Annex N

HNP Contributions to Combating HIV/AIDS
Background Paper to the World Bank HNP Strategy

Background

HIV/AIDS is a health priority for low- and middle-income countries (LMICs). HIV/AIDS is the fourth leading cause of death and disability in LMICs (Mathers et al. 2006), and in many countries, particularly in Africa, the epidemic poses a major threat to their economic development. Although the global HIV incidence appears to have peaked, the number of new infections and deaths continues to rise (UNAIDS 2006). Recent financial and political commitments for combating HIV/AIDS have created new opportunities, but also new challenges. Much of the new funding is focused on increasing access to antiretroviral therapy (ART). In the last two years, the number of people on ART in low- and middle-income countries has more than tripled to 1.3 million by the end of 2005. Yet this represents only 20 percent of those estimated to need treatment (UNAIDS 2006). Scaling up HIV prevention and treatment in a sustainable way will depend on health systems that can deliver care, fiscal space, and the ability of the international community to provide the financing.

A comprehensive response to HIV requires action across many sectors. The health sector, however, has a unique and central contribution to make, especially in scaling up clinical aspects of prevention and treatment (e.g., voluntary counseling and testing, behavioral counseling for people with HIV, prevention of mother-to-child transmission (PMTCT), treatment of sexually transmitted infections, treatment for co-infections with tuberculosis and opportunistic infections, and ART), as well as for other public health functions such as disease surveillance and monitoring.

In 2005, the World Bank articulated its Global HIV/AIDS Program of Action (GHAPA) for supporting the global, regional, and national AIDS response. The Africa Region of the World Bank is developing an "HIV/AIDS Agenda for Action in Sub-Saharan Africa" to further articulate the Bank's role on HIV/AIDS in the Region most affected by HIV. The HNP Strategy is intended to complement these responses. This annex to the HNP Strategy

- Identifies the main constraints of health systems in contributing to the fight against HIV/AIDS and ways of overcoming these constraints.
- Reviews the special challenges of financial sustainability in HIV/AIDS and health programs and identifies ways of overcoming these constraints.
- Outlines the key contributions that HNP sector can make to combating HIV/AIDS.

What is the relation between health system strengthening and priority-disease approaches?

The decades-old tension between health system strengthening approaches and priority-disease approaches has changed to a growing consensus that both types of approaches depend on the other to achieve their common goals (High-Level Forum 2005; Mills 2005; Peters et al. 2006; Stillman and Bennett 2005). It is also recognized that the old labeling of "vertical" versus "horizontal" schemes is not an accurate portrayal of either HIV/AIDS or health system strategies. Although many HIV/AIDS programs have created separate organizational units, with separate personnel, management, and accountability systems, the World Bank and other agencies have worked with countries to encourage programs to be broadly based and operate across sectors and civil society. By the same token, not all health system strengthening approaches are integrated "horizontally." Projects that focus on essential drug management or

strengthening health information systems may be more "vertical" than HIV/AIDS programs when they use separate and hierarchical management and accountability structures, even if they function across diseases. In any case, important concerns remain about which approaches work best and how to find synergies between disease-specific and systems approaches.

Some have argued that priority programs such as for HIV or disease eradication should be able to strengthen health systems generally (Buve et al. 2003; Melgaard et al. 1999). Yet beyond the strength of expert opinion, there has been little evidence that these spillover effects actually occur (Peters et al. 2006). Some studies note that, although large disease control programs can be effective in addressing the specific problems they target, they can also harm the general health systems when they create duplicative and uncoordinated management entities, financing structures and reporting systems, or replace local priorities with those of donors, or distort salary and incentive structures and distract from other activities (High-Level Forum 2005; McKinsey and Company 2005; Stillman and Bennett 2005). In reviewing studies that examine approaches to strengthening specific programs and studies that attempt to strengthen a range of health services, Øvretveit and colleagues (2006) find little scientifically robust evidence for or against the view that disease-specific programs deflect overall health services from local needs. Nonetheless, they note that some strategies to deliver certain services, such as special payments to provide immunizations, can reduce the motivation to provide other services. They conclude that disease- or service-specific strategies on their own are unlikely to bring about the changes needed in health systems to achieve the Millennium Development Goals (MDGs).

Overcoming Health Systems Constraints

A number of recent studies have identified common types of constraints in health systems in low- and middle-income countries, which affect both disease-specific and health systems (Hanson et al. 2003; Oliveira-Cruz et al. 2003; Travis et al. 2004). These constraints can be examined by how they relate to the incentives environment for the health sector (table N1).

Table N1
Incentives Environment and Constraints for Health Systems in Low- and Middle-Income Countries

Level of incentives	*Examples of constraints*
Individuals and communities	Lack of demand; limited access to information; lack of financial resources; exclusionary social norms; fractured or weak community institutions; low community participation; limited influence over providers, health bureaucrats, and political leadership; physical barriers to care
Health service providers	Limited staff; inadequate provider skills, poor training and technical guidance; weak motivation; weak supervision and management systems; poor compensation and rewards systems; poor physical work environment (e.g., inadequate drugs, equipment, and buildings)
Health sector	Weak sector leadership and vision; inappropriate sector planning and regulatory systems; weak accountability mechanisms; purchasing and provider payment systems unrelated to performance; poor collaboration with nongovernmental organizations and private sector stakeholders; reliance on donors and donor priorities
Macro environment	Insecure or unstable social and political conditions; macroeconomic instability; poor governance and corruption; trade and migration pressures; weak sectors critical to health (education, communications, agriculture, labor); weak systems for reconciling cross-sectoral development priorities; inefficient, unresponsive, and rigid government bureaucracies; confused or insufficiently supported decentralization strategies; poor physical environment (poor roads and communications infrastructure)

There is little strong evidence to indicate which constraints are most important, or what strategies are most effective in overcoming these constraints. The reason is that the studies that comprise the evidence basis for the reviews are mostly of limited scientific value, due to flaws in study design. The studies often do not define the particular strategies under investigation or cannot attribute change to the strategies pursued (Øvretveit et al. 2006; Peters et al. 2006).[1]

The HIV epidemic itself places additional pressures on weak health systems by increasing demand for health care and reducing the supply of health workers. It also reduces the supply of a given quality of health services at a given price, while increasing health expenditures (Over 2004).[2] This is likely to translate into higher national health care expenditure in absolute terms and as a proportion of national income. This leads to reduced non-HIV patients' access to other health services, unless additional expenditures are made to finance those services.

[1] The common deficiencies in research design include: (i) The strategies or intervention that are being pursued are not described in detail, so that it is hard to determine what the intervention actually consists of or whether it was implemented, and very different strategies are often given the same label; (ii) Many strategies involve multiple components that are not specified or studied in a way that would indicate which component is essential, or where there are synergies between components; (iii) Most studies do little to examine factors beyond the health system or the intervention itself that may influence the results being examined; (iv) There are limited attempts to design studies that can actually attribute results to the strategy, including use of time series, before-after data, or comparison groups and randomization.
[2] The effects in a given country will depend on factors such as its HIV prevalence, demographic patterns, costs of ART, availability of health insurance, supply of health workers, their perceived and actual risks to HIV infection, and the costs of providing services at the same level of quality (Over 2004).

Health financing constraints

The contrast between the enormous unmet health needs of poor countries and the resources they have to pay for them is well recognized. In a recent synthesis of health financing in low- and middle-income countries, Gottret and Schieber (2006) find that developing countries account for more than 90 percent of the global disease burden, but only 12 percent of global health spending. Between US$25 billion and US$70 billion in additional aid per year has been projected as needed to achieve the MDGs. As described by Gottret and Schieber (2006), the Bank is concerned about a number of characteristics of development assistance for health (DAH) that are particularly relevant to HIV/AIDS:

- *Volatile and short-term aid.* The amount of DAH funds countries receive varies greatly from year to year, though the reasons may differ.[3] Although funding for HIV/AIDS has increased rapidly, due largely to funding from the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), more than 70 percent of these funds are concentrated in about 25 countries, whereas donors have health programs in about 140 countries.[4] Volatile and short-term DAH makes it difficult for ministries of health and finance to make necessary long-term plans such as employing more doctors or nurses, raising wages, or expanding access to ART.
- *Funding distortions.* Fragmentation of donor assistance to health has created distortions in funding, making it difficult for governments to finance their system requirements for staff, supervision, training, management, and maintenance. For example, a government of Rwanda report identified how donor funding has helped create a six fold difference in per capita health spending between provinces (Republic of Rwanda Ministry of Finance and Economic Planning, Ministry of Health 2006). Physicians working for nongovernmental organizations (NGOs) providing HIV/AIDS services received six times the wages of MOH physicians, compromising human resources and service delivery in the public sector. The MOF argues that funding for HIV/AIDS is "disproportionate" when there is little funding for child health or other strategic objectives. The MOH says "single-issue funds and single-issue projects are being used to disburse funds through centralized allocation mechanisms that do not respond to the relative importance of needs as perceived by patients and health providers." Paradoxically, as donors move to provide more general budget support, spending on health and HIV/AIDS may decrease if governments choose different allocation priorities, particularly if they feel that donors will provide other support for health and HIV/AIDS.
- *Allocative inefficiencies*. The large influx of funding for HIV/AIDS raises the question about whether the funds are used to their maximum net benefit. The recent emphasis on expanding access to ART has not been met by a similar expansion of prevention efforts. Although ART appears to have a net beneficial effect on preventing HIV infection, and both can be relatively cost-effective, preventive interventions will have a bigger impact on reducing new HIV infections and are more cost-effective (Bertozzi et al. 2006; Hogan et al. 2005; Salomon et al. 2005). The problem is particularly striking in PEPFAR, the largest funded program for HIV/AIDS, where prevention spending is falling and constrained by requirements for abstinence-until-marriage activities (Government Accountability Office 2006). If funding continues to increase for

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[3] These include the short-term commitments of donors—often no more than 12 months at a time—exchange rate fluctuations, and administrative delays by donor or t recipient, and aid conditionalities.
[4] GFATM grants typically have a two-year initial phase and a three-year second phase, with funding for the second phase conditional on acceptable progress in the initial phase, although grantees can apply for concurrent grants. PEPFAR was originally announced as a five-year program, with renewal under discussion.

HIV/AIDS, and ART in particular, without concomitant increases in funding for other priorities, the question must also be asked if some funds would be better spent in other ways that can make a larger contribution to peoples' health or better address inequities. Alternative uses include programs targeted at the health of poor and vulnerable populations, other high- priority conditions that are relatively under funded such as neonatal health, or desperately needed investments in human resources for health and other aspects of health systems.

- *Need to create fiscal space.* Large increases in public spending on HIV/AIDS or health initiatives that create future spending commitments must be considered in the context of government's ability to provide resources from current and future revenues and donors' willingness to provide long-term funding. The problem is compounded if large expenditures are financed by borrowing, which requires additional revenue to service the debt and has potential to impair overall economic growth. In the case of Rwanda, only 14 percent of the donor spending on health passes through the government. This makes it very difficult for government to diagnose fiscal problems or plan a response to manage large influxes or reductions in short-term aid (Republic of Rwanda Ministry of Finance and Economic Planning, Ministry of Health 2006).

The Bank's contributions in financing for HIV/AIDS

The Bank will specifically contribute to financing HIV/AIDS programs and health systems in several ways:

- *Providing increased, long-term, predictable funding.* The World Bank is committed to leveraging and providing increased and predictable long-term financing for HIV/AIDS and the health sector. This includes a commitment to financing recurrent costs of HIV/AIDS and health programs in ways that help them to increase their effectiveness and reduce wastage. When the World Bank funds ART programs, it will seek to do so in the context of long-term program funding, such as through Adaptable Program Loans or find new ways of funding cohorts of people on HIV treatment (e.g., 20-year horizon), rather than just through short-term projects. Shorter-term project support for HIV/AIDS and health initiatives should be selected and designed to meet shorter-term objectives, such as to test innovations, help create new institutions, support transitions in ongoing programs, or bridge especially unstable conditions.
- *Creating fiscal space and reducing distortions.* The Bank will work with client countries, the IMF, and other donors to help them develop ways of enhancing country capacity to absorb fiscal shocks and reduce their adverse effects. This would involve working with Ministries of Finance, other sectoral Ministries, and donors to ensure better complementarity of external financing flows and domestic resource mobilization. External flows should facilitate and help catalyze domestic financial resource mobilization rather than increase debt or aid dependency. The Bank will also ensure that financing and reporting procedures support local systems and are harmonized with those of other donors, as outlined in the Paris Declaration on Aid Effectiveness[5] and the "Three Ones" for HIV/AIDS programs.[6]

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[5] The Paris Declaration on Aid Effectiveness includes a commitment to increase support for programmatic approaches that share the following features: (i) leadership by the host country or organization; (ii) a single comprehensive program and budget framework; (iii) a formal process for donor coordination and harmonization of donor procedures for reporting, budgeting, financial management, and procurement; (iv) efforts to increase the use of local systems for program design and implementation, financial management, monitoring and evaluation.

[6] The "Three Ones" are a set of guiding principles for coordination of national partners and partners involved in HIV/AIDS control, and include: (i) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (ii) one National AIDS Coordinating Authority, with a broad based multisectoral mandate; and (iii) one agreed country-level monitoring and evaluation system.

- *Enhancing accountability.* The Bank will promote budgetary and financial reporting processes that accommodate and respond to the views of critical stakeholders within the country. These processes will need to account for the interests of the poor, vulnerable, and marginalized groups, including people living with HIV/AIDS, in order to increase accountability and enhance people's voice. These processes offer important opportunities for debating and resolving concerns about allocative efficiency and equity, and for public disclosure of information and decisions over policy, financing, and program direction.
- *New types of financing.* The Bank will provide financial, technical, and convening support to countries that request help with developing health financing systems that promote accountability, efficiency, and financial protection, and which form the framework for financing of HIV/AIDS prevention, care, and treatment at the country level. The Bank will also test new approaches to its own financing of HNP and HIV/AIDS. Emphasis will be put on linking Bank financing to performance in purchasing HIV/AIDS and other health services, rather than rely on financing inputs. Such approaches accentuate the importance of using information and demonstrating results in HIV/AIDS and health sector programs.

More funding is not enough

Although additional funds will be necessary for scaling up HIV/AIDS and other health services, additional funding can also play an important role in overcoming some health systems constraints such as poor supply of drugs and equipment or weak demand for services (Hanson et al. 2003). However, there is an emerging view that funding alone is not sufficient to overcome constraints. Johnston and Stout (1999) argue that it is the continuous commitment to improvement, analysis of constraints, flexible implementation, and positive macroeconomic and governance environments that are most useful in strengthening health services. Lewis (2005) holds that the keys to effective absorption of funding for HIV/AIDS will require building up institutions and human capacity in the health sector, as well as broader governance capacity. Whitty and Doherty (2006) argue that the biggest barriers to fighting disease are not financing or political will, but the failure to match the recent investments in new drugs and tools with investments in training people and developing efficient systems to deliver them. This is exactly where the World Bank's HNP Strategy can assist countries to better tackle the HIV/AIDS and health problems they face.

Vision for HNP Contributions to Combating AIDS

In the "preferred future," countries' health sectors will make significant contributions to combating HIV/AIDS and improving their people's health, and the World Bank will help client countries

- Improve health status among vulnerable groups and the general population, including achieving the MDGs. Curbing the incidence of HIV infections across all key subgroups and the general population is a vital part of this.
- Fashion effective, equitable, accountable, affordable, and sustainable health systems that provide a full range of preventive, curative, and rehabilitative health services and make full use of public and nongovernmental health actors and engage with and contribute to institutions outside the health sector. The Bank shares the collective goals of universal access to ART for people with HIV, universal childhood immunization, antenatal care and safe deliveries for all pregnant women, provision of directly observable treatment for all TB infected, and full access to other elements of locally defined "essential packages" of care.
- Reduce the number of people plunged into poverty by health care costs.

- Help individuals and households to make informed choices about healthy life styles and use of health services.

What should the Bank do to contribute to HIV/AIDS through health systems?

The focus of health system strengthening for HIV/AIDS is to improve and expand HIV prevention, treatment, and care via the health systems that deliver these services. The HNP Strategy outlines how the Bank will focus on strengthening aspects of health systems related to its comparative advantages in financing, creating the right incentives environment, working across sectors, and demonstrating and using results in the context of countries' human and economic development.

In addition to addressing financing of HIV/AIDS and health (discussed above), the World Bank plans to strengthen health systems to contribute to HIV/AIDS by

- Integrating HIV/AIDS and health system programming to ensure that planning and financing of the health sector and HIV/AIDS programs support each other and do not create duplicative and competing structures. The Burkina Faso Health Sector Support and Multisectoral AIDS Project is an example of the way health sector and HIV/AIDS allocation decisions can be made collectively: a common lending instrument is supporting two pooled funds (one for the health sector, one for multisectoral HIV/AIDS activities), which will facilitate alignment of financing, management, and monitoring systems.
- Learning from the experiences of the AIDS Strategy and Action Plan (ASAP) service and the Global AIDS Monitoring and Evaluation Team (GAMET) program to provide task teams and country stakeholders with resources and tools to improve strategy development, engagement of civil society, and monitoring and evaluation.
- Funding interventions that are important to the HIV epidemic or the health situation that might otherwise be neglected because they are politically difficult for other agencies to finance (e.g., prevention and treatment programs for prisoners, harm reduction programs for injection drug users).
- Refraining from funding popular programs that other agencies can finance with grants (e.g., commodities for ART and prevention of mother-child transmission) or activities for which Bank support systems are inadequate (e.g., clinical trials).
- Supporting systematic identification, monitoring, and evaluation of country-based Bank assistance to HIV/AIDS programs and the health sector to ensure that:
    - Country strategies, PRSPs, MTEFs, and sectorwide approaches adequately address HIV/AIDS and other priority health concerns, the interests of the poor, and health system requirements for delivering services. These strategies will need to be appropriately budgeted and aligned with the country's macroeconomic framework and have sustainable financing that does not skew balanced development of the economy. They will also need a focused and balanced approach to demonstrating results.
    - The proposed financing and implementation arrangements for HIV/AIDS and the health sector are supportive of the "Three Ones" and the Paris Principles on Aid Effectiveness.
    - Support to specific-disease programs or institutions is contingent on identification of any potential harm to the health system (or other health programs and prior establishment of appropriate risk-mitigation strategies.

In day-to-day operations, the World Bank has numerous levers of influence to support HIV/AIDS and the health sector at country level. Table N2 outlines these levers and summarizes how they can be translated into specific actions.

Table N2
Levers of Influence for the World Bank in HIV/AIDS and Health Systems at Country Level

Levers of influence	
Direct interventions	*Bank actions in HIV/AIDS and health systems*
Financing investments and operations	• Provide funding for agreed public sector programs that appropriately finance HIV/AIDS programs and health systems in the context of PRSPs and MTEFs • Direct health sector financing, for capital investment (buildings, equipment) and recurrent costs (staff, training, drugs, supplies, and activities) for HIV/AIDS programs, development of health systems, and delivery of services.
Purchasing outputs/outcomes	• Link funding to provision of health or HIV/AIDS services, or locally relevant performance targets, affirming that results have been achieved as basis for disbursement.
Expenditure control	• When financing inputs, ensure that fund disbursements conform with procurement procedures acceptable to the Bank. • Assure probity of Bank funds through audits.
Influencing strategies	
Linking HIV/AIDS and health sector to public policy and financing	• Facilitate communication between Ministries of Finance and sector ministries for development of national strategies, planning, and evaluation to ensure that financing is sustainable and balanced across sectors and that the health sector and HIV/AIDS programs have a relevant role. • Bring together health with other sectors and civil society organizations over broader government reforms (e.g., civil service reforms).
Convening key actors	• Bring together critical players within civil society and government within country for learning, consensus building, strategy development, and planning for HIV/AIDS programs and the health sector in the context of PRSPs and MTEFs. • Network with experts and colleagues across countries to ensure that the best possible technical advice is considered. • Facilitate learning by critical players within country through communications, training, sharing materials, and dissemination of research and evaluation results.
Designing HIV/AIDS programs, health services, and their support systems	• Use project preparation and supervision to ensure the best available technical assistance, software, training, and support systems in the design or redesign of programs and support systems. • Focus Bank technical resources to strengthen policy and strategy cycles, financing systems, monitoring and evaluation systems, poverty concerns, and intersectoral linkages.
Monitoring and disclosing	• Ensure that appropriate plans for the monitoring and evaluation of health systems are developed, financed, and implemented and that the data are used for management and allocation decisions and for public disclosure and discourse. • Review performance of projects and HIV/AIDS and health sector programs for planning and disclosure purposes.

Levers of influence	
Providing knowledge and advice	• Commission or conduct studies on relevant HIV/AIDS and health policy and operational issues, such as impact evaluations of major programs and innovations. • Pooling and synthesizing information and experience on health systems, health financing, and links to HIV/AIDS with a focus on translating knowledge into local policy and practice.
Negotiating actions for disbursements	• Agree on actions for disbursement of Bank funds in the context of Poverty Reduction Strategy Credits that support HIV/AIDS and health sector objectives. • Ensure that agreed actions are taken by the borrower when a basis for Bank financing

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