Global health initiatives: opportunities or challenges?

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In response to the 2000 global commitment towards Millennium Development Goals (MDGs) and the 2001 UN General Assembly Special Session on HIV/AIDS, there were significant increases in global funding for disease-specific interventions, in particular HIV/AIDS and other diseases such as TB and malaria. These increases in financial resources demonstrated a moral commitment and a sense of urgency to halt deaths from these major diseases.

Three global HIV/AIDS initiatives contribute most of the direct external funding to resource-poor countries for scaling up HIV/AIDS prevention, treatment and care. These are the World Bank Global HIV/AIDS Program including the Multi-country AIDS Program (MAP); the Global Fund to fight AIDS, Tuberculosis and Malaria; and the United States President’s Emergency Plan for AIDS Relief (PEPFAR). The Global Alliance on Vaccines and Immunization (GAVI) has contributed significantly to scaling up routine immunization coverage while also introducing hepatitis B and Haemophilus influenzae B vaccines, and recently pneumococcal conjugated and rotavirus vaccines.

This commentary identifies opportunities and challenges posed by these global health initiatives (GHIs). It discusses and recommends how to maximize opportunities and minimize risks to the sustainability of national priority health programmes in the longer term beyond the funding.

Opportunities

A GHI furnishes a number of opportunities. It claims to promote transparency and accountability among recipient countries, for example through pay for performance mechanisms. It increases coverage and access through scaling up of cost-effective interventions when more financial resources are available. The claim that GHI contributes to health system strengthening is controversial; strong health systems are the prerequisite for successful GHI implementation. Some G such as GAVI and the Global Fund started to provide...
health system strengthening support to a number of country programmes. It seems the significant GHI contribution is scaling up interventions in resource-poor settings resulting in improved access.

The impetus to scale up has created opportunities to improve health outcomes by expanding services in low-income settings. There are a number of examples where GHIs have had a notable impact. For example, evaluation of PEPFAR operations (Institute of Medicine 2007) found that by 2006 more than 800,000 people living with HIV/AIDS were given antiretroviral therapy; more than 6 million women were covered by prevention of vertical HIV transmission; and more than 4.5 million people living with HIV/AIDS were given care and support.

It is increasingly recognized that scaling up needs to strengthen health systems for impact to be sustained. In this regard, the World Bank’s MAP fared better in observing country ownership and focused not only on disease-specific interventions, but also provided investment in health systems strengthening (Gorgens-Albino et al. 2007). For example, 39% of total disbursement was on systems strengthening and 36% on HIV prevention. MAP also set the foundation for significant resource mobilization, and provided financial support to other sectors involved in the response to HIV.

GAVI’s approach to health system strengthening had a number of components. First, there was a performance-based payment system which provided incentives to increase immunization coverage. These rewards are not string-tied but GAVI empowered a country’s inter-agency coordinating committee to decide what to spend on the improvement of immunization systems. Second, a medium-term financial sustainability plan for immunization is required for proposal application to ensure sustainability and requirement of government contributions. Third, the GAVI health systems window provided an opportunity for countries to apply for funds for health system strengthening according to their health systems context; for example, health information systems improvement and incentives to health workers at primary care level.

The GAVI programme in China was successful; during 2003–06, approximately 15.4 million children in China-GAVI project counties in the poor Western provinces received three doses of hepatitis B vaccine, preventing an estimated 1.47 million chronic hepatitis B viral infections in children and 265,000 future deaths attributable to chronic hepatitis B infection (Centers for Disease Control and Prevention 2006). However, the results are mixed in the weaker health delivery system of India where GAVI funding did not yield good results in hepatitis B coverage. Clearly, this indicates that GAVI resources provide opportunities to improve immunization systems in health systems with stronger capacity like China and vice versa in India.

Challenges

This commentary supports the discussion by Mangham and Hanson (2010) on barriers to scaling up, in particular in relation to health systems capacity among GHI recipient countries. One particular challenge is the ability to harmonize donor programmes among different donors and with national plans. There is, of course, a paradox here, with those countries most desperately in need of additional resources having the least capacity to exert pressure on donors to harmonize their activities. The UNAIDS commitment to the ‘three ones’ (one national HIV/AIDS plan, one coordinating mechanism, and one monitoring and evaluation framework) has not had an observable impact in many settings. Empirical evidence shows that early Global Fund programmes did not promote coordination, harmonization and monitoring at the country level (Brugha et al. 2005).

PEPFAR requirements appear to have imposed particular rigidities on programmes, undermining national leadership and ownership. For example, the focus on abstinence, faithfulness and consistent use of condoms clearly limits the harmonization of PEPFAR programmes with government and other donor programmes. Likewise, PEPFAR’s application of rigid US Congress-determined budget allocations is not consistent with country-led programming and ownership. For example, 33% must be spent on treatment; 20% on prevention, of which 33% must be spent on abstinence-until-marriage programmes (Institute of Medicine 2007). Moreover, the imposition of the requirement that only antiretrovirals that have received US Food and Drug Administration approval can be purchased prevents the achievement of long-term financial sustainability by the recipient countries when PEPFAR support ends. These antiretrovirals are mostly branded and expensive products. If it becomes necessary to switch to generic versions at some point in the future for budgetary reasons, this may undermine patient confidence and adherence, with adverse health consequences.

The scale of additional resources brought by GHIs can be huge in comparison with government budgets, and cause problems for absorptive capacity. For example, in 2006, the total budget of the Zambian Ministry of Health was US$136 million while PEPFAR provided resources targeted specifically to HIV amounting to US$150 million (De Maeseneer et al. 2008). Huge resources from the Global Fund have flooded into HIV/AIDS programmes in Mozambique, Uganda, the United Republic of Tanzania and Zambia. Moreover, such large grants can undermine transparency in the allocation of national resources. For instance, donors often seek to demonstrate that their programmes are additional to government commitments, but governments may choose to divert their own budgets to other priority health programmes that do not receive donor funding. A short-term assessment showed that low-income politically stable countries that are recipients of Global Fund resources had high implementation rates (Lu et al. 2006) of Global Fund programmes.

GHIs may cause further distortions through their impact on the health workforce. Higher levels of staff remuneration in GHI-funded programmes may attract well-trained professionals from elsewhere in the system, causing interruptions of non-GHI-funded programmes.

More generally, the GHIs have not adequately addressed the health systems bottlenecks which is fundamental for sustaining programme implementation (Hanson et al. 2003; Travis et al. 2004). These bottlenecks lie, for example, in problems of physical inaccessibility, poorly motivated staff with inappropriate skills, weak planning and management, lack of intersectoral action and partnership, and poor quality care amongst private providers. Not until recently have GAVI and the Global
Fund introduced health systems-strengthening windows in their country support.

Finally, while global attention has focused on HIV, the GHIs have failed to address maternal, newborn and child health. Compared with the Global Fund and PEPFAR focusing on HIV/AIDS, GAVI resources contributing to childhood survival (MDG4) are negligible. The current level of aid devoted to these population groups is inadequate and provides only a fraction of the total resources required to achieve MDG4 for child and maternal health (Powell-Jackson et al. 2006). The challenge is to ensure that a sufficient share of new funds is channelled towards the scaling up of key maternal, newborn and child health interventions in priority countries.

Conclusion and recommendations

Despite the massive injection of resources into disease control programmes, the opportunities created by the GHIs have not been fully exploited. GHI funding has focused on HIV/AIDS interventions and in particular antiretroviral treatment. Inadequate investment by the global community in maternal, newborn and child health, and health systems capacity strengthening should be corrected with strong global commitments. At times GHIs create fragmentation, especially when countries have little capacity to negotiate and harmonize donor programmes.

Greater balance is therefore required from the GHIs. For example, donor investment should be more evenly allocated across MDG targets (HIV/AIDS, malnutrition, maternal, newborn and child health); there should be greater balance between HIV prevention and ART, and between disease-specific vertical programmes and horizontal health systems strengthening. To obtain greater balance requires global leadership, country ownership and the capacity to harmonize donor programmes. The ongoing health systems-strengthening support from the Global Fund and GAVI and the renewed commitment by the G8 2008 summit in Toyako focusing on health systems strengthening are positive developments towards maximizing the effectiveness and sustainability of GHI investments.

References


