Newsletter Date: August 2008 Volume 1, Issue 4

Health Systems Action Network

Highlights…

- **In this special feature, HSAN presents arguments from leading health professionals addressing the question of whether or not vertical funding helps or hinders health care in developing countries.**

Courtesy: HS 20/20 Project Archives

HSAN is a global network of committed professionals for strengthening health systems through effective involvement of diverse stakeholders and better management of resources that is guided by evidence. HSAN's vision is to become a leading global network facilitating the development of equitable, accountable and sustainable health systems for improved health outcomes.

The views expressed in the following articles reflect those of the authors only and are not necessarily the views of HSAN or its members.

Can Vertical Global Health Initiative Funding Strengthen Comprehensive Primary Health Care?

By: Donna Barry and Joia Mukherjee, Partners in Health

Over the past few months, there has been a great deal of discussion at conferences, in medical journals and on global health list-servs about shifting international health funding from vertical programs (such as HIV) to more comprehensive programs relating to primary health care and strengthening all health systems in a country, not just disease-specific facilities and systems. This is due to a combination of factors including the recently reauthorized US PEPFAR program which includes $48 billion for AIDS, TB and malaria ; a newly published books by Helen Epstein, Elizabeth Pisani, and James Chin; Roger England's piece in the British Medical Journal calling for the end of UNAIDS[i]; the formation of International Health Partnership, the new Positive Synergies project at WHO and the UK's Department for International Development funding priorities for 2009.

> *"... when HIV testing and AIDS treatment is integrated into the delivery of primary care rather than directed as a vertical program, health systems are strengthened as are services to the most vulnerable."*

At Partners In Health we believe that this is a false debate. The interest in and funding for HIV has allowed us to expose the woeful underfunding in health systems and given us a long awaited chance to invest in developing health systems. We have documented that when HIV testing and treatment is integrated into the delivery of primary care[ii] rather than simply directed as a vertical program, health systems are strengthened[iii] as are services to the most vulnerable[iv].

When we adopt the logic frame that prevention of HIV and treatment of AIDS are inseparable from the most basic aspects of health care, including the case detection and treatment of tuberculosis and sexually transmitted infections and the provision of women's health, then it follows that vertical funds should be used to support health systems. This approach has allowed us to use monies targeted for HIV to provide adequate compensation for general medical staff, improve public health infrastructure to allow for the management of both acute and chronic diseases and provide tools for the provision of general health services.

Our work in Las Cahobas, a rural town in Haiti's Central Plateau, provides a striking example of how health care has improved after we expanded our HIV Equity

Initiative in 2003. HIV counseling and testing visits which were not available before 2003, jumped to 2,000 tests per month during the first year of the project[v]. After scaling up care in 2003, over 200 patients were on TB treatment (DOTS) after the first 14 months, as opposed to the nine cases that were detected the previous year[vi]. Prenatal visits increased from less than 100 per month to over 500 per month in the first year and patient visits in general went from approximately 500 per month to over 6,000.

In Haiti's Central Plateau we performed more than 76,000 HIV tests in 2007 and currently have 3,500 patients on AIDS treatment. In addition, from January 2006 to September 2007, over 65,000 prenatal visits were completed, 4,200 institutional births were attended, 301 Caesarian sections were performed at our hospitals, and nearly 40,000 women were using hormonal contraception. Reproductive health and obstetric care constitute just one of many other health interventions that can be strengthened by improved health systems that are boosted with vertical funds.

On the eve of the 30th anniversary of the Alma Ata Declaration, it is good to see all the renewed attention to strengthening primary health care and health systems. What is worrisome however, are those who call to reduce funding for vertical programs, rather than increasing funding for these programs in addition to calling for more funding to help integrate them into an overall comprehensive health system and strengthen the public health system itself.

Donna Barry is PIH's Advocacy and Policy Director. Joia Mukherjee is PIH's Chief Medical Officer. ■

[i] England, Roger. The writing is on the wall for UNAIDS. PERSONAL VIEW. *British Medical Journal*. 10 May 2008. 336;

[ii] Ivers LC, Freedberg KA, Mukherjee JS. Provider-initiated HIV testing in rural Haiti: low rate of missed opportunities for diagnosis of HIV in a primary care clinic. *AIDS Res Ther*. 2007; 4(1):28.

[iii] Mukherjee JS, Eustache E. Community health workers as a cornerstone for integrating HIV and primary healthcare. *AIDS Care*. 2007; 19 Suppl 1:S73-82.

[iv] Walton DA, Farmer PE, Lambert W, Léandre F, Koenig SP, Mukherjee JS. Integrated HIV prevention and care strengthens primary health care: lessons from rural Haiti. *Journal of Public Health Policy*. 2004;25(2):137-158

[v] Ibid.

[vi] Ibid.

AIDS funding is not the answer to primary health care strengthening

By: David Egilman, Global Health through Education, Training and Service (GHETS)

Quoting from Paul Farmer, Director of Partners in Health (PIH) "The influx of AIDS funding can indeed strangle primary care, distort public health budgets, and contribute to brain drain. But these untoward or "perverse" effects are not inevitable; they occur only when programs are poorly designed."[i] We disagree in part with Farmer's statement. Vertical programs such as those run by PIH, which focus attention on preventing and treating a single disease, are harmful even when "successful", because they distract us from implementing programs that address the root causes of disease in under-developing countries. In Haiti, vertical HIV interventions have led to a perverse, counterproductive outcome. Haitians no longer fear contracting HIV; they see a positive test as the easiest – and often the sole path to survival. If they contract HIV, they get free health care, food and housing. No other disease, diagnosis, social program or policy guarantees these basic and essential services. While the PIH program has improved a variety of health indicators, as Laurie Garrett, the Council on Foreign Affairs, noted "during the … [2002-2006 period] Haiti actually went backward on every other health indicator" other than HIV.

Furthermore, a local model, no matter how effective, must be reproducible if it is going to be brought to scale. Keusch, noting this as a major problem with the PIH program in Haiti, was "struck by the fact that the nature of leadership, characterized by competence, commitment, compassion and charisma is not included among the lessons learned in Haiti. It is necessary to raise this, because in many, if not most, places attempting to replicate the success of the Haiti programs, the critical "Cs" will not be there and may be substituted by corruption, control, competition and condescension."

We agree that some intensive HIV interventions covering limited populations can and do improve general health. However, it is wrong to base policy prescriptions on non-scalable, exceptional cases. This is particularly true since vertical programs divert attention from more critical systemic issues that typify the public health crisis in Haiti and other under developing countries. We use the term "under developing" because as with Haiti,

most health indicators and economic conditions have gotten worse in Sub-Saharan Africa and similar locales in the past decade. For example, only 14% of Haitians have access to sanitation. As a result 22,000 children die annually before reaching the age of 5 (WHO 2006). Few, if any, of these deaths are related to HIV. Instead, they are caused by treatable and preventable illnesses such as pneumonia and diarrhea. For instance, only 31% of children under the age of 5 with symptoms of pneumonia saw an appropriate health care provider, and 19% of infant deaths were caused by diarrhea.[iv] Diarrhea related death is twice as common in children as AIDS or HIV and is easily preventable at low cost.[v]

Solutions to these problems can be found through horizontal interventions, which focus on treating and preventing all illnesses present, rather than a single disease. Horizontal interventions directly concentrate on these types of problems because horizontal approaches are holistic and are driven by community-professional partnerships that set priorities that maximize the impact of limited resources.

The most unexpected adverse consequence of vertical programs is their impact on the way we think about the underlying social and economic causes of disease. Vertical programs force us to focus on viruses and bacteria, while at the same time diverting our attention from the social and economic injustices that are the real disease vectors in under developed countries. Vertical programs, proposed narrow, medical-technical interventions to specific diseases. They prevent us from even conceiving of ways to get at the root causes – inequality and social injustice. Instead, we should focus on community oriented primary care programs (COPC) – horizontal programs that call for interventions and methods. Program such as these tackle the underlying causes of disease, both in form – by mobilizing communities – and in substance.

As Gish noted, "Alma-Ata affirmed health as a human right and sought to have interventions focus on the underlying social, economic and political causes of disease and illness as well as for comprehensive health care. This project was intended to support a larger struggle by the marginalized for their well being and their rights. The emphasis on addressing the root causes of poor health and the efforts to put health in the hands of the people posed a threat to entrenched interests."[vi] Vertical programs do not do this. The entrenched interests (global capitalism), including much of the NGO and donor communities, recognized this political threat to their power and to the world order. Halfdan Mahler, the head of WHO in 1978 and the architect of the Alma-Ata approach, recently explained the demise of the primary health care movement: "We were crushed by the IMF. The hammer that was used to crush us was the vertical intervention – 'selective primary care'."[vii] Vertical programs make it appear that we are "helping", while in fact we are undermining political interventions that deal with the underlying causes of disease. In this way, such programs violate the first rule of medicine - *primum non nocere*. Even if vertical programs improve indicators widely, they do not fundamentally change power relationships or the underlying social structures that are the ultimate cause of diseases.

Global health organizations that promote the vertical approach fear that demand for more viable primary care through horizontal funding will trigger a reduction of funding for vertical programs. Their unspoken "worry", however, is that informed donor communities will contribute money that serves the interest of the Haitian populace, rather than the interest of the NGOs and do-gooders. PIH does not disagree in principal with horizontal funding for health care, yet, the assumption that funding is available to support an increase in both horizontal and vertical funding is merely a pipe dream and ignores the conditions on the ground. In 2005, 90% of health expenditures in Haiti were paid out of pocket, the bulk of which went to basic primary medicine (WHO). If organizations such as PIH continue to insist on vertical funding, they will only exacerbate this problem by misallocating scarce resources and requiring more Haitians to pay for their basic health care out of empty pockets.

David Egilman MD, MPH is the President of Global Health through Education, Training and Service (GHETS), a professor of community health at Brown Medical School and a physician. ■

---

[i] Paul Farmer, From "Marvelous Momentum" to Health Care for All, January 23, 2007.

[ii] Laurie Garrett, The Challenge of Global Health, January 23, 2007.

[iii] Commentary: Spreading Effective AIDS Care in Poor Countries, Thoughts on the Partners-in-Health/Zanmi Lasante Experience in Haiti, Gerald T. Keusch, Journal of Public Health Policy, Vol.25, No.2 (2004), pp. 159-161.

[vi] UNICEF, http://www.unicef.org/infobycountry/haiti_statistics.html, Accessed June 23, 2008.

[v] World Health Organization, http://www.who.int/countries/hti/en/, Accessed June 23, 2008

[vi] Gish, O., in Sickness and Wealth: The Corporate Assault on Global Health, edited by Meredith Fort, Mary Anne Mercer, and Oscar Gish (South End Press, 2004)

[vii] Cueto, M. The Origins of Primary Health Care and Selective Primary Health Care. Am J Public Health. 2004 Nov. 94 (11): 1864-74.

Leveraging Vertical Funds to Expand Health Care

A response from Donna Barry, Partners in Health

A recent editorial in *The Lancet Infectious Diseases*[i] on whether HIV/AIDS requires an exceptional response is a terrific review of why HIV/AIDS still deserves to receive special attention in global health funding. "We need to take the many lessons learned from the HIV/AIDS story and apply them to other diseases, and work towards maximizing the positive effects of HIV funding to date."[ii] These lessons should not only be applied to other diseases but to expanding comprehensive primary health care and strengthening health systems. While we work to increase funding for these efforts, we need to ensure that funds devoted to specific diseases are also used to strengthen overall health care services and structures.

In our approach to integrated, community-based, high quality health care, we have not seen the perverse effects that Dr. Egilman refers to in his piece and in fact, have consciously resisted causing said effects. It's true that many patients treated by PIH and our in-country partners do receive wrap-around services including food packages, water filters, new homes and school fees for their children, but this is determined by the level of poverty faced by these patients and their families, not only disease status.

Distribution of locally produced cereal-legume blend and ready-to-use therapeutic food for malnourished children in Lascahobas, Haiti. Courtesy: Andrew Marx, Partners in Health

Over the past few years, Partners In Health has expanded its programs to three African countries: Rwanda, Lesotho and Malawi. In all instances, we were invited by the host government to help address the care deficits in their countries. Thus, with full government support we have begun working in the most impoverished and rural areas to strengthen Ministry of Health hospitals and clinics to treat the big 3 infectious diseases (AIDS, malaria and TB). In the process, we have also helped to improve immunization programs and coverage, provide safe childbirth, and increase visits for family planning, prenatal care, pneumonia, diarrheal disease and hundreds of other conditions and diseases. We aim to improve socio-economic conditions as well through programs to improve food security, provide clean water sources and improve sanitation, build houses, pay school fees, and introduce micro-credit programs.

HIV/AIDS and GFATM funding provides baseline resources for us to expand services to all patients and leverage additional funding to provide primary health care, surgical care and the programs to improve socio-economic conditions. We don't disagree with Dr. Egilman on the need for far greater funds to improve comprehensive care for those who have not been infected with HIV, malaria and TB as well as to address the poverty that underlies many of these problems. In fact, we continue to advocate for those funds at all levels. But until such time as those funds are available, we'll continue to apply our mission of expanding health care to all by leveraging the vertical funding currently available. ■

[i] Does HIV/AIDS still require an exceptions response? 2008; 8:457.
[ii] Ibid.

Upcoming HSAN Events

In light of limited rigorous evidence available in support of or against the positive impact of GHIs on overall HSS, HSAN would like to encourage readers to submit information on potential candidate projects that might be examined more rigorously to determine impact, This will allow HSAN to compile a list of potential case studies to be taken forward later in 2008 and 2009. We welcome your thoughts at info@hsanet.com.

HSAN Voices

Do you have a topic for Ask the Expert Session that you would like featured on the website?

Email info@hsanet.com to send your suggestions.

See highlights from ATE 3 at http://www.hsanet.org/ATE3_discussion.htm

HSAN's quarterly e-newsletter provides regular overviews of current issues in health systems strengthening, and updates on ongoing and upcoming HSAN activities. To learn more about HSAN, become a member and/or join the mailing list , please go to **www.hsanet.org.**

Health Systems Action Network