INTERNATIONAL TREATMENT PREPAREDNESS COALITION
Treatment Monitoring & Advocacy Project

MISSING THE TARGET

6

The HIV/AIDS Response and Health Systems: *Building on success to achieve health care for all*

On-the-ground research in Argentina, Brazil, Dominican Republic, Uganda, Zambia, Zimbabwe

July 2008

The International Treatment Preparedness Coalition (ITPC) was born out of the International Treatment Preparedness Summit that took place in Cape Town, South Africa in March 2003. That meeting brought together for the first time community-based HIV treatment activists and educators from over 60 countries. Since the Summit, ITPC has grown to include more than 1,000 activists from over 125 countries and has emerged as a leading civil society coalition on treatment preparedness and access issues.

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ACRONYMS AND ABBREVIATIONS

The following acronyms and abbreviations may be found in this report:

ART = antiretroviral treatment

ARV = antiretroviral

CCM = Country Coordinating Mechanism (Global Fund)

Global Fund = Global Fund to Fight AIDS, Tuberculosis and Malaria

IDU = injecting drug user

IMF = International Monetary Fund

ITPC = International Treatment Preparedness Coalition

MoH = Ministry of Health

MSM = men who have sex with men

M&E = monitoring and evaluation

NGO = non-governmental organization

OI = opportunistic infection

PEPFAR = US President's Emergency Program for AIDS Relief

PICT = provider-initiated counseling and testing

PLWHA = people living with HIV and AIDS

PMTCT = prevention of mother-to-child transmission

PPTCT = prevention of parent-to-child transmission

STD = sexually transmitted disease

STI = sexually transmitted infection

TB = tuberculosis

TRIPS = Trade-Related Aspects of Intellectual Property Rights (through the WTO)

UNAIDS = Joint United Nations Programme on HIV/AIDS

UN = United Nations

VCT = voluntary counseling and testing

WHO = World Health Organization

WTO = World Trade Organization

EXECUTIVE SUMMARY

ABANDONING the United Nations (UN) and Group of Eight (G8) commitments to universal access to HIV/AIDS services, as rich nations of the world have begun to do, is not a strategy to accomplish better health care for anyone. For this sixth edition of *Missing the Target*, civil society research teams in six countries—Argentina, Brazil, the Dominican Republic, Uganda, Zambia, and Zimbabwe—investigated the impact of the significant scale-up of HIV/AIDS services on broader health systems. The results were distinct in each country but point to several broad conclusions.

First, the HIV/AIDS response to date has had far-reaching positive impacts on health care in many settings: building infrastructure and systems, raising the bar on quality, extending the reach of health care to socially marginalized groups, and engaging consumers.

Second, significant new investments in HIV/AIDS services have revealed existing fragilities in health systems, and in some cases have placed increasing burdens on these systems by expanding demand and stretching already overextended human resources.

Third, the push for HIV/AIDS treatment access has not been just about the money. Although these efforts have brought considerable new financing, the mobilization of activists and health care consumers themselves has also forced global and national leaders toward a more vigorous sense of accountability and urgency.

If the UN's health-related Millennium Development Goals (MDGs) are to have any chance of being realized, we need to do for health systems what we have done for AIDS while increasing the momentum of AIDS service scale-up. With increased resources, accountability for outcomes, and consumer engagement, the move toward broader health systems strengthening will have enormous benefits for communities as a whole, including people living with HIV. But if the business-as-usual, bureaucratic approach to health systems prevails, the world risks failing communities and leaving the millions living with HIV without desperately needed care.

ON-THE-GROUND REALITIES AND TODAY'S GLOBAL HEALTH DEBATE

Our research found that in Argentina and Uganda, scale-up of HIV/AIDS services has led to improvements in several aspects of health care, including how services are delivered and who receives care. In Brazil, HIV/AIDS services have been scaled-up in conjunction with the expansion of general public health care, though clear and distinct benefits for maintaining dedicated HIV-related services continue to be identified. In

the Dominican Republic and Zambia, HIV/AIDS services have established models of care that with adequate resources could be applied more broadly. In Zimbabwe, HIV/AIDS funding has become a "lifeline" for a health system on the verge of collapse.

Some voices in the health care debate are claiming that the international response to HIV/AIDS is weakening primary care in many countries, *diverting* funding and health care personnel and *distorting* health systems. Our investigation suggests that the global mobilization on HIV has not "diverted" resources but instead greatly expanded total health financing. It has "distorted" health systems to the degree that it has increased the accessibility and quality of services for one devastating disease. In most countries with serious HIV epidemics, health systems were not healthy prior to HIV's arrival: they were suffering from decades of disinvestment due to structural adjustment policies and chronic underfunding. AIDS has opened up a sense of possibility for change, for progress in providing health care to all who need it.

RESEARCH PROCESS AND MAJOR FINDINGS

Missing the Target civil society research teams used a standardized research template to interview key informants in their countries, including government officials, UN and other global agency staff, and program managers, as well as health care workers and consumers. Research teams asked a range of questions about: how the response to HIV/AIDS had affected different aspects of health care, both positively and negatively; lessons learned from scale-up of HIV/AIDS services; and priorities for improving prevention of parent-to-child transmission services. Key findings are listed below.

IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

Research teams found that the response to HIV/AIDS has had **notable positive impacts in several areas,** though this impact has been distinct in each country. Frequently noted positive effects of HIV/AIDS service scale-up included:

- promoting integration of HIV, TB, and other health services;
- relieving demand for hospital beds, emergency room services, and antibiotics that the AIDS crisis had created;
- motivating and expanding the capacity of health care workers;
- increasing access by marginalized populations and the poor to health services;
- raising community awareness about health, sexuality, and human rights issues;

- making AIDS-financed clinics, laboratories, and equipment available for other health services; and
- improving commodity procurement and negotiation skills with suppliers.

In addition, a variety of information, management, monitoring, and logistics systems implemented to enable HIV/AIDS service scale-up have helped improve care delivery and could be adapted to advance other health services.

Missing the Target 6 research also identified areas where the response to HIV/AIDS **has revealed fragilities in health systems and created new challenges,** including:

- increasing demand for services, sometimes leading to drug stock-outs;
- raising new concerns about corruption and lack of transparency as increasing resources came from outside sources;
- increasing the workload on health care personnel;
- imposing new budget pressures on governments;
- taking government focus away from other aspects of health services as it strove to meet demands of donors and a growing HIV/AIDS service system;
- attracting high quality health care personnel away from other health services; and
- creating an unequal system where some AIDS drugs are free while other treatments are only available at substantial cost.

LESSONS LEARNED FOR STRENGTHENING HEALTH SERVICES

Country chapters in this report identify a variety of lessons learned in scale-up of HIV/AIDS services that should inform strengthening of broader health systems. They include the following:

- **Investments in HIV services have paid off.** All teams found that the impact of HIV service scale-up has been visible and dramatic. Yet in most of the countries included in this report there remains considerable unmet need for HIV treatment and prevention services and additional resources are required.
- **The engagement of health care consumers has been indispensible to success.** The involvement of people living with HIV in demanding services, helping to design programming, promoting transparency and accountability, and addressing stigma has been essential to the success of HIV/AIDS programming—and in some cases has had spill over effects to other areas of health care.

- Significantly **increased financing has been critical** to expanding service capacity and quality, making necessary infrastructure improvements, and attracting and retaining health care personnel.
- At the same time, **significant expansion of resources requires accompanying efforts** to: support increased training opportunities and financing for human resources generally; improve anti-fraud and transparency measures as increasing resources enter the system; and expand infrastructure to accommodate new services.
- The mobilization around HIV/AIDS services has **created valuable, though often untapped, opportunities** to improve broader health delivery, such as more efficient procurement systems, models for program management and monitoring, and community engagement in health planning.

IMPROVING DELIVERY OF PREVENTION OF VERTICAL TRANSMISSION SERVICES

In several countries, targeted prevention of parent-to-child transmission (or PPTCT, also known as PMTCT) strategies have been highly successful in reducing HIV infection among newborns and, in some settings, providing an entry point for HIV treatment for women. In several cases, however, uptake of services is impeded by geographic barriers, lack of access to HIV testing, inadequate education and outreach, fear of stigma, and high costs of accessing care. There are also concerns about substandard HIV treatment for pregnant women. To improve the impact of PPTCT services, report authors make a variety of recommendations, including to better integrate these services with maternal and child health and primary care services, expand access in rural areas, raise awareness about the availability of services, and ensure the health care needs of pregnant women and new mothers are adequately addressed.

IMPLICATIONS FOR POLICYMAKERS

The beneficial factors in the HIV/AIDS response will be essential to the success of the International Health Partnership (IHP+) and other efforts that place increasing emphasis on “horizontal” financing to support health systems. A simple reshuffling of health resources toward more generalized health functions at the expense of effective disease-specific programs, such as HIV/AIDS, would jeopardize the remarkable advances that have been achieved.

The promise of Alma-Ata[1]—30 years old this year—of health care for all will be belatedly realized by building on (instead of dismantling) those programs that have produced demonstrable results. The dichotomy between vertical and horizontal financing and programming is a false one—outdated and largely theoretical. We can and must do both: strengthen health systems **while** fighting HIV/AIDS. We can't be lulled into thinking that by doing one of these alone, the other goal will be automatically achieved. That is the lesson of this report.

HIV/AIDS advocates are by definition health systems advocates. The advent and increasing global availability of antiretroviral treatment (ART) has made HIV infection a chronic manageable illness for many people, a condition handled at the level of primary care over a lifetime. We need strong health systems: our lives depend on them. But the work of addressing the HIV/AIDS epidemic has just started, and only one in three have access to urgently needed ART. Today's challenge is not to unravel the benefits of this extraordinary response or find an excuse to abandon the 33 million people living with HIV, but to take advantage of what has been learned and what has been built and make significant new investments in health services for all.

1 The "Declaration of Alma-Ata" was signed at the conclusion of the World Health Organization's International Conference on Primary Health Care in September 1978. The meeting was held in Alma-Ata, then part of the Soviet Union and now part of Kazakhstan (and known as Almaty). See: www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

Country Reports

Argentina

By Dr. María Lorena Di Giano

KEY POINTS

1. HIV/AIDS services have had positive impacts on other health services, including raising awareness of other STIs and reproductive health.

2. HIV/AIDS strategies have improved access to the health system of traditionally stigmatized and isolated populations, including drug users, sex workers, transgendered individuals, and migrants.

3. Equipment and infrastructure installed to provide HIV/AIDS services has enhanced laboratories' overall capacity to provide diagnostic services.

4. Mortality from AIDS has decreased significantly since the advent of free ART in 1997, but universal treatment access has still not been achieved.

5. VCT uptake has increased nationally, but only around half of the estimated 134,000 people with HIV are aware of their status.

6. Individual provinces are responsible for health care provision, so quality of care varies widely and access to HIV/AIDS services for those in rural areas is extremely difficult.

7. HIV-related stigma and discrimination in health care settings, excessive bureaucracy, and logistical problems in the drug supply system have all combined to create obstacles to treatment access.

RESEARCH PROCESS AND METHODOLOGY

Research for this report was conducted in April and May 2008. It consisted of an extensive literature review and in-depth interviews based on semi-structured questionnaires. The interviews were tape-recorded and later transcribed. A total of 24 people were interviewed in eight cities across Argentina: Buenos Aires, Conurbano Bonaerense, Córdoba, Formosa, Mar del Plata, Rosario, Tres Arroyos, and Tucumán. They included HIV/AIDS program managers; health care workers and service providers; representatives from the federal Ministry of Health (MoH), multilateral agencies (WHO and UNAIDS), and the Global Fund CCM; PLWHA and health care consumers; and advocates.

1. IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

In Argentina's federal system, individual provinces are responsible for most aspects of health care. As a result, there are significant differences around the country in regards to quality of care available. Three sectors are involved: public, private, and the social health insurance system. This report focuses on the public sector.

Most people interviewed agreed that the positive impacts of HIV/AIDS services on other health services stem not from any coordinated plans. Instead, they tend to result from strategies implemented in a mostly ad hoc manner in certain jurisdictions[2]. The following are some examples:

- HIV prevention and education campaigns have raised awareness about other sexually transmitted infections (STIs) and sexual and reproductive health issues among the general population, especially young people, and increased demand for related screening and treatment services (such as for syphilis and HPV [human papilloma virus]).
- HIV/AIDS strategies have improved access to the health system of traditionally stigmatized and isolated populations, including drug users, sex workers, transgendered individuals, and migrants. Health care facilities and workers are now far more welcoming to members of these populations[3].

2 The director of the National AIDS Authority acknowledged the current lack of strategies or mechanisms to measure and document the impact of HIV/AIDS programs on the overall health system.

3 For example, local regulations have been adopted in both the city and province of Buenos Aires mandating that transgendered people should be registered and called by their name of choice in all health care centers.

HIV/AIDS strategies have improved access to the health system by traditionally stigmatized and isolated populations, including drug users, sex workers, trans-gendered individuals, and migrants.

- Equipment and infrastructure installed to provide HIV/AIDS services have enhanced laboratories' overall capacity to provide diagnostic services.
- HIV/AIDS strategies have facilitated the availability of and access to information related to the correct, consistent, and systematic use of condoms.

At the same time, however, the expansion of HIV/AIDS services has posed challenges to the overall health system. The specialized care HIV infection demands has required greater interaction among various health services not only within the same health centers but also more broadly among those working in associated pathologies at different centers.

Although the AIDS mortality rate has decreased significantly since the advent in 1997 of free ART to all in need in Argentina, there are still cases of people seeking health care for the first time only when they are gravely ill with an HIV-related condition. They need hospital beds, specific supplies and resources, and specialized (and often costly) care—as do, in some cases, individuals experiencing serious side effects from ARVs and those coinfected with hepatitis.

Other impacts are summarized below by category.

COMMODITIES PROCUREMENT AND LOGISTICS

HIV/AIDS treatment provision has posed extraordinary challenges related to necessary budget increases and improved procurement and distribution logistics required to guarantee universal access for those in need. Such steps have only been possible with the cooperation of local health system structures.

HIV/AIDS programs have promoted and ensured free availiability of condoms at all health care facilities. And in some jurisdictions, such as Rosario City, implementation of harm reduction policies has prompted the use of public resources to purchase and distribute syringes to IDUs.

PROGRAM MANAGEMENT

HIV/AIDS programs have created new models of management by involving civil society, activists, and PLWHA in program design, implementation, and M&E.

HUMAN RESOURCES FOR HEALTH

In some jurisdictions, HIV/AIDS programs have prompted the development of capacity-building trainings on topics such as sexual diversity, gender, and secondary pathologies (e.g., substance dependence). This has undoubtedly helped sensitize and improve the quality of care provided by health care workers at all levels.

NUMBER OF PEOPLE SEEKING HEALTH CARE SERVICES

Partnerships between civil society organizations and governmental institutions have increased the number and scope of HIV testing campaigns and uptake of VCT services. The impact has been particularly noticeable among members of populations specifically targeted, including young people, sex workers, MSM, and pregnant women. (It should be noted as well, however, that an estimated one half of HIV-positive individuals in Argentina are not currently aware of their HIV status.)

ACCOUNTABILITY, TRANSPARENCY, AND GOOD GOVERNANCE OF HEALTH DELIVERY

The provision of free HIV care, including ART, came about in response to advocacy from civil society (including PLWHA groups). Advocates have continued to focus on transparency and accountability as they monitor and engage in all areas related to HIV/AIDS services; for instance, activists on bioethics committees have successfully pushed for improvements and transparency in drug research protocols. The models and policies they advocate for have largely been adopted across the health system.

MATERNAL AND CHILD HEALTH SERVICES

The national MoH has implemented and promoted a national policy to offer HIV testing to all pregnant women at the first level of health care. This strategy has greatly enhanced access to PMTCT services and substantially reduced the vertical transmission rate.

HIV/AIDS programs have created new models of management by involving civil society, activists, and PLWHA in program design, implementation, and M&E.

The increased interaction of HIV/AIDS services and maternal and child health services has facilitated early diagnosis; increased HIV-positive women's access to comprehesive health care, including contraception information and materials and prophylaxis treatment; and raised awareness about the potential risks of breastfeeding.

2. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

- Health consumers can offer vital and useful perspectives in regards to counseling, capacity-building, and ensuring greater transparency and accountability in all aspects of health care delivery. PLWHA and their advocates pioneered such engagement, which is now much more routine across the system.
- High-quality information systems, databases, and registries greatly improve caregivers' ability to serve health consumers in general. HIV/AIDS programs were the first to emphasize the importance of such monitoring strategies.

HIV/AIDS treatment provision has posed extraordinary challenges related to necessary budget increases and improved procurement and distribution logistics.

- VCT and HIV prevention services can be successfully integrated into the first level of primary care. This has happened in two cities, Rosario and Buenos Aires. In primary care centers in both cities, it is possible to get tested for HIV and receive condoms and other preventive materials; in Rosario, IDUs may also obtain sterile needles and syringes.

3. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

Despite important improvements over the years, much greater effort is needed to respond to HIV/AIDS in Argentina. For one thing, as noted previously, only about half of the estimated 134,000 HIV-positive people in the country are aware of their status. This points to insufficient promotion of HIV awareness, testing, and counseling. Other major problems include a poorly performing drug logistics and supply system; excessive bureaucracy requirements to obtain free ART (which is guaranteed by law to those in need); and lingering HIV-related stigma and discrimination in most health care facilities, especially at the provincial level. Taken together, these obstacles mean that universal HIV treatment access has not been achieved in Argentina.

4. IMPROVING PMTCT SERVICES

There was general agreement among research respondents that the most important challenge regarding PMTCT is the fact that many pregnant women do not visit health centers until relatively late in their terms. This is particularly true in communities isolated by geography and characterized by relatively low income and education levels.

Recent surveys indicate that the system has done better in terms of providing information about HIV (and recommending HIV tests) once a woman actually does seek out care during her pregnancy. However, as many as 15 percent of those tested do not return to obtain results after testing, and the quality of HIV-related counseling was reported to be insufficient for the most part.

Potentially useful steps to improve the situation might include:

- more fully integrating maternal health and HIV/AIDS services so that information and resources are shared more broadly;
- improving the quality of counseling among reproductive health workers, with specific attention paid to increasing their awareness of HIV-related issues; and
- incorporating PLWHA-provided peer counseling in all PMTCT-related strategies.

5. PERSPECTIVES OF HEALTH CARE CONSUMERS

Twelve health consumers were interviewed for this report, nine of whom were PLWHA. Their accounts indicate that access to health services varies by city and province. Adequate access is particularly difficult for those in rural areas, who often must travel hundreds of kilometers to receive care: this is due to the fact that HIV/AIDS services and specialists are concentrated in provincial capitals. Many respondents mentioned frequent delays and difficulties in getting routine diagnostics (CD4 and viral load tests) and associated blood work.

Most HIV-positive respondents said they were comfortable disclosing their HIV status and discussing it openly in health care settings. Several added, though, that HIV sensitization efforts should be re-emphasized to reach staff at all levels of health care delivery, not just professionals. They also expressed a wish for greater access to peer counseling, especially in provinces where health structures are still reluctant to incorporate PLWHA as service providers.

And finally, several respondents said there is an urgent need to improve treatment literacy, especially for newly diagnosed individuals, and to create more specialized programs focusing on improving treatment adherence.

RECOMMENDATIONS

The National AIDS Authority should:

- develop health systems indicators to evaluate the effects of HIV/AIDS programs on the general health system; and
- improve logistics and supply mechanisms for ARVs and other medicines, and reduce bureaucratic hurdles frustrating easy access to treatment.

National and local health authorities should work together and in partnership with civil society—including PLWHAs—to:

- implement, at national and local levels, a new way of planning HIV/AIDS programs so that the overall health system is i) better supported and prepared to address HIV-related issues, and ii) all its vertical components are integrated into the general health system.

HIV/AIDS program managers should interact with national and local health authorities in order to address the urgent need to:

- integrate HIV testing and counseling in primary care facilities across the country, which at the very least would require increasing resources and capacity for HIV diagnosis and strengthening counseling and testing in all health centers;

- build capacity among all health care workers in regards to HIV, a step that would improve care not only for PLWHA and members of vulnerable populations, but for members of the general population as well; and
- develop and implement stigma-reduction trainings for all health care workers, with special attention paid to those in primary health care facilities—which is where most HIV-positive individuals or those at risk first present.

Brazil

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KEY POINTS

1. ART is universally available, but about one third of people do not know their HIV status. Therefore, many people seek treatment when they are already very ill.

2. PMTCT services have been available since 1996, and are generally high quality. However, additional energies should be used to promote condom use, strengthen ART education and adherence, increase early access to care and treatment for pregnant women, and provide HIV testing for sexual partners.

3. Civil society has played and continues to play a vital role in helping service users demand their rights. It has taken on the bulk of HIV prevention activities while leaving treatment and care to the public health system.

4. The scale-up of HIV/AIDS services has had a positive impact on provision of other services—notably for TB and hepatitis B and C.

5. Efforts to uphold the rights of PLWHA have helped raise awareness about the right to health in general and made health professionals much more sensitive and effective.

6. A push by policymakers to integrate HIV/AIDS services into the broader health structure from the outset has eased frictions between the National STD/AIDS Program and other health programs despite early resentment over the large investment of relatively scarce resources for the HIV/AIDS response.

RESEARCH PROCESS AND METHODOLOGY

Research for this report includes document reviews and interviews with 15 people across Brazil. Among those interviewed were three managers of the AIDS programs (one at the national level, one at a state level, and one at a municipal level)[4]; two AIDS activists; two feminist activists from women's organizations that work on HIV/AIDS issues; four people living with HIV; three researchers; and the president of the National Health Council.

1. SUMMARY OF KEY FINDINGS

CHANGES NEEDED IN THE HEALTH SYSTEM TO BETTER MEET THE NEEDS OF PLWHA

Most of the interviewees said that although there is need for improvement in the health system's performance, no structural changes are necessary given that the Brazilian Unified Health System (SUS) was initiated quite recently (1989) and has been constructed over the same period of time as the Brazilian response to HIV/AIDS—both being a result of intense civil society mobilization for better public health care. They do believe, however, that it is important to take measures to implement the system in the way that was originally intended. To that end the priorities would be not only to increase the volume of resources allocated to health as a whole but improve the management capacity at all levels, especially at the local level; fight vigorously against corruption; increase the capacity of civil society to monitor the actions of the state; and intensify accountability in all spheres.

PRIORITY LEVERAGE POINT TO IMPROVE TREATMENT ACCESS OVER THE NEXT YEAR

Respondents agreed that it was important to expand outreach efforts to increase early diagnosis among persons who have HIV but are unaware of it. This requires an extra effort on the part of public authorities and civil society, sectors that should collaborate more extensively to identify and build trust among members of vulnerable and socially stigmatized populations who may be unaware of or disinclined to access vital health

4 The individuals interviewed were an employee of the Ministry of Health (at the federal level); a state coordinator of the AIDS program (at the state level); and the coordinator of the AIDS program at the municipality level in one state capital. The names of the states are not specified because all three individuals agreed to be interviewed only if they were not identified.

services. This effort should include targeted campaigns (not merely broad and general media campaigns) for each population to stimulate the demand for tests. Steps taken to increase testing must, however, be accompanied by a parallel increase in capacity for offering high quality pre- and post-test counseling within the framework of human rights.

LESSONS LEARNED FROM THE BRAZILIAN EXPERIENCE

The first funding specifically focused on HIV/AIDS activities in the public health system in Brazil was allocated in 1994, eight years after the National STD/AIDS Programme was organized (1986) within the Ministry of Health (MoH). Implementation of the National STD/AIDS program coincided with the implementation of the SUS, and several of the latter program's overall guidelines and principles—such as universality, comprehensiveness, equity, and decentralization—were included in the former.

The involvement and engagement of civil society deserve special attention. For example, civil society groups worked to obtain direct access to funds through tendering processes of the National STD/AIDS Program, thereby enabling many NGOs to provide services directly to people living with HIV. Civil society organizations also focused, from the very beginning, on ensuring that the human rights of HIV-positive people would be the cornerstone on which all HIV-related services were delivered. Such actions have improved the ability of all health care consumers to obtain access to services and to demand their rights under the SUS.

Civil society groups worked to obtain direct access to funds through tendering processes of the National STD/AIDS Program, thereby enabling many NGOs to provide services directly to people living with HIV.

Prevention activities—not only those carried out by the Brazilian National STD/AIDS Program, but also those undertaken by NGOs—have also increased awareness and discussion of issues related to sexuality, sexual diversity, sexual rights, and minority rights. As such, they were extremely important in the consolidation of a health system that promotes equity as one of its main principles. Those discussions and debates might never have taken place had it not been for the direct financing provided to civil society, which took on the greater part of HIV prevention activities—and for the most part has left care and treatment activities under the responsibility of the public health system.

The epidemic continues to demand a rapid response that justifies the need for resources directed specifically for HIV/AIDS. Currently, almost all resources utilized in the HIV/AIDS government response in Brazil are national resources, due to the fact that international cooperation supports specific and smaller projects performed by NGOs. The process of decentralization has made it more difficult for civil society to monitor allocations and expenditures, because when the budget is transferred from the national level to the county level, the specification of the activities under the budget is broad, e.g., "improvement of primary health care" that can include (or not include) HIV prevention activities. Some

The epidemic reinforces the urgent need to strengthen the health system as a whole... but in the short and medium term it is still necessary to have both: specific funds for HIV/AIDS and funds for the health system in general.

people interviewed therefore argued that the system as a whole is still fragile and that if resources come into the SUS without being specifically allocated for HIV/AIDS, they may not have any impact on the epidemic.

In a more cross-cutting vision, the epidemic reinforces the urgent need to strengthen the health system as a whole because people who have been diagnosed with HIV start to use overall health services more frequently, not just those units that work specifically with HIV/AIDS. But in the short and medium term it is still necessary to have both: specific funds for HIV/AIDS and funds for the health system in general.

OTHER LESSONS LEARNED FROM THE SCALING-UP OF HIV/AIDS SERVICES:

- To be effective, PMTCT activities need an extensive network of reference laboratories and qualified personnel to oversee all aspects related to HIV testing of pregnant women and follow-up care. Such steps have been taken in Brazil.
- Similarly, domestic production of medicines (including generic versions of ARVs) and, more recently, condoms, has strengthened the health technology and innovation sector.
- HIV-specific capacity-building for health professionals has strengthened the health system overall, thereby leading to improvements in dagnosis and care of other conditions.

INTEGRATING HIV/AIDS INITIATIVES

If increased support is needed for a certain HIV-related priority, such as for community mobilization, education, and human rights programs, then there is also the need to inject significant resources into strengthening health services as a whole. The strength of the entire system is a key factor in the effectiveness of HIV-specific care, ensuring a well-trained and well-paid staff, high-quality services, and pharmaceutical and laboratorial support. But it is also necessary to ensure that the HIV/AIDS response remains at the same high level. Thus both are needed: direct funds to HIV/AIDS and funds to improve the health system. Otherwise there is a risk that the Brazilian response will be less comprehensive and extensive.

2. IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

The scale-up of HIV/AIDS services has had a positive impact on the provision of some other services, particularly those for TB and hepatitis. In 1996 the old National TB Program was restructured with the goal of improving it in general and integrating it more effectively into the SUS. The National Viral Hepatitis Program was launched a few years later, in 2002. Standards and guidelines in both have been influenced by HIV-

focused NGOs' strong and successful efforts to uphold the rights of HIV-positive people to health care. Such developments contributed to make health professionals, especially doctors, more sensitive and effective in their administration of care.

The establishment of Serological Guidance and Counseling Centers (COAS) within the SUS was another important initiative because it instituted counseling as a standard service, available free of charge to those in need. The COAS now undertake a series of activities that include information and counseling for HIV, STI, and hepatitis prevention; distribution of condoms to all who request them; and referral services for members of stigmatized groups including drug users, transgendered individuals, and sex workers.

It is necessary to keep the AIDS response at the same high level we have at the moment.

Expertise and experience in HIV-related health services also prompted improvements in the public laboratory network, including in regards to better infrastructure; capacity-building for staff in their ability to diagnose other transmittable diseases; staff's ability and inclination to negotiate lower prices with laboratories; and more efficient procurement and purchasing policies.

The impact has not been one way only, which is perhaps unsurprising given that the Brazilian response to HIV was launched at the same time as the SUS was created. For example, other health system initiatives, including the Family Health Program[5]—created with the intent of providing universal community-based primary care—and the Policy on Integral Health Care for Women have increased the extent and type of important information about HIV and other diseases available to members of populations not typically serviced by NGOs focusing on HIV issues.

And finally, it is important to note that the large investment of human and financial resources directed toward HIV/AIDS at the beginning of the Brazilian response caused some resentment. This stemmed from the comparative paucity of resources available elsewhere in the MoH and the fact that HIV incidence and prevalence were relatively low. Other officials and stakeholders, meanwhile, were uncomfortable or upset for reasons related more closely to HIV-related stigma and discrimination. However, policymakers have, from the beginning of the Brazilian response, put considerable effort into integrating HIV/AIDS services into the broader SUS structure. As a result, friction between the National STD/AIDS Program and other SUS health care programs has been reduced considerably.

5 Implemented in 1996.

3. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

The importance of civil society mobilization is the most vital lesson stemming from the development and success of the National STD/AIDS Program in Brazil. Civil society groups play two roles that, taken together, greatly help to improve the HIV/AIDS response. On the one hand, they seek to hold government authorities accountable and ensure transparency. And on the other hand, they often work closely with authorities and provide community-based expertise that improves the quality and reach of services.

Another important lesson learned concerns integration with other SUS programs. Since the National STD/AIDS Program was launched, care has always been taken by decision-makers to ensure that representatives of other programs participate in its technical advisory commissions. As a result, the National STD/AIDS Program has fostered discussions and debate in the overall health system in areas including dental health; specialized care for women, adolescents, and children who are victims of domestic or sexual violence and abuse; and the sexual and reproductive health of young people. (It should be noted, however, that these discussions have not necessarily led to appropriately concrete actions. Guidelines have been changed in many cases, but the level and quality of services available for women, elderly people, and youth have not sufficiently improved.)

Also still lacking is extensive integration of services provided through the basic health care network and those offered primarily for people living with HIV. Many services needed by PLWHA do not require a high degree of complexity, which means that they can (and probably should) be provided through the primary care network. Such services include promoting adherence, counseling, psychological support, and the provision of nutritional guidance.

4. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

All individuals interviewed for this report agreed that there was no need for major structural reforms in the health system in order to provide better care and attention to the needs of people living with HIV. Some adjustments were deemed necessary to perfect the implementation of

Making medicines available to all those who need them has been an important success on the part of the Brazilian government and its civil society partners (including PLWHA). However, crucial challenges persist given the complexity and diversity of such a large country—and one with such extreme local and regional disparities.

the SUS—especially regarding its management capacity at the local level. Several respondents also highlighted the importance of improving the allocation of personnel and services because they are presently more heavily concentrated in some regions of the country than in others. Another potentially useful development would be an increase in civil society monitoring of SUS health councils at the local, state, and national levels.

Treatment access per se is not a problem in Brazil. It is estimated that everyone who tests positive for HIV can get treatment if and when needed. The problem is that an estimated one third of people infected with HIV are either not aware of their status or are unable or unwilling to access the system. There are far too many cases of HIV-positive individuals only seeking care when they are very ill; ART is often less effective in such situations. Thus there is a need to stimulate uptake of HIV testing and to encourage those who test positive to obtain routine care and treatment. This could be achieved in several different ways. Potentially effective strategies would include:

- expanding women's access to prenatal examinations and routinely offering HIV testing to those who participate;
- regularly recommending HIV tests to all women who come into contact with the health system;
- strongly encouraging tests to those who acknowledge engaging in potentially risky behaviors (such as injecting drug use and, for men, same-sex relations); and
- prioritizing outreach among individuals who are rarely if ever linked to health care systems, such as the homeless and people deprived of their liberty (prisoners).

In regards to the final point noted above, all people have the right to use SUS services—even those incarcerated. However, most prisoners continue to receive substandard health care. In general they have relatively decent access to ART and HIV tests, but some other key services—such as diagnosis and treatment for STIs and OIs—are less commonly obtainable.

5. IMPROVING PMTCT SERVICES

PMTCT services in Brazil are quite good and have been steadily increasing their coverage since the nationwide program was first implemented in 1996. Additional emphasis should be placed on more extensive counseling regarding the use of condoms, women's adherence to treatment after childbirth (when necessary), HIV testing of sexual partners, and earlier access to care and monitoring services by pregnant women. Some civil society groups have claimed that current PMTCT activities are far more concerned about children and subsequently ignore women's needs. For example, some respondents noted a tendency among health staff to suggest tubal ligation for HIV-positive women.

Female PLWHA interviewed also recommended more monitoring to ensure better implementation of a policy providing mothers with medicines that halt the flow of milk. Many had their breasts bound to stop the flow of milk. In addition to being painful, breast-binding can be quite stigmatizing because it openly signals HIV-positive status, especially among other pregnant women.

6. PERSPECTIVES OF HEALTH CARE CONSUMERS

HIV-positive individuals interviewed all agreed that they received good quality care in general, particularly in terms of access to ART and routine check-ups. Several did say, however, that the care provided in terms of treating OIs and drug side effects was of lesser quality. Some also reported having difficulty obtaining much-needed social benefits on a regular basis, including unemployment benefits, basic food packages, and transport vouchers.

RECOMMENDATIONS

Making medicines available to all those who need them has been an important success on the part of the Brazilian government and its civil society partners (including PLWHA). However, crucial challenges persist given the complexity and diversity of such a large country—and one with such extreme local and regional disparities. Most notably, the decentralized nature of most federal programs, including the National STD/HIV Program, means that national rules are not mandatory. Regional and local local governments have significant freedom to adapt the rules to local priorities and to decide how they will allocate the funds for AIDS, and not every part of the country has a strong civil society sector to monitor and advocate.

It is in this national context that problems related to access and quality of care must be considered and understood, especially in regard to the particular needs related to gender inequalities and the lack of strategies for specific populations that remain widely underserved, such as prisoners and the homeless.

The following recommended steps are aimed at improving HIV/AIDS services in Brazil for everyone.

THE BRAZILIAN UNIFIED HEALTH SYSTEM (SUS) SHOULD:

- guarantee that local and state health authorities are committed to implementing the SUS guidelines, including the policies regarding HIV, TB, hepatitis, and sexual and reproductive health;
- implement measures and strategies to improve access to testing, especially for the most vulnerable populations and women in general;

- expand access to pre- and post-test counseling services provided by better-qualified counselors;
- implement more extensive capacity-building on HIV/AIDS issues among staff at the Family Health and Community Health programs: the community health agents need to improve their ability to serve PLWHA;
- place greater priority on non-medical prevention activities, such as awareness and education campaigns, both for the overall population and those aimed at members of vulnerable groups;
- strengthen and expand access by vulnerable populations to the benefit of resources, taking into account class, cultural, ethnic, and gender differences, and cultivating the ethical principles on which the production and distribution of such resources should be based on;
- make greater efforts to combat HIV-related discrimination in service delivery overall—and particularly in regards to services provided to PLWHA themselves. Special attention should be paid to eliminating barriers faced by women living with HIV who seek to access their sexual and reproductive rights; and
- resolve to take more seriously, and respond appropriately to, HIV-positive patients' complaints that health care personnel do not treat them humanely. Such complaints often stem from a lack of clear explanation of (and adequate treatment for) ARV side effects, perceived inexperience in prescribing and monitoring ARVs, and lack of dialogue with the patient in general.

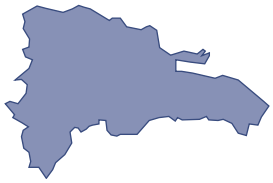
THE GOVERNMENT AND HIV/AIDS POLICYMAKERS SHOULD:

- place more emphasis on addressing the links between HIV/AIDS and negative social factors such as poverty and violence;
- devote additional funds and attention to HIV/AIDS activities directed at women and girls, and to better coordinate and integrate HIV/AIDS and sexual and reproductive health policies;
- provide funds for NGOs to carry out advocacy and public policy monitoring strategies, not just direct service delivery. Civil society partners should also be guaranteed assistance in building capacity to more effectively influence public policy at all levels;
- revise policies regarding intellectual property rights so as to more fully utilize legal rights under the World Trade Organization's agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). This would help to ensure the affordability and sustainability of Brazil's ART program;

- remove limitations regarding distribution of medicines, especially those that ultimately require consumers to return frequently to facilities and thereby contribute to adherence problems; and
- stimulate more vigorous private sector participation in HIV/AIDS prevention efforts.

CIVIL SOCIETY ORGANIZATIONS SHOULD:

- develop strategies and gather appropriate evidence to respond forcefully to the idea, increasingly common among donors, that targeted funds for HIV/AIDS hold back health systems in general;
- improve their ability to track international policies and developments regarding HIV/AIDS and strive to influence the negotiations undertaken regarding intellectual property and services within the multilateral bodies– an essential strategy in the current setting and one of the primary challenges in maintaining and enhancing the national response; and
- improve capacity to monitor HIV-related policies and programs at the local (municipality) level.



Dominican Republic

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KEY POINTS

1. There is a two-tier health system: the public system is under-funded, overcrowded, and riddled with corruption, while the private system is poorly regulated and excessively costly. Multiple barriers to accessing inpatient hospital care, referrals, and specialists exist in both systems.

2. Nearly 10,000 PLWHA are receiving ART at more than 50 treatment sites across the country.

3. Access to ART is further restricted by a recent government requirement that patients must present a Dominican ID card to register with the National AIDS Program to receive care. A large percentage of the country's 10 million residents lack proper documents or may be reluctant to provide confidential information to government-run health authorities.

4. HIV treatment programs tend to be viewed as separate and autonomous from the health system (largely due to external funding of these programs), leading to a lack of integration and sustainability.

5. There are frequent and widespread shortages of medicines for OIs and lack of public funds for routine laboratory tests, some of which were previously funded by World Bank loans.

6. Expansion of VCT services has been limited because lab technicians—who have a monopoly over the provision and reading of rapid tests in public hospitals—oppose the additional training of nurses and other health workers to perform these tasks.

7. If sufficient resources and political will were made available, the rapid expansion and utilization of resources for HIV treatment and care in the Dominican Republic could serve as a model for other areas and the entire health system as a whole.

RESEARCH PROCESS AND METHODOLOGY

Research conducted in April and May 2008 consisted of reviews of documents and websites with information about HIV treatment programs and the Dominican health system, as well as interviews with more than 40 people. Those interviewed included doctors, nurses, psychologists, peer counselors, hospital directors, people living with HIV, NGO staff members, government administrators, and representatives of multilateral agencies.

1. IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

By June 2008, nearly 9,300 PLWHA in the Dominican Republic were receiving ART at more than 50 treatment sites across the country. Despite persistent gaps and myriad challenges, this still represents one of the country's most impressive public health achievements in the last five years. Therefore, it was surprising that many people interviewed, particularly those working on the ground in the public health sector, were reluctant to attribute broader and more wide-ranging positive impacts of improved access to HIV treatment services on other aspects of the Dominican health system. They viewed HIV treatment scale-up in recent years as important but also largely isolated and insulated from the rest of the health sector due to the substantial amount of external financing of HIV programs, separate drug procurement and distributions systems, and unique and effective activism by PLWHA and others that has helped stimulate and implement needed changes.

Most consulted did agree, however, that the substantial scale-up of ART and associated services has had noticeable and important impacts on the health and well-being of thousands of primarily poor people living with HIV in the country, which is clearly important in and of itself. Several noted that the expansion of infrastructure, the opening of specialized HIV treatment sites, and the hiring of specialized staff (including nurses, doctors, counselors, psychologists, and administrators) to work in these sites has improved the quality of care available to PLWHA—which, if sustained, will continue to do so in the future. Such developments have undeniably reduced HIV-related stigma because they have lessened the incidence of disease progression, hospitalization of PLWHA, OIs, wasting, and death. These achievements are important, but many respondents asserted there is little evidence of similar, much-needed resources and improvements in other areas across the strained and long-neglected public health system in general.

Despite the clearly positive impact of these targeted programs for people living with HIV, numerous reports continue to surface of PLWHA facing discrimination and multiple barriers—especially in the underfunded public health sector—to accessing inpatient hospital care, referrals, and access to specialists.

Some of these challenges merely reflect and are the result of overcrowding, inefficiency, and corruption; minimal government investment; and shortages of dedicated and committed health workers to manage all diseases, not just those affecting PLWHA. Deficiencies in the public health system have, over many years, resulted in the creation of a multi-tiered system in which those with money and resources typically prefer to access what is perceived as a higher quality care in the private sector while the majority, and particularly the poor, must rely on the under-resourced and poorly managed public sector.

[Interviewees] viewed treatment scale-up ... as important but also largely isolated and insulated from the rest of the health sector due to the substantial amount of external financing of HIV programs, separate drug procurement and distributions systems, and unique and effective activism by PLWHA and others that has helped stimulate and implement needed changes.

Additional challenges primarily reflect persistent stigma, racism, and exclusion specifically targeting PLWHA, both within Dominican society and the health care system. These multiple factors combine to powerfully restrict tens of thousands of largely poor PLWHA from receiving appropriate care. Such limitations extend both to those enrolled in the government-funded HIV treatment programs and the estimated 50,000 or more PLWHA who may ultimately need treatment but have yet to access it and register at government-run treatment sites.

In regards to broader impacts of HIV/AIDS programs, it is important to recognize that the expansion of the government-subsidized free HIV treatment program has incorporated numerous private, religious, not-for profit, and NGO-supported clinics. This has served to strengthen the health system because (unlike traditional privately run services) epidemiologic data from patients receiving ART and other HIV care and services at these sites are reported to the National AIDS Program, and therefore available for further aggregate analysis by the Ministry of Health. Thus, as result of efforts that have created new systems that allow for at least partial synthesis of public, private, and civil society epidemiological reporting mechanisms, HIV treatment programs are unique. They do not currently—but should and could in the future—serve as a model to better link the disparate, fragmented, and sometimes overlapping and duplicative private, public, military, and social security-managed health systems and individual health centers, hospitals, clinics, etc.

One additional specific cause for concern with respect to the lack of integration of HIV care into the public health system is that hospital administrators and others tend to view HIV treatment programs, even those established within public hospitals, as separate and autonomous—and thus functionally independent of the public health system. These attitudes stem from the fact that HIV treatment sites have been largely

The capacity of the public health system to meet additional health needs of PLWHA is relieving some stress from other areas of the health system, such as hospital emergency rooms, even as the treatment program itself is strained in many ways by the increased demand.

dependent for a considerable (if not disproportionate, compared to non-HIV services and the public health system in general) share of their funding from COPRESIDA, the government agency managing more than $60 million provided by the World Bank and Global Fund for HIV/AIDS programs. While in other ways HIV treatment programs have reduced stigma, as mentioned previously, the separate and privileged status of HIV services funded by external resources has in some cases served as a barrier to integration and contributed to continued stigma associated with patients seeking care at HIV treatment sites. These issues may pose problems for ensuring the long-term sustainability and better integration of, in the best of cases, relatively "specialized," high quality, respectful, and confidential HIV care into the public health sector.

Finally, expansion of access to ART has not only increased demand for medicines, but also the willingness of PLWHA to access certain public health services. On the one hand, increased ART access has and will continue to reduce morbidity and mortality and enable earlier and more frequent opportunities for detection and treatment of OIs, including TB. However, this increased demand has also resulted in frequent and widespread shortages of medicines for OIs, coupled with an ongoing lack of sufficient public funding for routine laboratory testing previously supported in part by World Bank loans (which must now be repaid). These achievements and challenges indicate that the capacity of the public health system to meet additional health needs of PLWHA is relieving some stress from other areas of the health system, such as hospital emergency rooms, even as the treatment program itself is strained in many ways by the increased demand. However, it was evident from site visits that even the extra resources and staff allotted to the rapidly expanding specialized HIV treatment sites and laboratory facilities as result of external funding for treatment scale-up are often still insufficient. More resources and coordination are needed to fill gaps in HIV treatment programs, to better integrate HIV care into the public health system, and to improve the quality of care in the public system as a whole.

2. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

As suggested in Section 1, the rapid expansion and utilization of resources for HIV treatment and care in the Dominican Republic could serve as a model for other areas and the entire health system as a whole. For example, the director of the National AIDS Program said that some monitoring and logistics systems implemented for HIV treatment sites could and in some cases already were being studied and transferred to other departments managing government-run health programs.

However, the effectiveness of this transfer and other lessons learned from HIV treatment expansion will obviously be contingent upon and require immediate and continuous improvement of the same logistics and supply chain management of drugs, tests, medical records, and access to primary

and specialized care for PLWHA, the original intended beneficiaries. Otherwise programmatic expansion and replication elsewhere in the overall health system (inspired from HIV treatment scale-up) may prove costly, create additional problems, and not necessarily help solve existing ones.

3. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

One extremely controversial and potentially discriminatory measure that could restrict already limited access to ART and other health services for tens of thousands of PLWHA is a requirement that a Dominican ID card be presented in order to register a patient into the National AIDS Program, which subsidizes drugs, lab tests, doctor consultations, and other services. Government authorities issued an order in late April 2008 to all treatment sites requiring that patients present national ID cards in order to receive care. However, a significant share of the approximately 10 million people living in the Dominican Republic are believed to currently lack proper official documents. They include Haitian migrants, Dominicans of Haitian ancestry, and Dominicans living in rural areas. Many others, who hold valid ID cards may also be reluctant to show them out of fear of confidentiality breaches. Health authorities claim that these stricter registration policies to enter the National HIV treatment program reflect Global Fund requirements and are needed to prevent fraud and diversion, since they allow for auditing the distribution of ARVs and other medicines. Regardless of the merits of this claim, it is more likely that in practice this new policy may ultimately exclude and deter many of the most vulnerable PLWHA from accessing health services and potentially lifesaving medicines.

Instead, improved monitoring and control could be achieved through the hiring of additional community health workers, including people living with HIV, who are trained in HIV prevention and care and in other basic health issues. This would allow for an increased number of home visits, expanded adherence counseling, more individualized patient follow-up, the creation and sustaining of more support groups, and the strengthening of primary care services for PLWHA and others. If deemed necessary, a less restrictive system based on anonymous tags or numbers could be created to collect information about those enrolled in treatment programs. Such a system would be less likely to violate patients' confidentiality or deny medicines or access to health services for those lacking proper documentation.

4. IMPROVING PMTCT SERVICES

The quality of PMTCT services would be greatly enhanced by improving access to crucial diagnostics, including rapid HIV tests for pregnant women in primary care settings. Currently, the provision and reading of rapid tests in public hospitals are monopolized by lab technicians, who

have blocked the additional training of nurses and other health workers for administering the tests and delivering the results in a timely way. This has limited an expansion in access to testing for both pregnant women and the entire population.

Furthermore, HIV test results—if in fact free HIV tests themselves are even available and stocked in the hospital or clinic, which research indicated was not always the case—often take days to be delivered and many women are potentially lost in follow-up. Ideally, rapid test results should and could be delivered within an hour or less after a pregnant woman is tested. Instead, in many public hospitals, they are often collected by laboratory technicians and performed by centralized hospital labs at certain times each day or week, rather than being performed and read and delivered individually for each patient.

HIV-positive pregnant women also need better access to CD4 and viral load tests, both of which help determine the most effective and appropriate ART regimen to prescribe, if deemed necessary. Currently, a handful of pilot projects provide internationally recognized best practice regimens to HIV-positive pregnant women to reduce perinatal transmission; however, such protocols have not been implemented nationwide, and many women receive dual or monotherapy (using only nevirapine, or nevirapine and AZT) or no ARVs at all.

Significant expansion and improvement of the PMTCT program is an important way HIV/AIDS services could be better integrated into the primary care health system.

5. PERSPECTIVES OF HEALTH CARE CONSUMERS

"We need a hospital just for ourselves, in order to be able to receive care often denied or otherwise unavailable in public hospitals." That sentiment was voiced by an elderly female PLWHA in the small and crowded waiting room of what had originally been dubbed the public sector's flagship and model treatment site in one of the country's largest public hospitals. Grappling with the implications of such comments allows one to better appreciate patients' wishes for specialized services, including the hiring or training of health workers able and willing to care for PLWHA. It also indicates the failure of and disillusionment regarding efforts to integrate health services for PLWHA into the existing, often deficient, public health care system. The comment reflects both frustration with and an understanding of current realities on-the-ground by users of the public hospitals, while also raising concerns about continued stigma surrounding HIV in the health system.

The public health system must be improved in order for PLWHA to want to and be able to access needed public health services. If such services were more adequate and PLWHA were cared for with less discrimination, it is unlikely there would be a perception of the need for exclusive and

PLWHA and those working to provide and implement HIV services must therefore work with others to demand that the Dominican government and decision-makers worldwide protect basic human rights to universal access to health care.

potentially stigmatizing services targeting PLWHA. All people, including those with HIV, deserve access to potentially lifesaving medicines, and also to high quality, comprehensive care for all their health needs. Therefore, it is critical to build upon successful but still insufficient advances made in the provision of HIV care. PLWHA and those working to provide and implement HIV services must therefore work with others to demand that the Dominican government and decision-makers worldwide protect basic human rights to universal access to health care without exclusion, and invest needed resources to reduce or eliminate the currently widespread inequities. This would ensure that health systems continually work to meet the right to health care and improve health services not only for PLWHA, but for everyone.

RECOMMENDATIONS

- The National AIDS Program should modify its requirement that PLWHA must present national ID cards to receive ARVs and other HIV services. It should also take additional measures to ensure confidentiality while at the same time guaranteeing that no individual is denied access to drugs and care.
- The Dominican government must invest a larger share of its own resources in the purchase of ARVs in order to reduce exclusive dependence on the Global Fund. This step would help ensure current and future sustainability of ART availability and hasten integration of HIV/AIDS care into the broader public health system.
- The National AIDS Program should take the lead in increasing access to rapid HIV tests at all levels of the primary care health system nationwide.
- Government health authorities should make it a priority to improve the quality of and begin to integrate logistics systems for HIV medicines, lab tests, and supplies into the public health system. This would help increase and ensure access to ARVs and also help build efficient systems that strengthen procurement, logistics, and public health monitoring systems for all diseases.
- The Dominican government should take more aggressive measures to strengthen the public health system. This would entail making it more affordable and comprehensive, and taking steps that would reduce the disparities between public and private health facilities. Improving the public system will require increased funding, but in the long run the investment will be well worth it in terms of better quality care and treatment for the majority of the country's residents.

Uganda

Richard Hasunira, HEPS-Uganda[6], Prima Kazora, HEPS-Uganda, Aaron Muhinda, HEPS-Uganda, Rosette Mutambi, HEPS-Uganda, Beatrice Were, HIV/AIDS activist

KEY POINTS

1. HIV/AIDS claims the biggest share of health financing of any single disease in the country.

2. The massive inflow of funds from foreign donors for HIV/AIDS programs has resulted in broader improvements to public health, but significant additional funding is needed to meet health care needs.

3. HIV/AIDS programs have improved community mobilization, including TB and village health teams.

4. There are limited successful examples of integrating HIV/AIDS care into primary health care services.

5. The epidemic has placed increased workload and strain on medical personnel—whose numbers have not increased proportionally to the demand—and on infrastructure.

6. Personnel working in HIV/AIDS are better paid, and their facilities better equipped, a situation that has led to further attrition in other health services.

7. An increase in funding has not led to the efficient delivery of services and commodities. There continue to be many reports of late deliveries, wrong deliveries, and stock-outs.

8. The availability of huge amounts of money, without adequate resources to strengthen accountability and good governance, has fueled leakage of funds and corruption.

9. The demand for treatment continues to outstrip supply because infection rates have stopped falling and reports indicate they may have started rising again.

RESEARCH PROCESS AND METHODOLOGY

Information and observations for this report were obtained primarily through interviews and literature reviews. Informants for this survey included staff from the Uganda AIDS Commission[7], Health Sector Development Partners Group[8], the Ministry of Health (MoH)[9], the Joint Clinical Research Centre (JCRC)[10], Pallisa AIDS Project[11], The AIDS Support Organization (TASO)[12], and Family Health International (FHI)[13]. Other participating respondents included three health care consumers and a representative from two PLWHA groups, Uganda Young Positives[14], and Together Against AIDS Positives Association[15].

The research team also reviewed Uganda's Second Health Sector Strategic Plan (HSSP II) and the PMTCT policy. Team members attended meetings convened by civil society and the Health Policy Advisory Committee. Internet resources were also used.

1. IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

Supported by a wide array of foreign donor institutions, HIV/AIDS programs have over the years expanded to claim the biggest share of health financing for any single disease in Uganda. Medical personnel have been trained, recruited, and paid under HIV/AIDS programs. HIV/AIDS clinics built within general hospitals are treating other diseases such as TB, malaria, diarrhea, and other OIs. Safe water programs for PLWHA have benefited whole communities, thereby improving public health more broadly[16]. Social mobilization systems, including village HIV/AIDS

6 HEPS-Uganda is the standard abbreviation for a local NGO, the Coalition for Health Promotion and Social Development. HEPS-Uganda is a health consumers' organization that advocates for health rights and responsibilities. The organization is a coalition of health consumers, health advocates, health practitioners, CSOs, and CBOs and is concerned about bottlenecks that hinder access to quality health care for the majority of Ugandans and the Uganda *Missing the Target* team that includes: Richard Hasunira, Rosette Mutambi, Prima Kazora, Beatrice Were, and Aaron Muhinda.

7 Two officials were interviewed at the Uganda AIDS Commission: Rose Nalwadda, the director of planning and monitoring; and Dr. Jim Arinaitwe, the Global Fund coordinator.

8 Luc Geysels, health advisor, Belgian Technical Cooperation, and spokesperson, Health Sector Development Partners Group

9 Dr. Nelson Musoba, senior health planner, MoH

10 Dr. Peter Mugyenyi, JCRC director

11 David Mafabi, clinical officer

12 Peter Sebanja, Senior Advocacy officer, TASO

13 Dr. Angela Akol, project director

14 Sam Ocen, coordinator, Uganda Young Positives (UYP)

15 Betty Muhangi, coordinator, Together Against AIDS Association (TAAPA)

16 Peter Sebanja, Senior Advocacy officer, TASO

committees and village health teams set up initially to respond to HIV, have been used for other crucial health-related services—including to distribute insecticide-treated mosquito nets and anti-malarial medicines. Pregnant mothers on the PMTCT program are accessing family planning.

On the other side, however, the HIV/AIDS epidemic has undeniably placed extra pressure on the health system. The overall impact has been to increase the workload for health personnel, whose numbers have not increased proportionally to the demand, and to stretch infrastructure and public expenditure[17]. Another kind of challenge has been created by the parallel way in which HIV/AIDS services have been delivered; one result has been a tendency for AIDS units to be better equipped and their workers to be better paid. This has led to staff attrition from public general facilities to the relatively more attractive (public) HIV/AIDS units[18].

Some observers also believe the relatively massive investment in HIV/AIDS programs has compromised efficiency in allocation of resources in the health sector[19] For example, the money provided by PEPFAR alone in 2007 was estimated to have doubled the MoH's budget. Yet the long-chain of disbursing PEPFAR funds (through intermediary organizations), which is outside the government budgeting structures, leaks a lot of money due to high transaction costs. The Global Fund has been accused of taking up so much attention that other health areas (beyond HIV, TB, and malaria) are crowded out. According to one observer, "This is disrupting the rest of the health system."[20]

Medical personnel have been trained, recruited and paid under HIV/AIDS programs. HIV/AIDS clinics built within general hospitals are treating other diseases such as TB, malaria, diarrhea and other OIs. Safe water programs for PLWHA have benefited whole communities, thereby improving public health more broadly.

COMMODITY PROCUREMENT AND LOGISTICS

Some training has been done and more staff recruited, but the supplies and logistics procurement and distribution system remains poorly structured and inefficient. Far too may reports persist of late deliveries, deliveries that do not match the orders, and stock-outs, for example.

PROGRAM MANAGEMENT

Efforts to integrate HIV/AIDS programs with other disease programs have been few and far between. This is unfortunate because evidence vis-à-vis other diseases indicates that integration can be beneficial. The management of TB care has improved since TB programs were integrated into the overall health system, for example, and it appears as though the integration of malaria programs will have similarly positive results.

COMMUNITY MOBILIZATION FOR BETTER HEALTH SERVICES

HIV/AIDS programs appear to have improved community mobilization in general. Current mobilization initiatives include village HIV/AIDS

17 Dr. Nelson Musoba, senior health planner, MoH

18 Ibid.

19 Luc Geysels, spokesperson, Health Sector Development Partners Group

20 Ibid.

Because specialized HIV/AIDS units tend to have better facilities, equipment, and pay, they continue to attract highly qualified medical personnel. This is detrimental to general health services, however, which face a far more severe shortages of workers.

committees, TB teams, and village health teams, all of which are enabling communities to learn more about health and to access other health services.

HUMAN RESOURCES FOR HEALTH

Because specialized HIV/AIDS units tend to have better facilities, equipment, and pay, they continue to attract highly qualified medical personnel. This is detrimental to general health services, however, which face far more severe shortages of workers.

NUMBER OF PEOPLE SEEKING HEALTH CARE SERVICES

HIV/AIDS has undoubtedly increased demand for health services among HIV-positive individuals. It has not had a noticeable broader effect, however, as far as demand for general health care is concerned.

ACCOUNTABILITY, TRANSPARENCY, AND GOOD GOVERNANCE OF HEALTH DELIVERY

With substantial resources flowing into the country to finance expanded HIV/AIDS services, accountability, transparency and good governance seem to have been negatively affected. The Global Fund and PEPFAR are using tighter requirements for accountability and are spending a lot of money to ensure that allocated funds are not misused; however, neither they nor other funders have provided resources to strengthen the general health governance system.

MATERNAL AND CHILD HEALTH SERVICES

The PMTCT program has underperformed so far due to limited uptake. Nevertheless, it has improved the provision of maternal and child health services, at least at the centers where it has been implemented. HIV-positive mothers and their babies are being provided with not only ARVs, but also family planning, immunization, and other services.

2. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

- Increasing funding is essential for any expanded delivery of health services. HIV/AIDS programs have benefited from increased funding from the donor community, which has been instrumental in scaling up treatment, improving infrastructure, and attracting and retaining health personnel. But as more resources are invested in the health sector, accountability systems need to be strengthened; otherwise, the availability of huge amounts of money may just fuel corruption, as the Global Fund story has shown[21].

21 The Global Fund's work in Uganda was suspended in August 2005 after an audit revealed gross mismanagement, which included outright theft of funds by local officials. A judicial commission of inquiry confirmed the allegations. The suspension was lifted more than 12 months later in 2006, after a new management structure was put in place.

- Community sensitization, mobilization, and service/product delivery systems are key to improving health-seeking behavior in general. Communities need to be empowered to demand services, to participate in health planning, and to hold service providers accountable.
- Prevention should be a vital element in all programs and interventions. HIV/AIDS services have expanded, but demand for treatment continues to outstrip supply because infection rates have stopped falling and reports indicate they may have started rising again. When it comes to strengthening the general health system, public health campaigns, environmental health initiatives such as availing the poor with toilet facilities, and improved preventive care will be important to ensure demand does not surpass the system's capacity.

As more resources are invested in the health sector, accountability systems need to be strengthened; otherwise, the availability of huge amounts of money may just fuel corruption….

- There are some—but still too few—successful examples of integrating HIV/AIDS services into primary care in Uganda. Among the good examples are the following. In Wakiso district, community health workers who carry out HIV/AIDS sensitization also give out anti-malaria medicines, mosquito nets, and treat minor illnesses, such as obvious malaria, diarrhea, etc. Mengo and Rubaga hospitals, which are mission-owned, have outreach programs that focus on HIV testing, immunization, family planning, and prevention and treatment of common diseases. JCRC pays a stipend to all health workers and improves the general infrastructure at health centers where it runs its HIV/AIDS treatment program.

3. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

- The MoH should urgently improve health infrastructure. Clinics need to be renovated and equipped with medicines, and laboratories need to be built and equipped to conduct CD4 count tests, X-rays, organ-function tests, viral load tests, etc.
- The government should allocate more funds to train, recruit, and retain more health personnel, including doctors, nurses, and counselors throughout the health system. Supervision systems should be strengthened to ensure that facilities and programs work as intended.
- The MoH should make it a priority to establish more community-level clinics and health facilities, and those that already exist should be strengthened. Improvements at that level should be made in regards to patient tracking and follow-up, drug distribution, counseling, and fighting stigma. ART provision should be rolled out to lower-tier health facilities (health centre III) and communities should be involved in planning health services.

Communities need to be empowered to demand services, to participate in health planning, and to hold service providers accountable.

MEASURES TO TRACK EFFORTS TO STRENGTHEN BROADER HEALTH SYSTEMS

The following indicators could help in tracking progress in strengthening broader health systems and expanding access to general health care:

- *Out-patient department (OPD) attendance.* People seek health services if they perceive quality—which they define by the presence in health facilities of qualified staff, professional attitudes, full stocks of essential medicines, and adequate services (including those for surgery). Such factors signal that common illnesses are being treated. As such, OPD attendance captures a broad range of system-related issues.
- *Rate of completion of vaccination cycle.* Vaccination programs have cycles that require several visits (usually by children, who receive the majority of most common vaccinations) to a health facility. The completion of a cycle indicates that consumers believe the health care system performed well during their previous visits—that the vaccines, staff, and logistics were available, that the health centre is relatively easy to reach reach, and that the quality of care was satisfactory.
- *Ratios of medical staff to patients (and general population) and proportion of existing staff positions filled.* Perhaps the most telling and obvious sign of a health system in crisis is lack of sufficient (and sufficiently trained) staff. Whether seeking care and services for HIV or any other condition, consumers are likely to lose whatever confidence they once had upon visiting a depleted and poorly staffed facility.

4. IMPROVING PMTCT SERVICES

- In terms of PMTCT, priority should be placed on rolling out services from the health sub-district level (health centre IV) to grassroots health facilities (health centre III), establishing outreach services, sensitizing communities, and involving male partners. This will increase uptake and reduce stigma.
- The government needs to recruit more personnel—doctors, nurses, and counselors—with special skills in caring for children. Authorities may also need to take the lead in training more caregivers in this area.

5. PERSPECTIVES OF HEALTH CARE CONSUMERS

Observations from PLWHA on ART and PLWHA groups indicate that although medicines (including prophylaxis), counseling, and treatment for OIs are provided free of charge, access remains limited due to shortages of health workers, inability by poor PLWHA to afford transport, and

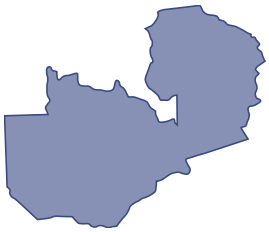
occasional medicine stock-outs. At some facilities, ARV supplies are inconsistent, medicines to treat OIs are frequently out of stock, and there are not enough counselors, nurses, and doctors to attend to all PLWHA in need.

It is not uncommon for patients to wait at a health centre for an entire day. Meanwhile, the single health worker on-site is trying to care for up to 100 patients, distribute ARVs, treat OIs, and offer counseling. Some accredited centers reportedly have not had ARVs in stock for months, with the result that patients have become sicker or even died. Services are still far from consumers because accreditation has gone only to HC IV's[22]. Some patients are too poor to afford routine transport to distant HC IVs for drugs, and must travel even longer distances to access crucial diagnostic services (CD4 count, viral load, and organ-function). ART and testing services need to be rolled out to HC III's, as do programs designed to provide nutritional support, educate AIDS orphans and vulnerable children, and initiate and support income-generating activities. Community systems need to be strengthened to fight stigma and ensure adherence.

RECOMMENDATIONS

- The government should streamline the supplies and logistics chain to ensure a more consistent and uninterrupted supply of ARVs and other essential medicines.
- The government and the donor community should channel more resources into improving infrastructure, with particular focus on increasing the number of laboratory facilities for diagnostic tests.
- The government should train, recruit, and retain key health personnel, including doctors, nurses, and counselors to attend to PLWHA.
- The government should strengthen community health systems to enhance sensitization, adherence to treatment, and to fight stigma.
- Donor agencies, including UNAIDS, WHO, PEPFAR, and the Global Fund, should strengthen accountability requirements for the funds they provide (but without making disbursement and utilization difficult).

22 Within Uganda's health structure, a health centre IV (HC IV) is at the level of a county. A health centre III (HC III) is at sub-county level; a health centre II (HC IV) at parish level and a health centre I—which in reality does not exist—at the village/community level.



Zambia

Paul Kasonkomona, Treatment, Advocacy & Literacy Campaign (TALC), Felix Mwanza, Treatment, Advocacy & Literacy Campaign (TALC

KEY POINTS

POSITIVE IMPACTS

1. The ongoing roll-out of ART has lowered HIV-related hospital admissions and reduced stress levels among most health care workers (according to the workers themselves).

2. There is less demand among PLWHA for antibiotics and other medicines used to treat HIV-related OIs, thereby lowering purchasing costs and increasing the availability of such medicines to treat other patients.

3. Capacity-building to coincide with expanded HIV treatment has benefited the entire health system, not just care for PLWHA, thus adding extra value.

4. The integration of PMTCT services into general antenatal care has increased HIV testing and HIV education among women.

NEGATIVE IMPACTS

1. Some basic health care services and supplies are not easily available in the public system, thus forcing patients to seek them in the private system at their own expense.

2. A serious human resource crisis has resulted from the lack of skilled health care staff in HIV treatment programs, a situation exacerbated by restrictive loan conditions imposed by the IMF and World Bank.

OTHER FINDINGS

1. The government is highly reliant on donor support, especially for the ART program, and neither donors nor the government are building up the capacity of local health personnel or management staff.

2. The shortage of health care workers and medicine in the public health institutions has led patients to turn to traditional healers or to self-prescribe with medicines purchased in pharmacies.

RESEARCH PROCESS AND METHODOLOGY

Research for this report consisted of document and internet reviews, interviews with 53 people, and five focus group discussions. Among those interviewed were PLWHA, health and women's rights advocates, health care workers and consumers, individuals with physical disabilities, and officials from the Ministry of Health (MoH).

1. IMPACT OF EXPANDED HIV/AIDS SERVICES ON HEALTH SYSTEMS

POSITIVE IMPACTS

From the perspective of an "ordinary" health consumer in Zambia, it may be hard to believe that HIV/AIDS services (or any other factor) have had a positive impact on the delivery of other health services in recent years. After all, most people still must spend hours in queues at health care facilities and pay consultation fees merely to get a prescription.

Numbers and other observations tell a different story, however, pointing to several important positive impacts overall. For example:

- the ongoing roll-out of ART has lowered HIV-related hospital admissions and reduced stress levels among most health care workers (according to the workers themselves);
- there is less demand among PLWHA for antibiotics and other medicines used to treat HIV-related OIs, thereby lowering purchasing costs and increasing the availability of such medicines to treat other patients; and
- capacity-building to coincide with expanded HIV treatment has benefited the entire health system, not just care for PLWHA, thus adding extra value.

NEGATIVE IMPACTS

In terms of negative impacts, the majority of informants for this report thought that by focusing so much attention on HIV/AIDS, the government was neglecting other important health issues. Other comments did not necessarily point to negative impacts from HIV/AIDS programs, but referred instead to situations that highlight continuing gaps in health care delivery in general.

For example, some respondents noted that shortages of basic supplies, including latex gloves, persist across the health system in general. Equipment for blood pressure tests reportedly is not available in most public facilities, thereby forcing patients to obtain such tests from private clinics (where they cost at least $1.50 each, a prohibitive sum for most Zambians). Several informants added that many clinics in rural areas have limited supplies (if any at all) of various drugs and patients not participating in ART programs are often expected to pay fees for them. In comparison, they said, all HIV treatment services, including ARVs and other medicines, are available free of charge—even in the same clinics where fees are required for other drugs.

The ongoing roll-out of ART has lowered HIV-related hospital admissions and reduced stress levels among most health care workers (according to the workers themselves)

IMPACTS BY SECTOR AND CATEGORY

Commodity procurement and logistics. Managers of health care facilities said they were frustrated by the government's slow pace in establishing extensive systems for logistics and procurement of medicines and supplies for the overall health system. They said that the government has instead continued to rely on donor-run policies and systems, which they do not believe are sustainable. Government informants claimed the problem was lack of funds, adding that they believe the International Health Partnership (IHP)[23] is a positive development because it will enable them to set priorities and allocate resources that will build capacity across the health system in general.

Program management. Most health financing in Zambia—including the HIV/AIDS response, for which an estimated 90 percent of funds are provided by donors—is dependent on donors, which also set conditions. Moreover, most donor-driven programs bring in their own people to manage them and do not focus enough on transferring skills to local stakeholders and health personnel. Major gaps in expertise will subsequently occur when donors leave.

The government has done very little to address this looming problem; it could, for example, allocate more funding specifically to help build management and service-delivery skills across the health system in general. PLWHA organizations have not been very helpful in this regard either because they tend to focus almost exclusively on HIV/AIDS programs (especially ART access).

Community mobilization for better health services. There is not much community mobilization for general health in Zambia. People are not assertive enough to stand up and demand improvement in health services, nor are they aware of how they should do it. Strategies used to

23 See www.internationalhealthpartnership.net/ihp_plus_faq_01.html

Most donor-driven programs bring in their own people to manage them and do not focus enough on transferring skills to local stakeholders and health personnel.

great effectiveness in HIV/AIDS advocacy could be applied to advocacy for health in general, but few steps have yet been made toward that end.

Human resources for health. The human resource crisis is Zambia's greatest health systems challenge in the last 25 years. This is not just a result of the HIV epidemic; in particular, loan conditions imposed by institutions such as the International Monetary Fund (IMF) and World Bank have forced the government to reduce or hold down health spending, thus prompting many qualified staff to leave the country and limiting the ability to train others.

The massive HIV/AIDS response may have brought major improvements such as ART access, but it has not led to any improvements in the health resources gap. It may even be argued that such programs have made the situation worse: HIV treatment programs do not always lead to the hiring of new staff, but instead often depend on health care workers who must deliver all other services as well. And when such programs do hire specialized staff, they often find them within the overall health system—thus limiting resources for non-HIV care.

Number of people seeking health services. Increased availability and awareness of ART services have helped reduce HIV-related stigma and have given renewed hope to tens of thousands of people. As such, they have promoted greater VCT uptake (at least in areas where these HIV/AIDS services are currently available). The impact on other health issues appears negligible, however. Most people have lost confidence in the health delivery system because they do not perceive any likely benefits from it; therefore, health-seeking behavior in general remains very low.

Several respondents noted, for example, that a typical scenario would involve paying a consultation fee, waiting hours to be seen by a harried and frustrated health care worker, and then being given a prescription to get medicines from somewhere else because of stock-outs at the clinic. Many people resort instead to traditional healers; prescriptions, among other things, are not required to visit them, and patients feel they have more time to explain their problems and be listened to.

2. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

There is no doubt that the HIV/AIDS response has yielded several beneficial results that can be used to develop the entire health system. Health care workers in HIV/AIDS programs are better motivated because they (usually) get better salaries and have on hand all the diagnostics, medicines, and other tools needed to provide adequate care. This also helps build consumers' trust and confidence and increases community engagement and ownership in health care delivery.

A number of successes have occurred in regards to integrating HIV/AIDS services into primary health care. Most notably, the integration of PMTCT into general antenatal care has led to more pregnant women being tested for HIV. Those who test positive are educated on how to limit transmission to their child and are provided ARVs for prophylactic purposes when required.

Other informants also pointed to improved integration of HIV and TB care. Individuals diagnosed with TB are routinely urged to take advantage of VCT services, for example, and are provided with appropriate treatment should they test positive for HIV as well. Also, increased distribution of insecticide-treated mosquito nets to women receiving PMTCT services and PLWHA in general has reduced mortality and morbidity among PLWHA.

Health care workers in HIV/AIDS programs are better motivated because they (usually) get better salaries and have on hand all the diagnostics, medicines, and other tools needed to provide adequate care.

3. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

The following are the three most important reforms needed in the national health system in order to better serve the needs of PLWHA:

- *Strengthen the process of empowerment by building an enabling environment.* Many of the factors that influence vulnerability to HIV and the ability to take action on HIV prevention, treatment, care, and impact mitigation are related to external factors that need to be addressed to enable effective responses. These factors include policy, legal and human rights issues, and the availability of services and commodities such as condoms, ARVs, and VCT. PLWHA and members of vulnerable populations must feel that they have the tools and ability to ensure access to these vital rights and services; otherwise, the HIV/AIDS response will weaken.
- *Recognize that health is a human right, which means that the right to health should be enshrined in the Constitution.* This would likely increase the government's ability and inclination to provide health services to its people responsibly, because it would be legally bound to do so.
- *Implement targeted policies to address personnel gaps.* If donor-driven programs such as PEPFAR continue to operate the way they have over the past few years, then donor organizations should be urged (if not required) to provide financial resources to train at least four health workers for each one they have hired to work for their projects. This should apply to all specialized programs and institutions that have hired health care workers from the public health system.

[PEPFAR and other donor programs should] provide financial resources to train at least four health workers for each one they have hired to work for their projects.

4. IMPROVING PMTCT SERVICES

HIGHLIGHTING THE IMPORTANCE OF PREVENTION BY INCLUDING HIV IN FAMILY PLANNING PROGRAMS

Greater HIV education and awareness among women is vital: this could help reduce the possibility that women are infected to start with and increase the likelihood that they know their status before deciding to conceive. Sexual and reproductive health services and programs must be enhanced to improve the quality and coverage of family planning and other reproductive health services. In some cases this will entail greater emphasis being placed on the use of condoms, both male and female, as a primary family planning method.

STRENGTHENING THE INFRASTRUCTURE FOR PREVENTING HIV INFECTION AMONG INFANTS

Women must have expanded access to antenatal care and must be encouraged to use these services frequently and earlier than currently is the case. Concurrent access to VCT and ART services for pregnant women must be more widely available as well, with specially trained health care workers to provide them. Such workers can assist in delivery, in preventing perinatal transmission of HIV, and in ensuring timely infant feeding counseling and support. Zambia has long been popular among most donors, so there should not be a problem in finding funds for and implementing a program focusing on these issues.

5. PERSPECTIVES OF HEALTH CARE CONSUMERS

Health consumers interviewed mentioned the shortage of health care workers in all public health institutions and the non-availability of essential medicines in most hospitals and clinics (especially in rural areas). These two problems have led many people to visit traditional healers and/or self-prescribe with medicines purchased in pharmacies.

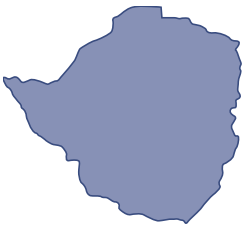
There were many comparisons made with ART centers, with consumers saying that the government and its partners should learn from them in order to improve the general health care system. Those interviewed acknowledged that there has been too much complacency on the part of the overall population when it comes to demanding appropriate health services. Many added that the government needs to be pushed by consumers in ways that PLWHA and their advocates have done in recent years; in their view, better integration of services and strengthening of the overall health system would be enhanced by communities working more closely with experienced HIV/AIDS activists.

RECOMMENDATIONS

The following measures could help strengthen broader health systems and expand access to general health care:

- The government must directly involve stakeholders in the development of a strategic framework for health workers. Those involved should include staff on the ground, their unions, and relevant civil society groups.
- Instead of shifting focus from HIV to other health priority areas, the government must work towards increasing funding for health care overall. This would help raise standards of other services in the health sector while maintaining the relatively high quality of HIV/AIDS services.
- Health care workers must receive better and more consistent training. The MoH should take on this responsibility and, if necessary, seek budgetary and human resource support from donors.
- Donor funding should not be a substitute for government funding. Budgetary allocations for training of health care workers must be made at least every year.
- Expanding antenatal care is vital. Civil society groups are ready to become involved if the government needs assistance.
- Civil society groups should initiate a program aimed at monitoring the hours people spend at clinics and the availability of essential medicines in the health institutions. Reports highlighting the long waits and gaps are likely to lead to improvements if publicized adequately.
- The MoH should consider measures to reduce doctor-to-patient and/or health care worker-to-patient ratios. This could be achieved by training more staff and paying them better.
- Key multilateral lending institutions, notably the IMF and World Bank, should eliminate inflexible conditions in loans that greatly limit countries' ability to improve health care systems. One such common provision requires recipient governments to agree to not pay civil servants more than certain amounts.

Many [interviewees said] that the government needs to be pushed by consumers in ways that PLWHA and their advocates have done in recent years.



Zimbabwe

Matilda Moyo, Pan African Treatment Access Movement (PATAM) and Southern African Treatment Access Movement (SATAMo), Caroline Mubaira, SATAMo, PATAM, Community Working Group on Health, Martha Tholanah

KEY POINTS

1. The political and economic crisis has had a direct negative impact on all aspects of health care.

2. Public health institutions are run-down, understaffed, overcrowded, and ill-equipped.

3. Key medical personnel are leaving the country, PLWHA are unable to get or afford basic foodstuffs, transportation to clinics is increasingly expensive, drug stock-outs are common, and basic prophylactic medicines can cost up to four times the average monthly income.

4. HIV/AIDS services, and especially provision of ART, have boosted delivery of health services overall, but the epidemic itself has placed great strain on the health system.

5. The private sector and faith-based mission hospitals have scaled up HIV/AIDS services in past five years. By May 2008, some 104,000 people were on ART, an increase of 58,000 from the previous year, but still a figure that represents around 40% of all people thought to be in need of ART.

6. The PMTCT program—integrating maternal and HIV services—has largely met its targets. There are now more women than men receiving ART in the public health system. However, women often cannot afford formula for their babies.

7. Some activists believe funds earmarked for PLWHA have been converted into "perks" for those in positions of power.

RESEARCH PROCESS AND METHODOLOGY

Research for this report was conducted through personal and group interviews, a focus group discussion, direct observations, and desktop research. A standardized questionnaire was used for the interactive data gathering. Respondents included heads of government departments, hospital administrators, pharmacists, representatives of aid agencies, doctors and nurses from both the public and private sector, caregivers, 60 PLWHA, staff from civil society organizations, and focal persons at the grassroots level.

BACKGROUND

It is important to discuss Zimbabwe within the perspective of the prevailing political and economic context, which deserves special attention in light of challenges that are properly regarded as severe even among other countries with high HIV burdens. The past eight years have been characterized by repression and economic and social disarray, accompanied by violence whenever elections are held. Among the consequences are hyperinflation, shortages of basic commodities, mass migration of skilled workers, a reduction in social spending, donor flight, increasing poverty, and 80 percent unemployment. Over the past few years perhaps one quarter of the population has fled the country, mostly in search of employment. These challenges have had a direct (and negative) bearing on all aspects of health care.

According to the Zimbabwe Association of Doctors for Human Rights (ZADHR), the country's health care system is in need of urgent attention. It is crippled by dilapidated infrastructure, drug shortages, equipment breakdowns, brain drain, and health care costs that have skyrocketed beyond the reach of the majority of Zimbabweans. Average life expectancy, according to the WHO, has declined from 60 years to 37 years for men and 34 for women during the past decade. Maternal mortality is rising to a level which meets that of the world poorest countries[24].

However, consistent focus on HIV/AIDS treatment and care programs by government and donors has had some benefits for the health delivery system at large, albeit on a minimal scale.

24 Statement by the Zimbabwe Association of Doctors for Human Rights (ZADHR) on World Health Day 2008.

HIV/AIDS services, particularly the provision of ARVs, have become a lifeline for the virtually collapsed health delivery system in Zimbabwe.

1. IMPACT OF HIV/AIDS SERVICES ON HEALTH SYSTEMS

IMPACTS ON OTHER HEALTH SERVICES

The main positive impact is that HIV/AIDS services, particularly the provision of antiretroviral treatment (ART), have become a lifeline for the virtually collapsed health delivery system in Zimbabwe. Although the country has experienced a flight of donors, some have rallied together to support key humanitarian programs such as ART. For example the Expanded Support Program, a pool fund by some major donors, supports ART provision to about 40,000 patients. However, developments before and after the presidential election re-run in late June 2008 have led to a new wave of sanctions that threaten to erode the limited aid that was trickling in and further cripple the struggling health system.

According to Dr. Owen Mugurungi, head of the AIDS and TB Unit in the Ministry of Health and Child Welfare (MoH), many resources intended for HIV/AIDS services and attempts to integrate these with other health services such as TB and malaria has resulted in joint activities. For example, the ministry, which has been affected by staff emigration, has managed to recruit and retain key personnel— including doctors, pharmacists, and laboratory scientists—using resources committed to ART programs through various partners, mainly in the 22 districts supported by the Global Fund. Similarly, logistics and infrastructure developed for HIV/AIDS services have benefited the wider health care system.

Increased availability of HIV/AIDS treatment has meant that many HIV-positive individuals no longer need to stay in hospitals; they are now treated as outpatients. This has opened space at hospitals by reducing bed occupancy by people with HIV-related infections[25]. In the late 1990s for example, prior to the introduction of ART, about 75 percent of hospital occupants were there due to HIV-related opportunistic infections, particularly TB, pneumonia, and meningitis. The comparable figure today is much lower, less than 25 percent.

Furthermore, comprehensive services for HIV patients, including provision of ARVs, counseling, and (in some cases) provision of food, are now available in specialized clinics. This has reduced the workload in various departments and allowed health workers to focus on patients with other ailments. The OI clinics, located at central hospitals, attend to all HIV-related treatment, including provision of treatment for opportunistic infections, ARVs, counseling, and in some cases food. They also follow up with patients and conduct studies on adherence.

25 Interview with Eunice Kapandura, executive director of Childhood HIV and AIDS Zimbabwe (CHAZ).

Increased availability of HIV/AIDS treatment has meant that many HIV-positive individuals no longer need to stay in hospitals; they are now treated as outpatients.

Generally speaking, increased HIV/AIDS services such as ART have created opportunities to address health system weaknesses in areas such as procurement of commodities and logistics.

At the same time, however, expanded HIV/AIDS services have revealed glaring shortcomings in Zimbabwe's general health delivery system. For one thing, the disease itself has had an overwhelmingly negative impact on the country's entire health system, a development exacerbated by the economic collapse. It has placed additional strain on the health care system, thereby compromising its capacity to deal with other chronic diseases. Over the past several years, the urgent need to provide HIV-related services has greatly limited caregivers' ability to respond to other conditions.

According to Lynde Francis, executive director of The Centre, a PLWHA organization in Harare, "The health system was under attack but the advent of HIV dealt it a death knell. HIV/AIDS has exponentially increased the number of people seeking health services that they are unable to access." Francis added that the training received by health personnel has been inadequate to cope with HIV, which impacted delivery of the other services. The introduction of structural adjustment programs (SAPS) in Zimbabwe since 1990 resulted in a reduction in social spending, compromising services such as education and health delivery. Further, the advent of community home-based care (CHBC) has created an outlet for health care personnel to parcel responsibility of caring for terminally ill patients to their ill-prepared families rather than address shortcomings in the system. Most of those receiving CHBC are AIDS patients that have been failed by the health system. Meanwhile, HIV/AIDS remains the major cause of morbidity despite the existence of ART.

COMMODITIES PROCUREMENT AND LOGISTICS

Shortfalls exist for even the most basic medical supplies and commodities. "The procurement and delivery of medicines is almost non-existent in the health system," Francis said. "One cannot even get aspirin," she added. Hospitals run out of stocks while drugs expire in storage; patients, meanwhile, often must purchase vital commodities (such as latex gloves, rehydration fluid, and reagents) required for their treatment prior to admission. Current shortages have forced many patients to depend on relatives in neighboring countries to buy their medication.

The situation in regards to ART has improved somewhat since the Zimbabwe National AIDS Strategic Plan (ZNASP) for 2006 to 2010 was initiated. However, as noted by Dr. Rashida Ferrand[26], "Although there is an improvement in availability of drugs, interrupted supplies are

26 Interview with Dr. Rashida Ferrand, a clinical research fellow affiliated with the Biomedical Research and Training Institute in Zimbabwe's Teenaids Project.

definite barriers that we are facing." Even though the plan focuses on procurement of ARVs, the lessons learned could be useful for procurement and logistics for other essential medicines in the broader health system. There has been some nominal benefit to the health system in that materials such as vans and cars for transport that were provided (often donated) specifically for HIV/AIDS have also been used to increase health centers' supplies of a far wider range of medical equipment and drugs[27].

PROGRAM MANAGEMENT

The last five years have seen an improvement in program management as a benefit of HIV/AIDS services. The private sector and faith-based mission hospitals, in particular, have experienced enormous scaling up of services and programs. Although not yet ideal, there has been improved integration in the overall health system with VCT, OI, TB, and STI clinics being used as entry points for ART and expanded care, a direct benefit of partner-initiated counseling and testing (PITC).

Expanded HIV/AIDS services have revealed glaring shortcomings in Zimbabwe's general health delivery system... the disease itself has had an overwhelmingly negative impact on the country's entire health system.

COMMUNITY MOBILIZATION

PLWHA support groups and other community-based organizations have played increasingly larger roles in improving access to care, particularly by demanding improved health services. HIV education and awareness campaigns, organized and ad hoc, have had a positive knock-on effect on many areas of social services that were taboo, e.g., domestic violence, marital rape, and child abuse[28]. One result has been less reluctance at the community level to be tested for HIV and greater inclination among many HIV-positive people to be open about their status. These developments have occurred at least in part because of the increased awareness about the availability of ART and the medicines' often beneficial impact. Even so, greater community involvement in delivering health care through experienced patients remains largely untapped despite its benefits[29]. Community home-based care programs have also resulted in communities playing a greater role in caring for patients, although the facility tends to overburden care givers who are often faced with the responsibility of caring for a loved one with inadequate support from the health system.

HUMAN RESOURCES

As noted previously, Zimbabwe has experienced a flight of skills fueled by lack of support, non-availability of commodities, drug shortages, inadequate facilities, and poor remuneration, particularly in the health sector. HIV/AIDS has further strained the sector's human resource base. According to ZADHR chairman, Dr. Douglas Gwatidzo, about one doctor is serving over 8,000 people compared with the world standard of 1 doctor

27 Interview with Dr. Owen Mugurungi, head of the MoH's AIDS and TB unit.

28 Interview with Lynde Francis, executive director of The Centre.

29 Interview with Dr. Rashida Ferrand.

The epidemic created a rallying point for communities to organize themselves and demand better health services, resulting in greater accountability in health delivery. There has been more openness to civil society, especially in the public health system, and doctors are more attentive and accountable.

to 500 patients[30]. Many health centers have no doctors and some clinics are being run by overworked nurses on 12-hour shifts[31]. Communities, especially those in rural areas, are considered lucky if a doctor visits once a week. An upsurge of violence and the sudden de-registration of NGOs in the period before June 2008 presidential election re-run resulted in medical personnel fleeing rural mission hospitals for their safety, thereby temporarily halting operations. After the election many health centers that had been closed were able to reopen.

One of the MoH's main priorities is to train, recruit, and retain personnel, but such efforts are often stymied by the ever-deteriorating economic situation.

Meanwhile, although the number of people seeking health care services has increased with greater awareness of the potential benefits of HIV treatment, their ability to actually obtain access to crucial services has been hampered by the economic crises. Most Zimbabweans lack the financial capacity to pay for services in an environment where both the government and medical insurance companies are scaling back their services and health care providers are demanding cash upfront for all services. Increasing and sustaining ART access thus remain major challenges, while basic health care has become a luxury few can afford.

ACCOUNTABILITY, TRANSPARENCY, AND GOOD GOVERNANCE

To some extent, the culture and management of health services have improved as a direct result of delivery of HIV/AIDS services. The advent of HIV and the growth of civil society have led to greater interaction among communities, patients, and health service providers. The epidemic created a rallying point for communities to organize themselves and demand better health services, resulting in greater accountability in health delivery. There has been more openness to civil society, especially in the public health system, and doctors are more attentive and accountable.

However, transparency and good governance in the public sector areas such as the National AIDS Council (NAC) are still lacking. Activists say they are neither adequately informed nor consulted about how funds allocated for HIV/AIDS services are spent or how decisions on broad policies that affect their lives are reached. For example, some believe that the National AIDS Trust Fund (NAFT), a 3 percent levy collected on all taxable income and administered through the NAC, is converted to "perks for the boys" and not used to benefit PLWHA, while the organization claims that 50 percent of that money is spent on procuring ARVs.

Bernard Nyathi, president of the Zimbabwe HIV/AIDS Activists' Union (ZHAAU), said, for example, "We are always reading about how much

30 *Christian Science Monitor.* May 30, 2008.

31 Interview with Lynde Francis, executive director of The Centre.

money donors have given to Zimbabwe for treatment, but we never get feedback on how that money is spent. People are still dying and have no access to drugs, so where is that money going and why is it not benefiting the people for whom it is intended?"

Examples of lack of transparency include claims that ARVs purchased with donor funds for the government's public program are being sold at exorbitant prices on the illegal market and at pharmacies, thus resulting in shortages at public hospitals. To curb this practice, Varichem pharmaceutical company is now labeling drug containers with donors' logos for ease of identification on the streets[32]. Such steps are helpful, but the public sector bears most responsibility for demonstrating good governance so that donors can be assured that their money is being spent appropriately. Improved governance and oversight would also likely result in increased donor resources for health services.

2. LESSONS LEARNED FOR STRENGTHENING HEALTH SYSTEMS

KEY PERSISTENT GAPS AND OBSTACLES

According to The Centre's Lynde Francis, "If we had proper primary health care, we would not have so many PLWHA. AIDS would disappear. There is absolutely no justification for anyone to develop AIDS. We have the tools to eliminate AIDS but we are not applying them."

Scaling up delivery of HIV/AIDS services has showed the need for active commitment and direction from all stakeholders through partnerships across ministries. For example, the Ministry of Finance and the central bank should work with other ministries (including the MoH) to ensure adequate services for all people in need.

The scaling up of HIV/AIDS services has also exposed gaps in the health delivery system and has demonstrated the need to continuously upgrade systems and ensure they remain relevant to effectively serve the population. It has highlighted the need to ensure sustainability of drug supplies, continuous training of human resources, and strengthening of logistics and procurement throughout the country on a broader level. It also has demonstrated the importance of finding innovative ways to deliver health within the prevailing economic context. For example, given the shortage of diagnostics such as CD4 count machines, the criteria for starting treatment should be revised rather than let patients die while awaiting access to such facilities.

It has also revealed the need for a stable and conducive policy environment if social services are to be delivered fairly to all citizens.

32 *The Herald.* Friday 16 May 2008.

For example, the sudden de-registration in June 2008 of all NGOs, some of which are health-related and provide treatment and food, left some PLWHA without support. Although the ban was lifted on organizations providing HIV/AIDS services, their operations were disrupted and in some cases, services did not resume immediately.

SUCCESSFUL EXAMPLE OF INTEGRATING HIV/AIDS SERVICES INTO PRIMARY CARE

The city of Harare has decentralized ART provision at its major institution, Wilkins Hospital, devolving patients to local clinics once they have stabilized. This strategy has reduced the burden on the hospital and enabled patients to get attention from their local clinic, thus reducing challenges and annoyances such as transport costs and long queues. Such a model could prove useful if rolled out to other cities.

3. MAKING HEALTH SYSTEMS WORK FOR PLWHA AND OTHERS

Zimbabwe's health system faces three key challenges that need to be urgently addressed so that PLWHA's needs are better met. These challenges relate to human resources, access to drugs and infrastructure.

HUMAN RESOURCES

The MoH's focus has been on training, recruiting, and retaining personnel. However, while Zimbabwe has the capacity to produce good health professionals, it has difficulty retaining them because of the political and economic climate[33]. Without the capacity to compensate staff appropriately, human resource retention will remain a major challenge and a significant drawback to the country's health sector.

Also, the HIV/AIDS crisis has made it impossible to uphold the traditional standards and basis on which doctors' remuneration was calculated—that, on average, a doctor should spend eight minutes per patient. This has proved impractical and inapplicable when dealing with HIV/AIDS because doctors need more time to consult with individual patients[34].

VITAL MEDICINES

In May 2008, a total of 104,000 people were on ART, up from 100,000 in December 2007[35]. This represents a significant increase from 82,000 patients in May 2007 and means 40 percent of the 260,000 individuals thought to be in need of ART are now receiving it. The May 2008 number is about 65 percent of the 160,000 patients targeted to be on ART by the end of the year.

33 Interview with Dr. Rashida Ferrand.

34 Interview with Dr. Owen Mugurungi, head of the MoH's AIDS and TB unit.

35 Ibid.

The current situation is both good and bad, according to Dr. Owen Mugurungi of the MoH's AIDS and TB unit: "We have enough drugs for the current number of patients for the next four to five months. For the first time we have more than the minimum stock, which is three months' supply, but only for the number of patients currently on treatment. While the drug situation remains stable, we have not been able to put more patients on treatment."

However, stock-outs persist of cotrimoxazole, painkillers, and other essential medicines. The possibility of successfully meeting targets and improving health delivery would be greatly enhanced if the Reserve Bank of Zimbabwe (RBZ) honored its pledge to provide no less than $2 million monthly towards the health system and ARV procurement. In October 2006, Gideon Gono, the RBZ governor, announced the following: "I am pleased to commit here and now, honorable minister, that the central bank will, without fail, provide you with not less than $1 million per month for general drugs and equipment and not less than $1 million per month for ARVs, TB, malaria, and other related diseases." He has not kept that promise, however.

INFRASTRUCTURE AND EQUIPMENT

In the 1980s, the government focused on expanding access to health care, including increasing the number of clinics and district hospitals to serve smaller populations. However, the expansion was not complemented by investment in adequate infrastructure and equipment, and it took place at the expense of the country's central hospitals. Public health institutions, which serve the bulk of the population, are dilapidated and ill-equipped—the equipment that is available is obsolete and broken down for the most part—in addition to being understaffed and overcrowded.

"There are so many different barriers to optimal adherence, such as stock-outs, poor nutrition, accessibility to health centers, availability of drugs, and stigma."

For example, according to media reports, only one out of 18 dialysis machines works at Parirenyatwa Hospital. At Harare General Hospital, only 3 out of 50 incubators are working, and the neonatal unit is seriously understaffed as nurses and doctors leave for more stable jobs abroad. There is only one radiologist who is servicing Harare and Parirenyatwa hospitals and the Zimbabwe National Army (ZNA). That radiologist is "borrowed" from the army[36].

Zimbabwe needs to develop infrastructure to cope with increasing numbers of patients and demand. The health system also faces logistical challenges such as a dire shortage of ambulances to ferry patients to health centers—a major barrier to care because most patients cannot afford transport to health centers in general. Although the government has tried to populate the country with clinics and hospitals in line with

36 *Christian Science Monitor.* May 30, 2008.

its standard that patients should not have to walk more than eight kilometers (5 miles) to the nearest health facility, such a distance remains impractical for weak and ailing individuals. The road network is poor and not being maintained. Vehicles cannot pass to reach patients in some rural areas. Either public transport has to improve (and be made more affordable), or health centers must have better access to ambulances and other vehicles to cater for patients.

4. IMPROVING PMTCT SERVICES

The PMTCT program has been largely successful in reaching its targets[37], thereby greatly reducing both child and maternal mortality. Integrating maternal and HIV services have also enabled health professionals to test and treat more women for STIs such as syphilis. Furthermore, the PMTCT program has provided an entry point to ART for both women and children with the result that more women than men are receiving ART in the public health system[38]. PMTCT in Zimbabwe has been integrated into all antenatal care and health units that deliver babies and efforts are underway to make it a routine service[39].

The challenges facing the PMTCT program are now more of a social nature. For example, women often are reluctant to test for HIV and enroll in the program because of stigma and lack of support at home. This points to a need to mobilize communities, particularly religious and traditional leaders who influence opinion at that level.

PMTCT services are built on a weak health system affected by staff shortages and inadequate equipment. For example, a patient giving birth at a clinic has to provide 10 pairs of latex gloves to be used by the midwives, a surgical blade, clamp cord, cotton wool, linen saver, and rehydration fluid. This costs nearly US$40, which is well beyond the reach of any ordinary Zimbabwean[40]. As a result, many patients opt to deliver babies at home. This makes it difficult to monitor PMTCT adherence in home deliveries and babies often miss out on a single-dose nevirapine course within the recommended 72 hours after birth[41].

One possible strategy would be to change the program's name from prevention of mother-to-child transmission (PMTCT) to prevention of parent-to-child transmission (PPTCT). That term is all-inclusive and does not stigmatize the mother. Antenatal care and family planning services should be made male-friendly and inclusive to encourage men's involvement and subsequent community support. Further, all PMTCT

37 Interview with Lynde Francis, executive director of The Centre.

38 Interview with Dr. Owen Mugurungi, head of the MoH's AIDS and TB unit.

39 Ibid.

40 *Christian Science Monitor.* May 30, 2008.

41 Interview with Eunice Kapandura, executive director of Childhood HIV and AIDS Zimbabwe (CHAZ).

programs should also be integrated with ART because it is not enough to just give a single dose of nevirapine to the mother and child. Provision of formula is also essential to ensure that HIV-negative babies of HIV-positive mothers remain uninfected as many women and families cannot afford formula on their own.

The MoH should ensure consistency in provision of logistics, e.g., stocks, testing kits, appropriate counseling, and constant awareness-raising, to encourage uptake and ensure that parents seek attention early. In addition, primary health care service provision should be improved.

5. PERSPECTIVES OF HEALTH CARE CONSUMERS

As observed by Dr. Rashida Ferrand, "There are so many different barriers to optimal adherence, such as stock-outs, poor nutrition, accessibility to health centers, availability of drugs, and stigma." The notable obstacles are examined below.

FOOD AND NUTRITION

PLWHA complain that it is almost impossible to get adequate nutrition, an important part of a comprehensive treatment approach. Food is often unavailable in shops or extremely expensive when available. As a result, it is difficult for people on ART to adhere to recommended diets. Only a few health centres that are linked to NGOs provide food as part of the ART package.

ACCESS TO MEDICINES

PLWHA receive a month's supply of ARVs at a time and therefore must visit a clinic every 30 days or so. This is difficult for many given the dire transport problems across most of the country. For example, a single trip to the nearest health facility in Harare costs up to $3—yet the majority of people in Zimbabwe live on less than $1 per day. The costs are even higher for rural patients, some of whom must travel to urban areas for their care and medicines.

Drug stock-outs remain a major challenge of the government ART program. Patients complained that due to frequent stock-outs, their regimens are constantly being changed and they are not sure how this will affect their health in the long term. "Sometimes we get Triomune and sometimes we get Nevilast," said ZHAAU's Nyathi. However, even private health facilities are experiencing stock-outs.

Better availability of children's formulations is also necessary given that some hospitals still resort to breaking tablets for children. This has made many children hate treatment even more than might be expected, thereby affecting their adherence. It also has raised the need for guidelines on administering ART to children[42].

42 Interview with Eunice Kapandura, executive director of Childhood HIV and AIDS Zimbabwe (CHAZ).

Prophylactic medicines, including antibiotics and cotrimoxazole, are usually unavailable. When available, their costs are astronomical. For example, in May 2008, a seven-day course of the antibiotic amoxicillin cost Z$5.6 billion, in a country where the average monthly salary was Z$1.5 billion. (These numbers change regularly due to inflation, but the relationship remains the same.)

CONVENIENCE AND AVAILABILITY OF SERVICES

Improved integration of services would be of great assistance to PLWHA. Nyathi illustrated the problem: "You are tested at the New Start centre, then referred to the New Life post-test centre, then sent to the referral hospital, then sent for counseling, then sent to the laboratory for diagnostics and back to the hospital. Why can't all these services be provided in one place?" He noted that not only does the situation cause a lot of stress, but turns out to be very expensive in terms of transport costs. Providing complete HIV services as was done at the onset of ART in 2003 would enhance the quality of service to PLWHA.

There is also a need for child-friendly HIV/AIDS services. Children and adults visit the same OI clinics and although children get priority treatment, the environment is not conducive for them[43].

RECOMMENDATIONS

The quality of overall governance in a country directly affects the environment in which health systems operate and the ability of government health officials to exercise their responsibilities[44]. While political and economic change remain the greatest fundamental reforms that Zimbabwe needs, there are other actions that can be taken by stakeholders to improve health delivery to PLWHA[45]. They include the following:

- The government should consistently adhere to the Abuja Declaration of 2001 by committing 15 percent of its annual budget towards health as agreed at the meeting of heads of state. This would contribute meaningfully towards the health delivery system. Zimbabwe only met the commitment in the 2007 budget.
- The MoH and its partners should commit resources either in real currency or commodities to cater to patients before setting targets, instead of setting targets and then scrambling for the resources. This would also counter the problem of drug stock-outs and the consequences of lack of adherence and drug resistance.

43 Ibid.

44 Health Systems Fact Sheet: Zimbabwe. March 2008. www.healthsystems2020.org

45 Interview with activists

- HIV testing and counseling should be part of general care through PITC. When people present for general health care they should be able to get a routine HIV test.
- The Reserve Bank of Zimbabwe should provide vital foreign currency to boost the health service by honoring its commitment to provide no less than $2 million per month to the health system for HIV services, including drug procurement.
- The MoH should invest more in strengthening the primary health care delivery system, decentralizing service, and educating the public about health across the board. It should revisit the principles of primary health care that focus on holistic patient care.
- The MoH should integrate HIV services with general health services. HIV testing, counseling, diagnostics, and treatment should be provided under one roof. Treatment of STIs, TB, and other illnesses should be integrated into HIV services.
- Sanctions and the withdrawal of support by bilateral and multilateral partners affect ordinary citizens the worst. Enhanced support by UN agencies and the donor community towards improving the health delivery system as a whole rather than just the ART programs would be effective in ensuring access to basic health care for the average person.

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