Chapter 2
Strengthening and expanding health systems

BACKGROUND

WHO defines a health system as “the sum total of all the organizations, people and actions whose primary intent is to promote, restore or maintain health”. A country’s health system embraces those who try to influence the determinants of health as well as those who deliver health-improving services.

So defined, a health system is more than the pyramid of facilities owned by government, private business and NGOs and of the healthcare workers and support personnel who staff those facilities. It includes a mother caring for an HIV-infected child at home; peer educators who deliver behaviour change communications; organizations run by and for sex workers and distributing preventive literature and condoms; health insurance providers; legislators who adopt health and safety and anti-discrimination laws; those who enforce the laws; and so on. A health system’s activities may include, for example, a multidisciplinary and multisectoral campaign to encourage the ministry of education to promote female education, a well-known determinant of good health, or to encourage the ministry of finance to approve sufficient funding of a programme to promote and support the sexual and reproductive health of out-of-school youth.

WHO believes that the principles on which health systems should be founded are those enshrined in the Declaration of Alma-Ata: universal access, equity, participation and multisectoral action, all within a framework of gender equality and human rights (see Box 3). That is, health systems should have multiple goals including improvement of health in ways that are equitable, responsive, financially fair, and make the best use of available resources. The way to reach those goals is by expanding coverage so it reaches ever more people with ever more effective health interventions.

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**BOX 3. KEY EXCERPTS FROM THE DECLARATION OF ALMA-ALTA**

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

VI. Health care ... is made universally accessible to individuals and families through their full participation and at a cost that the community and country can afford ...

VII. Primary health care:

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services ...;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development ...;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control ..., making fullest use of local, national and other available resources.

Available at: http://www.who.int/publications/almaata_declaration_en.pdf
In its framework for action on health system strengthening, WHO observes that the principles set out in the Declaration of Alma-Ata are more often observed in breach than in observance.\(^{15}\) However, it is clear that the response to the HIV pandemic has set precedents and has renewed momentum towards applying those principles. The rapid scale up of access to ART, in response to vigorous civil action with widespread involvement by people living with HIV, has led to an internationally endorsed and increasingly strong commitment to universal access. The recognition that the pandemic requires commitment from all sectors, not just the health sector, has taken firm hold. And the realization that prevention, care, treatment and support should all be part of the response to the pandemic — as per the principles for primary health care set out in the Declaration of Alma-Ata — became a tenet of the response to the HIV and, in turn, the response to TB, malaria and ill health among mothers, infants and children.

Despite those very positive and encouraging achievements, the response to the HIV pandemic remains inadequate. Health system weakness - the weakness of the organizations, people and actions that intend to produce health outcomes, including HIV prevention and treatment - remains a major barrier. This is true not just for low- and middle-income countries. High-income countries also face challenges in, for example, reaching most-at-risk and marginalised groups - sex workers, injecting drug users and men who have sex with men - with effective health system interventions that deploy resources efficiently. The biggest challenges of all are in countries with generalized epidemics, where HIV undermines the capacity of the health sector to provide services by increasing the sector’s workload at the same time as decreasing its healthy and productive workforce.

The structure and operations of health systems vary from country to country and from area to area within countries but WHO has identified six building blocks of all health systems. These are illustrated in Figure 1 and include:

1. Service delivery
2. Health workforce
3. Information
4. Medical products, vaccines and technologies
5. Financing

“Health system strengthening” can be defined as improving these six building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. In this chapter, five of these building blocks will be discussed as they relate to the scaling up the response to HIV and achieving the goal of universal access to HIV prevention, treatment, care and support. The chapter addresses the needs for action under the fourth of the five strategic directions named in the Introduction to this document: strengthening and expanding health systems. The remaining building block, strategic information (also the fifth strategic direction) is covered in Chapter 3.

**FIGURE 1: HEALTH SYSTEM BUILDING BLOCKS, DESIRABLE ATTRIBUTES, GOALS AND OUTCOMES**

**THE WHO HEALTH SYSTEM FRAMEWORK**

<table>
<thead>
<tr>
<th>SYSTEM BUILDING BLOCKS</th>
<th>ACCESS</th>
<th>OVERALL GOALS/OUTCOMES</th>
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</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td></td>
<td>Improved health (level &amp; equity)</td>
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<tr>
<td>Health workforce</td>
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<td>Responsiveness</td>
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<tr>
<td>Information</td>
<td></td>
<td>Social and financial risk protection</td>
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<tr>
<td>Medical products, vaccines &amp; technologies</td>
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<td>Improved efficiency</td>
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<td>Financing</td>
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<td>Leadership/Governance</td>
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2.1 SERVICE DELIVERY

Good health services are those which deliver effective, safe, high quality health interventions to the people who need them, when and where they need them, and with minimum waste of resources. These interventions may target individuals or entire populations, whether defined by geography (e.g., national, district or local) or characteristics (e.g., gender, age, nature of illness, occupation, behaviour). In the case of HIV, health services need to take into account that people living with HIV or most-at-risk of infection often face stigma and discrimination because of their infection or because they may belong to groups with particular behavioural or disempowering characteristics. Such groups include sex workers, men who have sex with men, injecting drug users, prisoners and youth. Reaching these groups with HIV prevention, treatment and care requires special interventions that are often best delivered through outreach, community groups or their own organizations.

WHO recommends that planning and implementation of HIV-related service delivery programmes take into account the needs for: integration and linkage of health services; infrastructure and logistics; demand for services; and management.

2.1.1 INTEGRATION AND LINKAGE OF HEALTH SERVICES

There are no universal models for good service delivery, but in the case of HIV-related services, it is agreed that services should be delivered across a continuum of care, which requires integrated and linked service provision at all levels of the health system from primary to secondary to tertiary (specialist) care and embracing all elements of the health system, including home-based and community-based outreach care.

“Linkage” refers to a relationship, for example, between a local health centre and a district hospital and “integration” refers to delivering multiple services or interventions to the same patient by an individual healthcare worker or by a team of healthcare workers and, possibly, workers from other fields. Strong linkages (with referral and coordination between service providers) and integrated services are needed in particular areas of healthcare, such as family planning, care for mothers and newborn infants, mental healthcare, care for people living with HIV, all of which may involve a range of services and services providers including home-based and community-based ones.

The case for integration of HIV-related services into all maternal and newborn care and all sexual and reproductive healthcare service delivery is particularly strong, and so is the case for integration of HIV-related and TB-related services into one package of services.

In many large health centres and hospitals, pregnant women with HIV are identified in the antenatal clinic and then referred for HIV-related services that are in another area of the facility or in another facility altogether. This often results in a significant “loss to follow-up”, with many women not appearing at an HIV clinic even if it is in the same facility. This is a reason why pregnant women who need ART often do not receive ART. To avoid this sequence of events, full integration of HIV intervention delivery within services for antenatal care, childbirth, newborn and postpartum care is a minimum requirement in any countries, districts or localities where HIV infection is common. Such integration should include HIV testing and counselling, assessment whether ARVs for treatment or prophylaxis are needed, initiation and monitoring of ARVs in women and exposed infants, follow up HIV testing for infants, clinical review, and cotrimoxazole prophylaxis when infants return for immunization.

Sexual and reproductive ill-health and HIV infection share the same driving forces, causes or contributors and these include poverty, limited access to information, gender inequality, cultural norms, and social marginalisation of the most vulnerable and at-risk populations. This explains why there is international consensus around the need for effective linkages between responses to HIV and responses to needs for sexual and reproductive health and also consensus around the need for integration of related services wherever feasible. These integrated services should include: promotion of condom use for prevention of unintended pregnancy, STIs and HIV; reproductive choice counselling and counselling for family planning and contraception; education on sexual health for people living with HIV; youth-friendly health services covering sexual and reproductive health.

The high incidence of TB among people living with HIV and the frequent occurrence of HIV infection among people with TB provides the rationale for linkages between responses to TB and HIV and integration of some TB-related and some HIV-related services. Such linkages and integration have already, just recently, resulted in substantial increases in the proportion of TB patients tested for HIV and then referred to HIV care services. In addition, HIV programmers are increasingly committed to TB control, to intensified TB case finding among HIV-infected patients and to offering INH prophylaxis after excluding active TB.

How exactly to go about linking and integrating services will depend on how the health service is organized, and also the characteristics of the HIV epidemic. For more on the latter, see Chapter 4.
**Summary of recommendations:**

Services for HIV should be linked or integrated with other services in the health sector including those for TB, sexual and reproductive health, and maternal and newborn health. They should also be linked or integrated with services provided by other sectors, such as education and social welfare, and to those provided within homes and communities by families, international and national NGOs, community-based organizations, faith-based organizations and groups or networks of people living with HIV. All such services should be provided as close to clients as possible.

However, when considering integration of health services, planners should opt for a pragmatic approach that takes into account and balances the specific needs of target populations (that might be marginalized), the characteristics of the particular health system, and the aim of providing a comprehensive package of services.

**Key resources:**

- Technical brief on integration of health services
  [LINK](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf)
- WHO IMAI/IMCI/IMPAC tools
  [LINK](http://www.who.int/hiv/pub/imai/IMAIPublicationSm.pdf)
  [LINK](http://www.who.int/hiv/capacity/imai/sharepoint/en)
- Linkage and integration with services for TB
  [Interim policy on collaborative TB/HIV activities](http://www.who.int/tb/publications/tbhiv_interim_policy/en/index.html)
- Linkage and integration with SRH and RH services

**2.1.2 INFRASTRUCTURE AND LOGISTICS**

Service delivery requires infrastructure and logistics and these include building, equipment, utilities, waste management, transport, and communications.

Physical space is required for receiving clients, triage, waiting, clinical management, counselling, care delivery, surgery, pharmacy, storage, management, and for the equipment required for all of those things as well as for laboratories, deliveries, communications, infection control, waste management and so on.

For people living with HIV, there should be particular attention paid to their needs for privacy and confidentiality, safe water and sanitation and hygiene, and infection control. The latter should take into account the needs to reduce the risk of bloodborne infections, such as HIV and hepatitis, and of other infections, such as TB. It is particularly important to reduce the risk of TB infection given the high incidence of TB among them and the emergence of MDR and XDR TB.

With the recent scale up of treatment for HIV infection, limitations in laboratory infrastructure are increasingly recognized as major obstacles stopping the roll out of services. For follow-up on ART, it is important to have access to some laboratory support on the periphery of the health service, where until recently it was not routinely available, as well as at higher levels of the health system. This means essential tests should be available on site at a local health centre or district hospital, as should the capacity to transport specimens to higher levels. Laboratory support for antiretroviral therapy, early infant diagnosis and TB diagnosis are important priorities for HIV-related lab services.

Chapter 1 provides detailed guidance on the types of laboratory tests needed to support treatment of people living with HIV and management of conditions frequently found among them, such as TB. Providing the tests is a huge challenge, the dimensions of which can be understood best if laboratory support is considered as a health sub-system. This entails giving consideration to service delivery, health workforce and the other building blocks of a health system, as shown in Figure 1, when planning to scale up laboratory services.
Safe medical waste management with separate containers and adequate disposal systems for sharps, other infectious or hazardous waste, and non-infectious and non-hazardous waste are important for infection control in all facilities.

An emerging issue is the relatively low access to information technology in resource limited settings. Computerization can markedly enhance efficiency of HIV service delivery, and computerized record keeping, monitoring and supply management can free up time for clinical tasks.

Communication between staff at local health centres and staff in health facilities and laboratories at higher levels of the health system is essential to ensuring HIV care of the highest quality. Facilitating this communication involves work to ensure that telephone, radio or other communications infrastructure is adequate and, ideally that infrastructure should include computers connected by intranet or internet.

**Summary of recommendations:**

The infrastructure and logistics of health service delivery should be configured so as to enable delivery on demand of services to people who need those services, wherever they may be located, and should also be designed to last. For the management for HIV infection, it is especially important that health facilities are designed for privacy and confidentiality, infection control, and ready access to laboratories and imaging services.

Every effort should be made to limit the spread of nosocomial infections (resulting from treatment in health care settings) and bloodborne infections (such as HIV and hepatitis) and that there be support for comprehensive infection control, including specific consideration of the risk of the spread of TB.

**Key resources:** 159 160 98 150

**District health facilities : guidelines for development and operations.**

[LINK](http://www.wpro.who.int/NR/drdonlyres/C0DA210-7425-4382-A171-2COF6FF77153/0/0/0/0/DistHealth.pdf)

**Management of resources and support systems: Equipment, vehicles and building**

[LINK](http://www.who.int/management/resources/equipment/en/index1.html)


[LINK](http://www.who.int/hiv/pub/meetingreports/labmeetingreport.pdf)

Chapters on infrastructure, laboratory strengthening for HIV service delivery and health workers safety in health centres in resource limited settings with generalized HIV epidemics are featured in the forthcoming Operations Manual. Gain access to the current draft via SharePoint by sending an email to imaimail@who.int.

### 2.1.3 DEMAND FOR SERVICES

In health service planning, most attention usually goes to planning on the supply side of services. The question as to whether the services will, in fact, be used is often neglected, even when it is clear that there are factors that could limit demand. Denial, fear, stigma, discrimination, and high costs are among the factors that limit demand for and uptake of health services and especially uptake of services for conditions such as HIV and TB, which are both surrounded by fear, stigma and discrimination. Chapter 1 discusses interventions that can generate demand, such as outreach to people in most-at-risk populations.

**Summary of recommendations:**

Raising demand requires understanding the user’s perspective, raising public awareness and overcoming cultural, social or financial obstacles. Overcoming such obstacles requires various forms of social engagement in the planning, delivery and monitoring of services. In the case of HIV-related services, people living with HIV and those vulnerable or most-at-risk should be involved in the design, management, delivery and monitoring of services. This can ensure that services meet their unique needs and address their unique concerns, such as fear of disapproval or open hostility on the part of staff and of disclosure of their HIV status and the possible consequences.

**Key resources:** 161 162

Website of the WHO-sponsored Preparing for Treatment Programme.
2.1.4 MANAGEMENT

Good leadership and management is about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources.5 While good leaders set the strategic vision and mobilize action towards its realization, good managers ensure effective organization and utilization of resources to achieve results and meet goals and targets.

The health sector response to the HIV epidemic requires different types of management action. There is need for strategic planning at the national and sub-national levels, need for operational planning throughout the service delivery system and need for facility management.

At the highest level of a health system, good management requires situation analysis, review of the health sector response (including existing policies and strategies), setting programme priorities, selecting key indicators and setting targets, and then coordinating and managing development and implementation of programmes, all of which are dealt with in Chapter 4. It also requires strengthening management systems, and ensuring the technical quality of services, both of which are dealt with below.

Increasingly, the management of implementation happens at district, facility and community level. The district management team, facility managers and community organizations need skills to plan implementation, then to mobilize resources and manage staff, finances and supplies. Training is usually organized and delivered at the regional or district level followed up by regular supportive supervision from the district team and by mentoring from experienced managers from other districts, communities or facilities.

At health facility level, the aim of good management is to provide services to the community in an appropriate, efficient, equitable, and sustainable manner. This can only be achieved if key resources for service provision, including human input, information, finances, and the hardware and process aspects of care delivery are brought together at the point of service delivery and are carefully synchronised.

2.1.4.1. STRENGTHENING MANAGEMENT SYSTEMS

Deficiencies in health system management are well-recognized as obstacles to efficient service delivery.

Summary of recommendations:

WHO recommends action to strengthen management capacity in the health sector. Such action should include ensuring an adequate number of managers at all levels of the health system, ensuring managers have appropriate competencies, creating better management support systems, and creating enabling working environments.

Key resources: 163 164 165

WHO. Strengthening management in low income countries

WHO’s MAKER website (Managers taking Action based on Knowledge and Effective use of resources to achieve Results) provides comprehensive guidance on managing health services.

The WHO website dedicated to strengthening management capacity in the health sector

The Treatment Preparedness Coalition is a community group supporting demand creation for HIV services

International Federation of Red Cross and Red Crescent Societies. Service delivery model on access to care and antiretroviral therapy for people living with HIV/AIDS. Geneva 2004
2.1.4.2. ENSURING THE TECHNICAL QUALITY OF SERVICES

Universal access to HIV prevention, treatment and care provided by the health sector requires that the package of interventions not only be accessible and affordable by the people who need those services but that they also be of good quality, so that they achieve the intended results.

Summary of recommendations:

Ensuring quality during scale up of HIV-related services requires:

- Establishing external and internal quality management systems. These should address clinical care, laboratory testing, and workplace improvement. It is of critical importance to involve the community and beneficiaries (people living with HIV and those vulnerable and most-at-risk of infection) in assessing and improving the quality of care,
- Regularly updating national normative guidelines and tools so they continue to reflect the best international practices and the latest recommendations. This requires convening technical advisory committees and working groups regularly, since HIV and AIDS are rapidly changing areas with new information constantly becoming available.
- Establishing standardized procedures to accredit health facilities and to certify health care providers in the delivery of HIV prevention, treatment and care. All facilities and providers, whether run by government, private business or NGOs, should be covered.
- Establishing national standards for HIV prevention, treatment and care.
- Ensuring quality of training through, for example, the use of experienced facilitators and attention to facilitator-trainee ratios.
- Establishing supervision and clinical mentoring systems, and a budget to prepare and deploy supervisors and mentors for post-training and on-the-job supervision.

Key resources: 166 98 77 167 168


Quality management sections in Operations Manual for HIV service delivery in health centres in resource limited settings with generalized HIV epidemics in the forthcoming Operations Manual. Gain access to the current draft via SharePoint by sending an email to imaimail@who.int.


LINK http://www.who.int/hiv/pub/guidelines/clinicalmentoring.pdf


WHO/SEARO. Guidelines on Establishment of Accreditation of Health Laboratories

LINK http://www.searo.who.int/LinkFiles/Publications_SEA-HLM-394.pdf

2.2. HEALTH WORKFORCE

Effective service provision requires trained service providers working with the right attitude, knowledge and skills, commodities (medicines, disposables, reagents) and equipment, and with adequate financing. It also requires an organizational environment that provides the right incentives to providers and users.

In many of the countries with the highest burden of HIV, international migration and domestic movement out of health sector employment contribute to the crisis in human resources and, in some of those countries, the crisis is aggravated by civil service hiring caps.

HIV itself contributes to the crisis, not only by increasing the demand for services but infecting and affecting healthcare workers. They may be disabled by illness, lost to death or required to spend less time at work and more at home taking care of HIV-infected family members, attending to those family members’ usual chores and attending funerals. Thus, the supply of healthy and productive healthcare workers is reduced.
Working with people living with HIV is labour intensive and can also be emotionally stressful and draining. When there are many HIV infected people, the demand for services increases and high workloads, poor pay and bad working conditions are added disincentives for healthcare workers to deal with HIV.

Working in the HIV area may also be unpopular with some health workers because they fear becoming infected with HIV or TB or because they cannot relate easily to clients with risk behaviours of which they disapprove. The latter is a problem especially countries with low or concentrated epidemics, where many people living with HIV come from marginalized groups such as sex workers, injecting drug users, MSM and prisoners.

The combined results of all of the above are that, first, it may be difficult to motivate health workers to take jobs providing HIV services unless they are provided with special incentives and, second, there is a severe shortage of skilled health workers in areas with high HIV prevalence.

Notwithstanding those challenges, a defining feature of the response to the HIV pandemic has been the ability of communities to mobilize resources to deal with the impacts of HIV and prevent its further spread. Groups of people living with HIV, community-based organizations, faith-based organizations and many others have faced up to the facts of the pandemic and taken responsibility not just for advocacy but for action. They learned to play a wide range of roles in the response to HIV, serving as outreach workers, home carers, adherence supporters, providers of psychosocial support, counsellors, and managers. This has led to the creation of entirely new health professions in some countries, and led to strong momentum in the direction of task shifting and strong calls for recognition and payment for some of the essential services they provide. Their roles are increasingly recognized and institutionalized, and are beginning to transform the debate on universal primary health care from a distant dream to an achievable goal.

Summary of recommendations:

To counter difficulties, in motivating and retaining health workers the following actions, WHO recommends:

• training additional health workers;
• sensitizing health workers for work with people living with HIV;
• ensuring health workers have access to prevention and other HIV- and TB – related services;
• Considering task shifting as a way of retaining existing health workers for as long as possible.

A full package of HIV prevention, treatment and care services should be made available to health workers and their families on a priority basis and tailored specifically to their needs.

In countries with generalized HIV epidemics and health worker shortages, efforts should be made to increase the number and the competence of health care workers. WHO recommends:

• recruiting and training additional health workers;
• ensure relevant HIV content in pre-service curricula;
• shifting tasks from more- to less-specialized health workers;
• developing in-service training and support for continued learning after training (including mentoring and continuing medical education)

To retain existing health workers the following policy changes should be considered:

• instituting codes of practice and ethical guidelines to minimize migration of health workers from low-income countries to developed countries;
• reducing the draw of private and NGO-run programmes on workers in public health programmes;
• improving the quality of the workplace, including:
  • establishing occupational health and safety procedures to reduce the risk of contracting HIV and other blood-borne diseases
  • addressing stress and burnout;
  • guaranteeing job security;
  • prohibiting HIV-related and other forms of discrimination;
  • providing social benefits;
  • adjusting work demands;
  • providing financial incentives;
  • providing non-financial incentives, such as career and training opportunities.
WHO also recommends recognition and support for the vital roles played by people living with HIV, community organizations and lay workers and that recognition and support take tangible forms, such as certification of skills in service delivery and pay. Such measures should be integrated into national plans for development of human resources for health and HIV.

**Key resources: 58 95 169 156 98**

Tools for planning and developing human resources for HIV/AIDS and other health services. (Management Sciences for Health and WHO 2006).

[LINK](http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf)

ILO/WHO guidelines on health services and HIV/AIDS

[LINK](http://www.who.int/hiv/pub/prev_care/ilohoguidelines.pdf)

WHO Guidelines on Task-Shifting (WHO 2008)

[LINK](http://www.who.int/healthsystems/TTR-TaskShifting.pdf)

The IMAI/IMCI/IMPAC family of training, programming and management tools. supports task shifting and health care worker education

[LINK](http://www.who.int/hiv/capacity/en)

The chapter on human resource management in the Operations Manual for Delivery of HIV Prevention, Care and Treatment at Primary Health Centres in High-Prevalence, Resource-Constrained Settings. Gain access to the current draft via SharePoint by sending an email to imaimail@who.int.

### 2.3 MEDICAL PRODUCTS AND TECHNOLOGIES

Many health systems continue to have weak procurement and supply management systems and the result is frequent stock-outs of antiretroviral drugs, medicines, and other essential commodities, including gloves, needles and testing reagents. Among 66 low- and middle-income countries reporting data on stock-outs of antiretroviral drugs in 2007, 25 countries reported having experienced one or more episodes. Globally, 18% of all reporting treatment sites experienced at least one stock-out of antiretroviral drugs, with Africa and Latin America reporting higher stock-out rates than other regions.

Methadone and buprenorphine were added in the WHO list of essential medicines in 2005. These medicines, and potent opioid analgesics, are controlled substances under the international drug control conventions, and are not sufficiently available in many countries, mainly due to 1) greatly exaggerated fears of dependence, 2) overly restrictive national drug control policies, and 3) problems in procurement, manufacture, storage and distribution of controlled substances. It is estimated that over 80% of the world population has no proper access to controlled medications, due to regulatory barriers, prejudice and lack of proper information at national and international levels.

Another concern is for the quality, safety and efficacy of the medicines that are available. The supply of good antiretroviral medicines is reasonably well secured by the WHO prequalification scheme, by the US Federal Drug Administration’s practice of giving provisional approval to generic medicines and by quality standards insisted upon by the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, the same is not the case for other essential medicines brought in by a variety of suppliers under the oversight of national regulatory authorities, who faces challenges in the exercise of their duties.

Summary of recommendations:

A well-functioning health system should ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, as well as access to their scientifically sound and cost-effective use. WHO recommends:

- establishing national policies, standards, guidelines and regulations for procurement of drugs and other commodities;
- providing health authorities and service providers with information on prices, international trade agreements and capacity to set and negotiate prices;
- ensuring reliable manufacturing practices and quality control for priority products;
- establishing procurement, supply, storage and distribution systems that minimize leakage and other waste;
- providing support for rational use of essential medicines, commodities and equipment through guidelines, strategies and training to ensure enforcement, reduce resistance and maximize patient safety;
- delivering on countries’ obligations under UN Conventions to provide access to analgesics and opioids for substitution therapy.

Send an email to imaimail@who.int.
Key resources: 170 109 171 172

AIDS Medicines and Diagnostics Service (AMDS) website is the main WHO gateway to most of the policies, information and tools developed to support access to medicines and commodities for HIV, including those for opioid substitution therapy and oral morphine for analgesia.
LINK http://www.who.int/hiv/amds/en

Guidance on how to ensure access to medicines and diagnostics, norms and standards, support for their quality, and policies to support it, are found on the website of the WHO Medicines department.
LINK www.who.int/medicines/en/

The WHO prequalification website provides information on which medicines are prequalified by WHO, assessment reports, and access about its procedures.
LINK http://healthtech.who.int/pq/

Global Price Reporting Mechanism, which publicizes the prices paid for ARVs, related drugs and HIV diagnostics.


2.4 FINANCING

After the UN General Assembly’s Declaration of Commitment on HIV/AIDS in 2001, funding for the response (including the health sector response) increased sharply each year until it reached an estimated US$ 10 billion in 2007. However, WHO and UNAIDS estimated that there was still a US$ 8 billion gap between what was available and what was actually needed to scale up the response to HIV at an acceptable pace. There is a similar gap between what is available and what is actually needed for other health priorities. In 2002, the WHO Commission on Macroeconomics and Health recommended that low- and middle-income countries spend a minimum of US$ 40 per capita on essential health services but many still spend far less than that amount.16

In many countries, the costs of HIV treatment and care (particularly antiretroviral therapy) are unaffordable for the majority of people, and even for their governments. In most countries heavily burdened by HIV, sustainable provision of HIV treatment and care will require external funding for the foreseeable future. This would be true even if they increased their domestic funding for the health sector to 15% of GDP, as many African countries pledged to do in the 2001 Abuja Declaration.17

While external and domestic government funding for the HIV response has increased considerably, many people living with HIV still find it difficult to access essential services. Even when drugs are provided free of charge, they incur out of pocket expenditures for the treatment and prevention of concurrent diseases and opportunistic infections, laboratory diagnosis, and formal and informal fees. This limits their access to essential services when they are poor or depend on others to cover their health care costs.

Summary of recommendations:

Health systems should raise and secure adequate funds for health in order to ensure people can use services they need and are protected from financial catastrophe or impoverishment because they have to pay for services. In 2005, the World Health Assembly urged it Member States to:18

- Ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;
- Ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that insurors will receive equitable and good-quality health services according to the benefits package;
- Ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole.

• Plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality; to reducing poverty; to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all.

With regard to access to services for HIV, WHO recommends that countries implement a public health approach to scale-up of services and, also, adopt a policy of free access at the point of service delivery to basic HIV services, including consultation fees, HIV testing and antiretroviral therapy.

**Key resources: 173 174 175 176**

For effective mobilization of financial resources, health sector strategic plans need to be realistically costed. UNAIDS’ Costing Guidelines provide detailed guidance and tools for costing HIV programmes. The UNAIDS resource needs estimates website has methodological background documents that could be used to justify resource mobilization.


The 2005 WHO technical brief for policy-makers on Achieving Universal Health Coverage: Developing the Health Financing System defines options that decision makers should consider.

**LINK** [http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf](http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf)

The financing Website of WHO gives access to policy guidance and tools for financing health sector work.

**LINK** [http://www.who.int/health_financing/en](http://www.who.int/health_financing/en)


**LINK** [http://www.who.int/hiv/pub/advocacy/promotingfreeaccess.pdf](http://www.who.int/hiv/pub/advocacy/promotingfreeaccess.pdf)

### 2.5. LEADERSHIP AND GOVERNANCE

Good leadership and governance can ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability. Leaders with consistent messages are needed to counter stigma and discrimination, support the involvement of people living with HIV in the response to HIV, ensure equity in access to services, deal with the gender dimensions of the epidemic, speed up progress towards filling the gap between resources available and resources needed to scale up the response and achieve the universal access goal. Leaders with consistent messages are also need to help people envision a better future and achieve that future through research and innovation that finds new methods and tools and ways of putting them to effective use.

Calls for leadership often seem to be aimed at politicians and others in position of great power. However, accelerating the response to HIV also requires leadership from business, industry, trade unions, academic and research institutions and, within neighbourhoods and communities, from community councils, faith based organizations, other community-based organizations, formal and informal groups and networks of people living with HIV, people vulnerable or at high-risk of infection, youth and so on. Health workers at all levels have opportunities to play leadership roles and use their professional and personal connections to advance the cause scaling up the response to HIV.

As for governance over the response to HIV, it has involved considerably over the last few years. It was once dominated by the health sector and lead by national AIDS programmes within ministries of health. It then shifted to national AIDS commissions, with representatives from multiple sectors and HIV-related programmes in ministries and other organizations responsible for action in those sectors. In many low- and middle-income countries, UN Theme Groups on AIDS have been established. Originally intended to coordinate the UN system’s contribution to national responses to HIV, they have expanded to include representatives from government, donors, civil society and the private sector and now seek to harmonize and coordinate action by all of those stakeholders.

When the Global Fund to Fight AIDS, Tuberculosis and Malaria became operational in 2002, it introduced **Country Coordinating Mechanisms (CCMs)** to foster national ownership and engage government, donors, civil society and the private sector in the response to all three diseases. CCMs are meant to build on already existing mechanisms, such as national AIDS commissions and Expanded UN Theme Groups on AIDS, while also increasing transparency and accountability of financing and implementation of the response to HIV. All of these mechanisms have the potential to make governance more complicated and difficult and increase rather than reduce duplication and waste if their roles and responsibilities are not clearly defined.

The increasingly complicated governance of the response to HIV may call upon health sector stakeholders to participate in several multisectoral country coordinating mechanisms. Participating is vital to ensuring their compliance with and their contributions to application of the “Three Ones” principles: a) **one agreed HIV/AIDS Action Framework** that provides the
basis for coordinating the work of all partners; b) **one** National AIDS Coordinating Authority, with a broad based multisectoral mandate; and c) **one** agreed country level Monitoring and Evaluation System.

In addition, health sector stakeholders are called upon to ensure that health sector HIV interventions are included and given appropriate priority and weight in national AIDS plans and action frameworks as well as in national health sector plans, medium term expenditure frameworks, and Poverty Reduction Strategy Papers (PRSPs) and that stakeholders working in other sectors are committed to collaborating with the health sector and supporting health sector HIV interventions.

At the same time as participating in all of those mechanisms and processes, health sector stakeholders need to maintain strong and coherent adherence to principles guiding the health sector in its contributions to the response to HIV, including commitment to universal access, respect for human rights and community involvement in the planning, governance, delivering and monitoring of HIV-related services.

These principles should be upheld not just within the health sector but also through regular reviews of policies, legislation and regulations governing different aspects of the epidemic and any appropriate actions that may arise from such reviews. For example, reviewing legislation that contributes to marginalization of most-at-risk populations might lead to advocating for legislative reform. Reviewing a ministry’s workplace policies might lead to promoting and supporting improvement of those policies. Other areas calling for attention include legislation or government regulations pertaining to the confidentiality of medical records or otherwise governing the health workforce and possibly impeding their ability to function as well as they might by, for example, shifting certain tasks to people outside of the health sector.

**Summary of recommendations:**

Effective leadership in HIV creates momentum for and provides oversight of the HIV response. It is defined both by its actions and by its outcomes. Leadership should create an environment that accelerates scale up of the HIV response, defines the values and principles that should underlie the process, holds the different stakeholders accountable, and supports innovation to maximize the impact of the interventions.

Among the outputs that should be expected of leadership are development, implementation and adaptation of Strategic Policy Frameworks (discussed in Chapter 3), policies, legislation and regulations that create a favourable environment for an effective response to HIV, coalitions and partnerships that contribute to a better response, and new and more effective interventions.

To promote and support effective coordination, health sector stakeholders should participate in and liaise regularly with key country mechanisms that have a coordination function, such as National AIDS Councils/Commissions (NACs), Country Coordinating Mechanisms (CCMs), UN Theme Groups and donor forums. They should also secure commitment of stakeholders from other sectors to actively participate in and commit to development and implementation of the response to HIV. For the health sector, establishing and strengthening coalitions and partnerships with a range of stakeholders (e.g. non-governmental, community-based and faith based organizations, people living with HIV, marginalised groups, academic institutions, and the private sector) are critical to scaling up to universal access.

Leadership should also support innovation and foster an environment conducive to the realization of human rights, including gender equality, women’s empowerment, reduction of stigma and discrimination.

**Key resources:**

- Global Fund Country Coordinating Mechanisms (CCMs) “Three Ones” Key Principles
  [http://www.who.int/entity/hiv/pub/advocacy/GHSS_E.pdf](http://www.who.int/entity/hiv/pub/advocacy/GHSS_E.pdf)
- International Guidelines on HIV and Human Rights provide technical guidance on operationalising a rights based approach (UNAIDS & UNHCR).
  [http://whqlibdoc.who.int/unaids/2006/9211541689_eng.pdf](http://whqlibdoc.who.int/unaids/2006/9211541689_eng.pdf)
- Ensuring Equitable Access to Antiretroviral Treatment for Women is the WHO/UNAIDS policy statement on equitable access for women in the context of the health sector.
- IAS. The Sydney Declaration: Good Research Drives Good Policy and Programming - A Call to Scale Up Research
2.5.1. **COALITION BUILDING AND PARTNERSHIPS**
For the health sector, building coalitions and partnerships with a range of stakeholders is critical to scaling up towards universal access.

2.5.2. **INVOLVING PEOPLE LIVING WITH HIV**
With 33.2 million people living with HIV globally and 6800 new HIV infections daily, people living with HIV are a vital resource in the response to HIV. There already exist ample experience on involvement of People Living With HIV in advocacy, in policy dialogue, service delivery, and in the effort to reduce stigma and discrimination. Innovative mechanisms have been developed to involve people living with HIV in HIV-related services, e.g., on clinical teams, as links with communities and as community health workers. People living with HIV can also serve as expert patients and trainers.

Integrated Management of Adolescent and Adult Illness (IMAI) is a WHO-organized initiative that provides tools to support the involvement of people living with HIV on clinical teams as triage officers and lay counsellors who support HIV testing, adherence to ART and TB treatment and infant feeding and also as data clerks, lab assistants and links to community support services. To be effective in these roles, they require training and appropriate supervision and remuneration. In many countries, there are policy constraints that prevent people living with HIV from taking on these roles and these constraints need to be addressed.

**Summary of recommendations:**
UNAIDS and WHO believe the meaningful involvement of people living with HIV is central to an effective, rights based HIV response. People living with HIV should be engaged in all aspects of planning, implementing, monitoring and evaluating health sector responses to HIV at the global, regional, national and local levels. This means that people living with HIV should be involved in the development and adaptation of normative policies, tools and guidelines, and in the delivery of services.

**Key resources:** 161 182 183

Website of the WHO-sponsored Preparing for Treatment Programme.
[LINK](http://www.who.int/3by5/partners/ptp/en/index.html)

The Greater Involvement of People Living with HIV (GIPA): UNAIDS Policy Brief
[LINK](http://www.unaids.org/en/PolicyAndPractice/GIPA/default.asp)

IMAI Expert Patient Trainer curriculum:
[LINK](http://www.who.int/3by5/capacity/expert/en/)

2.5.3. **INVOLVING CIVIL SOCIETY AND THE PRIVATE SECTOR**
Whereas governments, particularly ministries of health, may take overall responsibility for health sector responses to HIV, it would not be possible to have an effective and comprehensive response, ensuring equitable access to HIV services, without the active involvement of the private sector and civil society, non-governmental, faith-based and academic organizations.

Community mobilization is key to promoting HIV testing and counselling and prevention, and to preparing people for treatment and providing adherence support. Civil society contributions complement and supplement formal health services by playing key roles in: HIV education and prevention, especially in reaching most at-risk populations; creating demand for HIV services; ensuring that HIV/AIDS services are acceptable and of good quality; preparing people for treatment through information and education; supporting adherence to medicine and providing other forms of prevention, care and support. These roles need to be reinforced as much as possible through providing adequate resources for community-health activities and building strong links between health services and community organizations. Academic institutions have an important role in capacity building, adapting guidelines and tools for local use, supporting operational research and providing technical assistance.

In many countries, many or most health care services, including HIV-related ones, are not provided by government but, instead, by faith-based organizations, NGOs and private businesses. It is a serious mistake to exclude them from any key mechanisms or process for planning, coordinating, financing or monitoring and evaluating the overall response to HIV.

**Summary of recommendations:**
- National health sector strategies and plans should call for the active and meaningful engagement of civil society, NGOs, faith-based organizations, private businesses, and academic institutions in strategic planning, programme development and
implementation, and monitoring and evaluation. These non-government players often constitute a significant portion of all health care providers and, in any case, they can play critical roles in expanding access to services, particularly for most-at-risk, vulnerable and marginalized populations.

- There should be country mechanisms to ensure that all providers of HIV-related services in the health sector meet minimum standards.
- Appropriate referral and communication systems should be established or expanded and strengthened to ensure continuity of care and services across the different sectors and service providers.

**Key resources:** 184 185 186 187 188

WHO's Stakeholder Analysis tool
[Link](http://www.who.int/hac/techguidance/training/stakeholder%20analysis%20ppt.pdf)

Scaling up effective partnerships: A guide to working with faith-based organisations in the response to HIV/AIDS
[Link](http://www.e-alliance.ch/media/media-6695.pdf)

[Link](http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf)

The UNAIDS website on working with civil society
[Link](http://www.unaids.org/en/Partnerships/Civil+society/default.asp)

[Link](http://www.unaids.org/unaids_resources/images/Partnerships/061126_CSTargetsetting_en.pdf)

### 2.5.4 ADDRESSING STIGMA AND DISCRIMINATION

HIV-related stigma and discrimination, often prevalent within health services, have been consistently identified as critical obstacles to provision and uptake of health sector interventions. Stigma or, more correctly, stigmatization devalues people because of their traits or behaviours or illnesses and is often followed by unfair and unjust treatment. It results in lower uptake of HIV prevention, care and treatment services and also makes people living with HIV reluctant to disclose their status to their sexual partners, family members and health care providers. It disproportionately affects women and girls (who are often devalued merely because of their gender) and also sex workers, men who have sex with men, injecting drug users and also ethnic minorities, whose minority status may be due to the fact that they are displaced persons or migrants from somewhere other than where they are living now.

Despite the pervasiveness of stigma and discrimination throughout societies, it is seldom adequately addressed in national responses to HIV. Yet, it can be addressed through simple and practical measures within the health system, such as providing people with accurate information that allays their fears and dispels their misconceptions about HIV and how it is and is not transmitted. The health sector can also advocate for and play its part in implementing a multifaceted national approach to reducing stigma and discrimination. Reducing stigma and discrimination in health facilities requires not only addressing attitudes and practices of health care workers, but also meeting their needs for the information and supplies needed for universal precautions to prevent occupational exposure to HIV. All of these efforts not only will help countries reach targets for universal access, but also will promote respect for human rights and for people living with HIV and vulnerable minorities.

**Summary of recommendations:**

Systematically collect strategic information about stigma and discrimination by using existing tools (e.g., questionnaires used in behavioural surveillance) for measuring the prevalence of stigma and discrimination and their impact on the response to HIV.

Facilitate the inclusion of stigma and discrimination reduction in national strategic planning and programming activities.

Provide training on non-discrimination to health care providers and establish codes of conduct and oversight for service providers.

To scale up national responses to stigma and discrimination (and thus scale up access to HIV prevention, treatment and care) use a range of approaches to preventing and reducing stigma and discrimination among different key groups (politicians, religious leaders, health authorities, law enforcers and so on), to challenge stigma and discrimination in institutional settings, and to build capacity for the recognition human rights, including the establishment and enforcement of human rights legislation.
2.5.5 DELIVERING GENDER-RESPONSIVE HIV INTERVENTIONS

Gender inequalities are key drivers of the HIV epidemic. In sub-Saharan Africa, they include harmful gender norms and practices such as violence against women, denial of women’s access to and control over resources, and so on and they contribute to women and girls’ vulnerability to HIV. In other parts of the world with concentrated epidemics, gender inequalities contribute to the vulnerability of sex workers, injecting drug users, men having sex with men, and transgender people to HIV. In these settings women who are married or in long-term relationships with sex workers, clients of sex workers, injecting drug users and men having sex with men are also at risk of HIV and unable to protect themselves due to gender inequalities. For example, norms encouraging men to take sexual risks but discouraging women from learning about sexual and reproductive health stop men and women from protecting themselves.

In many settings, women and girls face barriers in accessing HIV services because they lack the financial means to access care or may need permission from their husbands or other family members to go to a health care facility or are afraid of being labelled as ‘promiscuous’ if they are seen to seek services for STIs or HIV. Health services can reinforce gender inequalities by stigmatizing those who seek HIV services, especially if they belong to marginalised groups. In many settings, too, doctors are mostly male and share prevalent attitudes of disrespect for females that may manifest as insensitive or rough treatment, especially of women and girls from poor or marginalized populations. For all these reasons, achieving universal access to HIV prevention, treatment and care is contingent on the health sector taking action to reduce gender inequalities.

Summary of recommendations:

“Know your epidemic in gender terms”: programme managers and policy makers in the health sector should understand not only who is at risk for HIV in different epidemic settings, but also what underlying sociocultural, economic and political factors increase their vulnerability. Knowing your epidemic in gender terms requires:

- disaggregating data, including data from programme monitoring and evaluation, by sex, age and other appropriate equity parameters in order to identify who is at risk, whether they are being reached equitably, and whether programmes are working for those most in need;
- building capacity of programme managers, policy makers and health care providers to understand and address the links between gender inequalities and HIV;
- ensuring that national health sector HIV policies and programmes explicitly address gender inequalities including by allocating resources;
- addressing women’s fear of — or potential experience of — negative consequences of HIV testing and counselling by incorporating safety planning as part of disclosure and risk-reduction counselling;
- reducing gender-related barriers to access to services including non-affordability, necessities to get permission from husbands or other family members, fear of stigma and discrimination, actual stigma and discrimination or rough treatment of women and girls by health workers;
- advocating for gender equality in policies and laws related to women’s rights including those related to violence against women, property and inheritance rights for women and access to education for girls.

Key resources: 179 189


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Key resources: 190 191 180

Integrating Gender into HIV/AIDS Programmes: A review paper (2003)

Addressing violence against women and HIV testing and counselling: A meeting report, 2007
Ensuring Equitable Access to Antiretroviral Treatment for Women: WHO/UNAIDS policy statement


Integrating gender into HIV/AIDS programmes in the health sector: Operational tool to improve responsiveness to women's needs. *Forthcoming, WHO 2008*