries and territories with continuous time-series data from 1960 to 2002, as available from World Bank World Development Indicators 2003 (online version).
AFRICA’S CRISIS

GDP wealth

Territory size shows the proportion of worldwide wealth, that is Gross Domestic Product based on exchange rates with the US$, that is found there.

www.worldmapper.org
and growth of poverty

• According to the World Bank’s most recent figures, in sub-Saharan Africa 313 million people, or almost half the population, live below a standardized poverty line of $1/day or less (Chen and Ravallion 2004).

• Sub-Saharan Africa is the only region of the world in which the number of people living in extreme poverty has increased - indeed, almost doubling between 1981 and 2001.
Why should a Japanese cow enjoy a higher income than an African citizen?
The Health System, its financing and human resources

**Recommended expenditure:** >$60/capita (Brundtland); >$34/capita (CMH)

<table>
<thead>
<tr>
<th>Number of countries</th>
<th>Amount of spending</th>
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<tr>
<td>4</td>
<td>&gt; $60</td>
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<tr>
<td>2</td>
<td>$34 - $60</td>
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<tr>
<td>11</td>
<td>$12 - $34</td>
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<td>18</td>
<td>&lt; $12</td>
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<td>13</td>
<td>Data not available or population &lt;1.5 million</td>
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A Split in the PHC Movement

In 1980s, a focus on cost-effective technologies and a neglect of social and environmental determinants and processes led to substitution of “selective” for “comprehensive” primary health care (PHC) –

e.g. UNICEF “Child Survival and Development Revolution”
Selective Primary Health Care
“Child Survival and Development Revolution”

Growth Monitoring
Oral Rehydration Therapy
Breast Feeding
Immunisation

Family Planning
Food Supplements
Female Education
## Comprehensive management of diarrhoea

<table>
<thead>
<tr>
<th>REHABILITATIVE</th>
<th>CURATIVE</th>
<th>PREVENTIVE</th>
<th>PROMOTIVE</th>
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<td>O.R.T.</td>
<td>EDUCATION</td>
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<td>REHABILITATION</td>
<td>SUPPORT</td>
<td>FOR PERSONAL &amp; FOOD HYGIENE</td>
<td>SANITATION</td>
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<td>MEASLES VACCINATION</td>
<td>HOUSEHOLD FOOD SECURITY</td>
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<td>BREAST FEEDING</td>
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Selective PHC is reinforced by certain aspects of Health Sector Reform
Emphasis on cost-effective technologies and a neglect of social and environmental determinants of health has proposed essential “packages” of interventions – reminiscent of selective PHC.

**Public Health package:**
- Immunizations
- School-based health services
- Family planning and nutrition education
- Programs to reduce tobacco and alcohol consumption
- Actions to improve the household environment

**Clinical package:**
- Pregnancy-related services
- Family planning and STD services
- Tuberculosis control, mainly through drug therapy
- Care for the common serious illnesses of young children - IMCI
Health sector ‘reform’

Quest for efficiency cont.-

The move from equity and comprehensiveness to efficiency and selectiveness leads to:

- A return to vertical programmes;
- Fragmentation of health services
- Erosion of intersectoral work and community health infrastructures
Declining Health Systems

Global Immunization 1980-2002, DTP3 coverage

global coverage at 75% in 2002

Figure 7.3  Country priorities for health systems strengthening

Number of proposals to the Global Fund for Tuberculosis, HIV/AIDS and Malaria, round 5

Source: (5).
Our Common Interest 2005:184

Burden of disease
- Africa: 25%
- Rest of World: 75%

Share of population
- Africa: 13.76%
- Rest of World: 86.24%

Share of health workers
- Africa: 1.3%
- Rest of World: 98.7%
The changing donor funding architecture and the emergence of Global Health ‘Partnerships’
DONOR FASHIONS

from

Project Support 1970s - 1990s
-Stand-alone projects and programs (regional or disease focus)

to  Sector-Wide Approaches late 1990s
-Donors and government put money in a ‘common pool’ to fund agreed activities
-SWAs exist in only some countries and ‘ear-marked’ donor aid continues

to  Global Health Initiatives early 2000s

New actors

Philanthropy (e.g. Gates), Pharma and Civil Society (e.g. NGOs)

New global governance mechanisms
outside of traditional multilateral bodies (WHO, World Bank, UN agencies)

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Categories and Purposes of GHIs

1. **Product (drug or vaccine) development (33)**
   Eg Global Alliance for TB Drug Development (TB Alliance), International AIDS Vaccine Initiative (IAVI)

2. **Increase access to health products (26)**
   Eg African Programme for Onchocerciasis Control (APOCH), Mectizan Donation Program (Mectizan), Mother-to-Child-Transmission-Plus Initiative (MTCT-Plus)

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Categories and Purposes of GHIs

3. Global Coordinating mechanisms including funding vehicles (11)
   Eg The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance for Vaccines and Immunization (GAVI Alliance), Roll Back Malaria Global Partnership (RBM), Stop TB Partnership (Stop TB), Global Alliance for Improved Nutrition (GAIN)

4. Health service strengthening (9)

5. Public education & advocacy (8)
GHPs, established 1974-2003, (overall) <www.ippph.org>
Features of GHIs and GHPs

• Exponential growth in new GHPs (> 90)
  – tailing off because an over-crowded terrain?

• Most are disease or product specific – often ‘selective’
  ie focussed only on ‘cost-effective’ interventions eg
  treatment or personal prevention

• Product devt. GHPs occupy (potential) market niches

• ‘Product Access’ and ‘Coordinating’ GHPs compete
  for the attention of recipient countries (and wealthy
  countries)

• All have global governance structures (many do not have
  a country presence)
Features of GHIs and GHPs(2)

• Most GHPs are competing for funds and are time-limited
  – Representatives of Coordinating and Product Development GPPPs spend much of their time knocking on donors’ doors

• Some bring new human resources into health delivery
  – NGOs, civil society, other sectors - e.g. to support mass campaigns

• Others compete for existing limited resources
  – multipurpose health workers at the delivery level
  – time and attention of national policy makers / program managers
  – contribute to the attrition (brain drain) of senior technical staff from public sector jobs
Total annual resources available for AIDS 1986–2005

Notes:
[1] 1986-2000 figures are for international funds only
[2] Domestic funds are included from 2001 onwards

2006 AIDS Disbursements in Africa by Major AIDS Donor (USD Millions)

- Other Major Donors, $1868, 44%
- MAP Africa*, $286, 7%
- Global Fund, $712, 17%
- PEPFAR*, $1320, 32%

Source: Authors’ construction using data from public reports and from the donors.
* MAP Africa funding does not include other HIV/AIDS disbursements from the World Bank. PEPFAR funding does not include disbursements made to the Global Fund.
Impact of GHIs on country health systems
Donor practices

5 highest burdens for LMICs *

1. donor driven priorities and systems
2. difficulties with donor procedures
3. uncoordinated donor practices
4. excessive demands on government time
5. delays in disbursements

* survey of 11 recipient countries cited in:
Guidelines for harmonising donor practices for effective aid delivery
OECD Development Assistance Committee, 2003

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AIDS and Aid may both disrupt health systems...

In 2000, Tanzania was preparing 2,400 quarterly reports on separate aid-funded projects and hosted 1,000 donor visit meetings a year.

Labonte, 2005, presentation to Nuffield Trust
Uganda National HIV/AIDS Funding (USD Millions)

Source: Lake, “Sector Based Assessment of AIDS Spending in Uganda 2006.”
Note: Based on the Ugandan fiscal year.
PEPFAR Obligations to Local and Non-Local ROs in FY2005

Mozambique

- ROs: $36.2 million, 78%
- SROs: $1.4 million, 58%
- $0.8 million, 32%
- $0.3 million, 10%
- 5% ($2.4 million) Sub-granted to SROs

Zambia

- ROs: $99 million, 99%
- SROs: $10.1 million, 51%
- $9.5 million, 49%
- 17% ($20.4 million) Sub-granted to SROs

Uganda

- ROs: $62.9 million, 54%
- SROs: $52.9 million, 46%
- $10.3 million, 44%
- $0.3 million, 2%
- 9% ($12.1 million) Sub-granted to SROs

Source: Authors’ calculations using OGAC data provided to CGD via the Center for Public Integrity.
PEPFAR Relies on its ROs to build Capacity

“If the organization has not received U.S. government funding in the past, it is difficult then to start to receive money through PEPFAR...It takes a while to create capacity to do this. That is why we still have lots of organizations that are sub-contracted from larger organizations, because it is difficult for them to receive money directly from the U.S. government. It is easier for the donors to manage a larger organization that manages a smaller organization, which guarantees that they will follow the U.S. government regulations.”

RO official, Mozambique
GHIs: Complementary or Competitive?

Global Fund  World Bank  Bilateral donors  PEPFAR

“When you have lots of money from President Bush and he wants to put his flag on a particular output, you who are at the level of delivering a service have your plan for say $100 million - a quarter of which is funded by Bush, a quarter by the Global Fund, a quarter by UK DfID, a quarter by . . . . It becomes very hard for you to attribute a particular output to a particular donor.”

(NGO in Uganda in 2004)
GHI s: Strengths and Weaknesses

- Each donor has clear strengths and weaknesses relative to the others
  - PEPFAR scores well on making its money move and on collecting data;
  - The Global Fund ranks high on tailoring programs and sharing data;
  - The World Bank MAP stands out for its long-term commitment to working with the government, strengthening systems and building local recipients’ capacity.

- Donors can greatly increase their collective effectiveness by jointly planning and coordinating their efforts, and working hand-in-hand with recipient country governments & other stakeholders involved in the national response.

- By learning from each other to fix what is not working and by sharing what is working, PEPFAR, the Global Fund and the World Bank MAP can individually and collectively improve their performance in the fight against AIDS in Africa.
Ethiopia
Challenges: Adherence - Default rate in ART patients is between 20-25%.

Banteyerga, 2007
Ethiopia
Human Resource Constraints

- ART scale-up made possible primarily through the use of currently employed health workers
  - Over half of all non-ART providers samples report splitting their time between the HIV/AIDS services and other services
  - Hospitals have not been able to hire new workers to make up the difference
- ART responsible for increased work burden among staff and of decreased health worker motivation
- Study found no evidence that the availability of non-focal service have decreased

Banteyerga, 2007
Ethiopia

Concern About Effects on Non-Focal Health Care Services

“Health providers are shifted from the medical and surgical departments to the ART clinic. This is creating work burden on health providers, for they have to cover services that used to be offered by the shifted staff”.

Regional hospital, head of the ART clinic.

Banteyerga, 2007
Ethiopia

Challenges: Medicalization of HIV/AIDS due to ART scale up: MAP& GF fund utilization by program (source HAPCO documents)

Fund Utilization by Intervention Areas in 000 Birr

- Prevention
- Treatment
- Care
- Capacity
- Management
- M&E
- Total

Banteyerga, 2007
Ethiopia: Questionable Sustainability of Programmes.

HIV/AIDS especially ART is donor dependent—HIV Spending (in Birr) by Source of Funds: Donor Vs Government

Banteyerga, 2007
Malawi

• Burden of HIV
  – HIV prevalence (15—49 yrs): 11.8%
  – Estimated # of PLwHA: 1m
  – # needing ARVs: 245,000. (June 07: 114, 375)

• Global Health Initiatives
  – Global Fund ($196m for 2003-08; $85m for 2006-11)
  – World Bank-MAP ($35m for 2003-08)
  – PEPFAR (? Budget, relatively smaller)

• Others
  – Multilateral Agencies (mainly technical Support)
  – Bilateral Donors (CIDA, DFID, NORAD, CDC & USAID)
  – Government of Malawi ($2m/year)
  – Private Sector

Mwapasa, Kadzandira 2007
Malawi

Implementation of HIV/AIDS Interventions

• Implementation of GHI-funded HIV/AIDS interventions
  – Started mid-2004
  – Central Hospitals → District Hospitals → sub-district facilities

• Roll-out of interventions by Dec 2005
  – ART & PMTCT: district hospitals
  – HIV Testing & Counseling (HTC): sub-district health facilities
  – Community Home-based Care: community level

• Health system challenges:
  – human resources
  – frequent stock outs of drugs and medical supplies
  – poor access to health services, especially rural residents

Mwapasa, Kadzandira 2007
Malawi
Health worker trends at District hospitals

- *Modest* increase in # of nurses, pharmacy and laboratory staff at district hospital but perceived decrease
Malawi

Workload and its effects

• Perceived increase in workload
  – Concomitant implementation of HIV and non-HIV services

• No shift of staff between programmes
  – Locums—but not in rural health centres

• No adverse effect on non focal diseases
  – Immunizations
  – Antenatal clinic attendance
  but no increase in coverage equivalent to ART

Mwapasa, Kadzandira 2007
Malawi
Trends in immunizations

District Hospitals  Rural Hospitals  Urban H/Cs  Rural in Urban Dist.  Rural H/C

Immunizations (Total) - Oct 2005-Dec 2005
Immunizations (Total) - Jan 2006-March 2006
Immunizations (Total) - April 2006-June 2006
Immunizations (Total) - July 2006 Sept 2006

Mwapasa, Kadzandira 2007
In South Africa most provincial departments have experienced problems with PEPFAR, and were facing communication challenges. Eg PEPFAR not keeping managers and Health Ministers in provinces informed about PEPFAR funded projects in their respective provinces.

Poor Communication

Although the Stop TB Partnership has a central website, there is not much information available regarding the partnership status and progress at country level. In addition to its lack of visibility, Barr et al also revealed that detailed knowledge of the Partnership seems to be confined to only a few key people.

“I don’t know about the Stop TB Partnership and I have been on the Portfolio Committee for nine years, what is it?”

Member (i) of the Portfolio Committee on Health, National Parliament of South Africa; in Barr D, Padarath A, Sait L, 2005, p58.
GHIs are untested social experiments:

Are they ‘good’ for developing country health systems?

Are they

1. Additional or substituting for existing funds?
2. Complementary or competitive with existing approaches?
3. If reliant on existing systems, by whom and by what criteria are priorities set?
4. Do they embody perverse incentives, attracting scarce health workers to the best funded programmes?
5. How do (drug, vaccine and other) product recipients participate in programme choices?
6. Sustainable / sustained support in relation to GHI goal?

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Conclusions

- Africa’s health crisis results from inequitable globalisation, ill-considered health sector “reforms”, the HRH crisis and HIV/AIDS
- GHIs have emerged as a response to this emergency and to fiscal crisis
- GHIs have resulted in large funding increases for particular diseases but privilege individually-focused interventions
- GHIs, especially PEPFAR, reinforce domination of policy and programmes by outside ‘experts’, likely delaying local capacity development, including of institutions
- Anecdotal and early research evidence suggest GHIs disrupt health system development and distort allocation of HRH
- Take-over of funding of these programmes by governments unlikely without changes in global macroeconomic policies
- GHIs may be strengthening ‘selective’ PHC and undermining comprehensive PHC
- Greater coordination of GHI efforts is urgently necessary