Health systems and HIV: Priorities for civil society advocacy

Michelle Munro
Interagency Coalition on AIDS and Development
Overview

• GTAG, civil society and health systems advocacy
• Health systems and health systems strengthening (HSS)
• How did HS get to a crisis state?
• Key advocacy issues – health workers, HIV for HSS, funding
GTAG

- Coalition of Canadian CSOs who advocate on global HIV issues and the right to health
- ICAD is a founding member
- 2003, 2006 & 2009 platforms include health systems
Why is HSS a priority for civil society HIV advocates?

In the countries most affected by HIV, none of the health Millennium Development Goals are unlikely to be achieved (UN 2008 MDG Report).

Weak health systems are the major reason for poor progress: WHO, 2008
Was GTAG’s health systems ‘ask’ coherent with our universal access and GFATM asks?

- HIV investments had exposed HS weaknesses
- GTAG would adopt a ‘Do no harm’ approach.
- better understanding of how HIV can best support HSS
What’s in a health system?

- Health services and care
- Health workers – health human resources
- Information systems
- Medicines, supplies, vaccines, technologies & infrastructure
- Financing
- Leadership and governance

Equity?
Gender?
CS Role?
Health systems strengthening

Health systems strengthening is building capacity in critical health system components to achieve more equitable and sustained improvements across health services and outcomes.
How did health systems get to a crisis state?
<table>
<thead>
<tr>
<th>Structural adjustment – pay off debt</th>
<th>↓ Public sector expenditure for HS</th>
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<tbody>
<tr>
<td>Health sector reform to reduce HS costs – user fees, private sector involvement, systems</td>
<td>Unsuccessful in countries with weak HS, ↓ equity, access &amp; CS participation in governance</td>
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<tr>
<td>Globalization</td>
<td>Exacerbate all of the negative effects</td>
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Where was Primary Health Care (PHC)?

- **Alma Ata 1978: Health for All**
  - Equity, the right to health
  - A comprehensive package
  - CS participation
  - Inter-sectoral cooperation
- But PHC quickly became **selective** and **vertical** – and this approach was then applied to entire health systems
Islands of sufficiency

The "vertical approach"

"Island of sufficiency"

minimum level

"the swamp"

additional health exp. vertical

health expenditure

island crumbling ...

current health expenditure

USD 40
USD 30
USD 20
USD 10

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Other effects of the ‘island’

- little development of transferrable capacity
- inequity
- duplication of effort and reporting
- weak governance
Aid effectiveness?

• Paris Declaration, 2005: Harmonisation, country ownership, shared accountability
• Sector Wide Approaches (SWAps) & Direct Budget Support/Programme Based Approaches (PBA)
• But managing a SWAp or programme is a huge task, doubly so where HS capacity is already weak (eg Malawi)
• The stigmatised can be excluded…
How does gender weigh in?

When HSs are weak there is:

- ↓ capacity to collect & analyse gender disaggregated data –
  ↓ understanding of gender issues
- ↓ reproductive health funding
- ↓ internal gender mainstreaming
Key HIV advocacy issues for Civil Society

Health systems and HSS are complex, crisis is not new & there are no easy answers.
1. Health workers
2. HIV’s role in HSS
3. Funding
HIV & the health workforce

Global HW shortage: 4.3 million

HIV ↑ workload & ↓ # of HWs

Weak HS & HW capacity

Weaker capacity
The countries with more diseases have fewer health workers, and less health investment.
HIV’s impact: the health worker crisis

- HIV has brought investment but also increased demand eg less stigma, more health seeking
- Incentives allow for scale up of HIV but unintentionally draw health workers from other health programs
- Task shifting (devolving work to less highly trained workers or volunteers) may help to manage the load but needs to be properly managed
Advocacy messages: health workers

- CS to monitor incentives
- Task shifting needs policies, training, supervision & remuneration
- NGOs & multi-laterals to adopt ethical recruitment & human resource strategies (see NGO Code of Conduct for HS)
- GoC & provinces to develop & fund a health HR policy
- No active recruitment by the private sector
- Gender mainstreaming
HIV as a HSS strategy

- **Diagonal** approaches – combining disease focused with systems approaches may be the way forward
- Some early but positive examples – Haiti, Cambodia, Rwanda
- GFATM has a health systems window that is separate & in addition to funding windows for the three diseases
Use HIV investments to improve the entire health system

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Advocacy messages: HIV funds for HSS

- Resources for **BOTH** HIV & HSS
- SWAps +: specific HIV & equity indicators
- CIDA & GoC: transparency on investments, protect HSS & HIV at the WHA
- GFATM: evaluate its HSS investments
- ‘Do no harm’ in all investments
- Private sector: equity & promote gender equality
- More evidence on HSS & what works
Funding & the financial crisis

• Long term under-investment by both governments and donors - worsened by the current crisis
• Amount invested in health often unrealistically low
• Most HS funds come from developing countries – not donors
African governments committed to investing 15% of total expenditure on health in 2001 (Abuja Declaration)

Government Health Spending as a Share of Total Expenditures, Selected African Countries, 2005
Financing innovations

- Insurance where the tax base is low
- Advanced Market Commitments (AMCs): assured markets for new vaccines & possibly drugs for neglected diseases or those that affect the poor
- Airline levy for HIV drugs
Advocacy messages: Funding

- 0.7% of GNI
- Double GFATM contributions
- Honour UN and G8 commitments to Universal Access
- Help Southern partners hold their governments accountable for Abuja
- Cancel debt and remove conditionalities
- Watch innovative funding & financing tools
- Support CSOs so that they can hold governments accountable
Questions?
Comments?
Thank you
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