

BRIEFING SHEET 1: SCALE-UP AND ACCESS TO HIV/AIDS SERVICES

KEY MESSAGES: SCALE UP AND ACCESS

- Global health initiatives (GHIs) have supported real increases in HIV/AIDS services; but health worker numbers have not kept pace with needs (see Briefing Sheet 2).
- There was little evidence to show that scale-up HIV/AIDS services has had a negative effect on non-focal disease coverage.
- Some countries expressed concern over apparent preference given to funding for treatment over that for prevention services.
- Geographic access to services was not equal, with differences between urban and rural services as well as between regions within countries.
- Stigma and marginalisation of those affected by HIV/AIDS was reported in some countries, which has undermined access to HIV/AIDS services.

Background

Global funding for HIV/AIDS has increased dramatically this decade. Most of the direct external funding to scaling up HIV/AIDS prevention, treatment and care is provided by three Global Health Initiatives (GHIs); The Global Fund to Fight AIDS, TB and Malaria (GFATM); The World Bank Global HIV/AIDS Programme including the Multi-country AIDS Programme (MAP); and The United States President's Emergency Plan for AIDS Relief (PEPFAR). In the high prevalence, low-income countries of southern and eastern Africa, the combined commitments from these initiatives can amount to over half of countries' total health budgets. In the context of the concentrated epidemics of middle-income countries the scale of funding is less, but the potential impacts on the containment of the HIV epidemic are still significant.

Findings presented in this briefing sheet are results from completed and on-going research by Global HIV/AIDS Initiatives Network (GHIN) members (see Box 1) in ten countries.¹ The issues contained in this brief are not exhaustive and aim to provide a synthesis of emerging themes. The findings draw on data collected between 2004 and 2007 using mixed quantitative and qualitative research methods. Research will continue throughout 2008 and 2009 in some of the countries. Many findings are country and context specific. Country specific research outputs can be found at www.ghinet.org. As the strategies employed by the global HIV/AIDS initiatives are constantly evolving, and the questions that the researchers within the Network are addressing are live ones, these briefing sheets will be channelled into policy debates at the country and global levels on an ongoing basis and additional briefing sheets will be prepared as further findings emerge.

Early findings from GHIN country studies

Scale up of service coverage

New HIV/AIDS related programmes and services have been introduced and others scaled-up quickly between 2005 and 2007 – including ART, PMTCT and VCT and preventative services such as harm reduction and condom supply – in GHIN research countries. While direct attribution is often not possible because funds are difficult to track, it is generally accepted that much of the scale up has been due to GHI-support. In some countries this is largely due to GFATM, in others to PEPFAR, and in some, to both initiatives.

- The numbers and types of HIV/AIDS services expanded substantially in Ukraine between 2004 and 2007. Interviewees attributed this largely to the GFATM monies, which represented 44% of total external and state HIV/AIDS funding in 2006. Client numbers increased in three case study regions for prevention services, ARV therapy, care and support and substitution therapy.
- In Kyrgyzstan the GFATM grant has supported existing NGOs to continue their work or expand into new HIV/AIDS activities, and has stimulated the establishment of new NGOs. By 2007 GFATM support had been allocated in-country as 167 sub-grants, which supported the work of 102 organisations, 80 of which were NGOs, 18 government institutions, and 4 private companies.
- In Zambia VCT services showed that Lusaka district recorded an increase in the number of visits for VCT from 16,723 in 2004 to 37,380 in 2006. Visits for ART in Lusaka showed an almost

¹Benin, China, Kyrgyzstan, Malawi, Zambia, Ethiopia, Ukraine, Georgia, Peru.

threefold increase from 8,764 in 2004 to 25,138 in 2005, before increasing again to 37,905 in 2006. None of the districts experienced stock-outs of first line ARV drugs in 2006.

- Sustaining increases has been difficult. In Ethiopia there were concerns about default rates among those receiving ARV therapy, due to lack of proper care and support including food, counselling, and medical follow up.
- Evidence on the extent to which scale-up of HIV/AIDS services has had an impact on non-focal disease service coverage is mixed. However, in Malawi attendances for immunizations, family planning, inpatient and outpatient services remained stable, in spite of increases in HIV/AIDS services.

Balance of types of services being scaled-up

Some countries expressed concern over the apparent preference of funding for treatment over that for prevention services and for longer term sustainability of programmes:

- Findings from Ethiopia highlighted that the focus on treatment and care has led to an increased medicalisation of responses to HIV/AIDS.
- In order to redress the balance which had emphasised treatment, Ukraine's proposal for Round 6 GFATM funding put increased emphasis on preventive services for high risk groups. This reflected internal concerns that too much funding was going to treatment in a country where the epidemic was still relatively concentrated among groups of sex workers, injecting drug users and prisoners. The need for prevention programmes was also recognised because evidence suggested the epidemic had started to spread into the general population.
- In Georgia treatment has been prioritised over prevention since 2006, and state funding for prevention activities had decreased, making the HIV/AIDS programmes more dependent on GFATM.

Access and stigma

There were a number of specific barriers preventing sections of the population, often those most marginalised or with least resources, from accessing services. Inequities in the distribution of GHI-supported HIV/AIDS programmes were a concern in Georgia, Kyrgyzstan, Ethiopia, Malawi, Benin, Ukraine and Peru:

- Geographic inequities existed in the distribution of HIV/AIDS services, with problems of access in rural areas, particularly in Malawi and Ethiopia.
- In Ukraine and Kyrgyzstan there were regional disparities in available services in relation to need. For example, GHI funds have increased the number of HIV/AIDS services and health personnel proportionately in the Kyrgyz capital Bishkek compared to Osh which has the highest HIV prevalence in the country.
- Information about HIV/AIDS services was uneven. In Ukraine a high proportion of clients interviewed had heard about the service they were using from a peer rather than through formal means. In Kyrgyzstan GFATM-supported information programmes were seen as inappropriate for more conservative populations outside the capital.

- In concentrated epidemic countries – including Kyrgyzstan, Georgia, Peru, Ukraine and Vietnam – stigma and discrimination inhibited access to HIV/AIDS services. This is partly due to the political and legal environments that hinder effective engagement with groups particularly at risk of HIV transmission, including injecting drug users and sex workers whose behaviour is criminalised by the state, and partly due to attitudes in the broader society. For example, in Peru, research suggested that children and women were more valued than transgender persons and sex workers, who may be excluded from services.

Box 1: Global HIV/AIDS Initiatives Network (GHIN)

GHIN is a network of researchers in 21 countries² that explores the effects of Global HIV/AIDS Initiatives on country health systems, at national and sub-national levels. Key research themes include:

- Scale up of HIV/AIDS services
- Health systems capacity including human resources for health and coordination of HIV/AIDS programmes and services
- Equitable access to HIV/AIDS services

GHIN research findings are reported on the website: www.ghinet.org and are disseminated through research briefing sheets and other short communications, presentations at conferences and meetings, and through journal publications. These cover both country specific and cross-cutting analysis. GHIN members regularly interact with national and international stakeholders both to inform decision-making and to shape research questions.

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² GHIN countries undertaking 2-4 year studies include: Angola, Benin, China, Ethiopia, Georgia, Kyrgyzstan, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam and Zambia.