Primary concern:
why primary healthcare is key to tackling HIV and AIDS
Acknowledgements

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**Acronyms**

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<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>BHU</td>
<td>Basic health unit</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organisation</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development, UK</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and health surveys – see <a href="http://www.measuredhs.com/">http://www.measuredhs.com/</a></td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria (herein referred to as “the Global Fund”)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IEO</td>
<td>Independent Evaluation Office</td>
</tr>
<tr>
<td>IHP</td>
<td>International Health Partnership</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>LGA</td>
<td>Local government area</td>
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<tr>
<td>LHW</td>
<td>Lady health workers</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NMS</td>
<td>National medical stores</td>
</tr>
<tr>
<td>OAU</td>
<td>Organisation of African Unity</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary healthcare</td>
</tr>
<tr>
<td>PLHA</td>
<td>People living with HIV and AIDS</td>
</tr>
<tr>
<td>PMCH</td>
<td>Patna Medical College Hospital</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of parent-to-child transmission</td>
</tr>
<tr>
<td>PRSP</td>
<td>Punjab Rural Support Programme</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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</table>

Please note that local currencies are also given in US$, with a rate from 23 February 2009, [http://www.bloomberg.com/invest/calculators/currency.html](http://www.bloomberg.com/invest/calculators/currency.html)
# Definitions

<table>
<thead>
<tr>
<th>Key terms</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 test</td>
<td>A CD4 test measures the number of healthy immune cells in a sample of blood. Healthcare providers measure CD4 cells to determine various actions such as: when to begin, interrupt, or halt anti-HIV therapy; when to give preventive treatment for opportunistic infections; and when to measure an individual’s response to treatment. The lower the CD4 count and the higher the viral load, the higher the risk of an individual developing an opportunistic infection.¹</td>
</tr>
<tr>
<td>Civil society</td>
<td>Civil society is composed of diverse actors and institutions such as charities, non-governmental organisations, community-based organisations and groups, women’s organisations, faith-based organisations, professional associations, self-help groups, networks of people living with HIV and AIDS, social movements, coalitions, advocacy groups etc.</td>
</tr>
<tr>
<td>Gender</td>
<td>Socially constructed characteristics, qualities and behaviours, assigned to human beings according to their sex, against which women and men are measured.²</td>
</tr>
<tr>
<td>Gender-based violence</td>
<td>Violence (physical, sexual, or psychological) that is perpetuated against a person because of that person’s gender, gender identity or performance, or the perpetrator’s understanding of gender roles and/or expectations. Gender-based violence is often, but not always, violence against women and girls. Transgendered or transsexual people, homosexual or bisexual people, and boys or men who do not conform to society’s gender expectations are often also the targets of gender-based violence.³</td>
</tr>
<tr>
<td>Health system</td>
<td>A health system consists of all organisations, people, and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, and care, and support to people in need of these services.⁴</td>
</tr>
<tr>
<td>HIV and AIDS (and related) services</td>
<td>For the purpose of this report, HIV and AIDS (and related) services will be taken to mean all services provided for HIV and AIDS prevention, treatment, care and support, as well as sexual and reproductive health and gender-based violence response services. Treatment services include the provision of anti-retroviral drugs, as well as treatment of opportunistic infections.</td>
</tr>
<tr>
<td>Opportunistic infections</td>
<td>Illnesses caused by various organisms, some of which usually do not necessarily cause disease in people with healthy immune systems. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.</td>
</tr>
<tr>
<td>Polyclinic</td>
<td>A type of health facility that provides a range of outpatient services (i.e. those that do not require an overnight stay).</td>
</tr>
<tr>
<td>Primary healthcare</td>
<td>There are two definitions depending on the structure of the health system:⁵</td>
</tr>
<tr>
<td></td>
<td>(1) In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary healthcare, as opposed to secondary healthcare or referral services.</td>
</tr>
<tr>
<td></td>
<td>(2) In systems with direct access to specialists, the distinction is usually based on</td>
</tr>
</tbody>
</table>
Primary concern: why primary healthcare is key to tackling HIV and AIDS

### Definitions

<table>
<thead>
<tr>
<th>Key terms</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary healthcare</td>
<td>Essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.</td>
</tr>
<tr>
<td>Secondary healthcare</td>
<td>Specialised ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary healthcare services. It can also include some specialist services provided in the community.</td>
</tr>
<tr>
<td>Tertiary healthcare</td>
<td>Refers to medical and related services of high complexity and usually high cost. Includes patients referred from secondary care for diagnosis and treatment, which is not available in primary and secondary care. Tertiary care is generally only available at national or international referral centres.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>A science focused on the transmission of health information in an electronic network.</td>
</tr>
<tr>
<td>Universal access</td>
<td>Universal access is the most recent and comprehensive commitment made by the international community in response to HIV and AIDS. The commitment was made in a United Nations General Assembly resolution adopted on 23 December 2005 that requested UNAIDS and its co-sponsors to assist in “facilitating inclusive, country-driven processes, including consultations with relevant stakeholders, including non-governmental organization, civil society and the private sector, within existing national AIDS strategies, for scaling up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it”.</td>
</tr>
<tr>
<td>Vertical programmes (health)</td>
<td>Vertical health programmes focus on specific health issues, in contrast with the horizontal programmes, which focus on the provision of general health services, providing prevention and care for prevailing health problems. The health system is made up of both vertical and horizontal health programmes.</td>
</tr>
<tr>
<td>Vertical transmission</td>
<td>Vertical transmission, also known as mother-to-child transmission refers to transmission of an infection, such as HIV, hepatitis B, or hepatitis C, from mother to child during the perinatal period (i.e. pregnancy, birth and during breastfeeding).</td>
</tr>
<tr>
<td>Viral load test</td>
<td>A viral load test is used to measure how much HIV is in your body. The lower the CD4 count and the higher the viral load, the higher the risk of an individual developing an opportunistic infection.</td>
</tr>
</tbody>
</table>
Executive Summary

“How can needs be met when, for 16 years, staff in [health] facilities have not gone for any refresher training, when essential drugs cannot be dispensed in the facility and patients are left at the mercy of chemists – most of which sell fake drugs? Or when pregnant women have to wait long hours to see one doctor who comes occasionally and when these pregnant women have to be assisted by untrained health workers or traditional birth attendants during delivery?”

Health worker in Rafin Zuru, Nigeria

Over a million lives could be saved and an additional three million people could remain free of HIV if country targets for universal access to HIV services were achieved by 2010. Yet, despite national and international commitments to achieve universal access to HIV prevention, treatment, care and support, many people still do not have access to the HIV services they need, especially in poor, rural areas. As a result, for every two people beginning HIV treatment, five are newly infected, and just one in five people at risk of infection has access to comprehensive HIV prevention services. With 2010 now just one year away, it is clear that the rate of progress needs to be stepped up.

Previous ActionAid research has identified inadequate primary healthcare as a significant barrier to meeting the universal access target, especially in poor, rural areas. Using community and national level research from India, Pakistan, Nigeria, Sierra Leone, Tanzania and Uganda, this report demonstrates the role that improvements to primary healthcare could play in achieving universal access to HIV services, as well as ensuring an effective, sustainable response to the long-term problem of HIV and AIDS.

The Alma-Ata declaration defined primary healthcare as “essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families... and at a cost that the community and country can afford”. But what are the essential health services that should be available at primary care facilities in relation to HIV and AIDS? The country research concluded that:

- voluntary counselling and testing (VCT), basic HIV prevention and treatment for simple opportunistic infections should be available in all primary healthcare facilities;
- the provision of other HIV services at primary healthcare level, such as anti-retroviral treatment and treatment for complicated opportunistic infections, should vary according to the needs of the community, levels of HIV prevalence and the resources available;
- primary healthcare facilities should provide clear, efficient and effective referrals to higher levels of the health system for all HIV services not available, including the provision of more complex services, such as viral load testing;
- HIV and AIDS services provided through primary healthcare should be integrated with other directly related services, including sexual and reproductive health (SRH) and gender-based violence response services.

The research showed that quality really matters. Inadequate primary healthcare creates inefficiencies within the broader health system and can result in low uptake of services, even by poor people who have limited alternatives. Improvements to primary healthcare, such as the integration of appropriate HIV and AIDS services, should be carried out because:

- primary healthcare is many poor people’s only option for healthcare within the formal health system. This applies especially to poor women and girls;
- improvements in primary healthcare will increase the community’s demand for healthcare;
- the integration of HIV and AIDS services with other related primary healthcare services, such as SRH services, will provide opportunities for cross referrals and increase the chances of people accessing all of the services they need in a convenient and affordable way;
Primary concern: why primary healthcare is key to tackling HIV and AIDS

- Investments in primary healthcare made by HIV and AIDS programmes, such as improvements to infrastructure, will also benefit other types of health services.

While the focus of this report is on the role that improved primary healthcare provision could play in meeting the target of universal access to HIV services, ActionAid recognises that meeting the broader rights and health needs of all, particularly the poor, requires a functional public health system, with a focus on comprehensive primary healthcare. However, many people, including those most vulnerable to HIV infection, such as sex workers, currently choose to opt out of the public health system. Furthermore, delaying HIV programmes until stronger health systems are in place will lead to high numbers of AIDS-related deaths. For these reasons, ActionAid believes that in the short and medium term, there remains a need for vertical HIV programmes, as well as for the private sector and NGOs to play a role in the delivery of HIV programmes. Nonetheless, the long-term goal should be to provide HIV services through the public sector health system, which should be designed to be accountable, sustainable, and efficient, making use of economies of scale and scope.

The research highlights that there are two key problems resulting in an inadequate provision of primary healthcare across the countries included in the study. First, there is not enough investment in primary healthcare and second, available finance is not being spent as effectively as possible. Improvements are needed in the areas of (a) funding, (b) policy design and implementation, (c) service design and (d) service delivery.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

(a) More and better, sustainable funding

“I tell you, the programmes end with them [the donors]. The activities need a budget. You cannot start if there is no budget.”

A health worker in Uganda highlighting the problems of sustainability

Adequate funding is essential to develop and sustain a health system that provides comprehensive and high-quality services. Lack of funding was identified as a key factor limiting the ability of the public sector to provide high-quality healthcare in all of the countries included in the research. In Uganda, for example, 74% of funds required for basic equipment and infrastructure maintenance, and 59.5% of funds required for primary healthcare drugs, were not made available in 2007-08.18 To close the financing gaps, it is essential to increase available funding from the two main sources of finance for primary healthcare in low and middle-income countries, namely national funding from the government budget and international funding from donors, including funding for HIV programmes. Furthermore, the research from India, Nigeria and Tanzania highlighted the need for improved accountability and transparency at all levels in the health system in order to tackle inefficiencies and corruption.

In the broader context of the limited availability of resources and the current financial crisis, available resources must also be spent cost-effectively. The 2008 World Health Report highlighted that “in countries where the envelope for health is very small, every dollar that is allocated sub-optimally seems to make a disproportionate difference”.19 Improvements in the efficient use of health resources are needed in three key areas: policy design and implementation, service design and service delivery.

(b) Policy design and implementation

“HIV/AIDS services have been widely scaled up during the past two years, and this has been mainly due to the integration of services within primary healthcare.”

Dr Momodu Sesay, National HIV/AIDS Coordinator in Sierra Leone

The main policy shortcomings identified in the country research can be translated into three areas for action. First, good policy must be developed, following meaningful consultation with representative community groups, and shared with all relevant people and organisations. Second, HIV and AIDS policy should be integrated with broader health policies, particularly those relating to health service delivery. Finally, given that policy is only useful if put into practice, policy implementation should be prioritised and supported by necessary staff capacity and resources.
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(c) Service design

“People from far-away communities have to charter a bike to come here and the bike has to wait for them and take them back to their village, which will cost them N300 (US$2) each way. To avoid this high cost and the possibility of not meeting a trained health worker, they would rather go to the central hospital in Benin City which only costs N100 (US$0.70) and they are sure of meeting a doctor.”

A female focus group participant in Nigeria

Once effective policies are in place, the next stage in providing healthcare is designing appropriate services; however, the country research highlighted shortcomings in a number of key areas. Although service design varied both within and across countries, with urban areas performing significantly better than rural areas, the research findings are that primary healthcare services are usually not comprehensive and integrated, gender sensitive, affordable and conveniently located. Furthermore, referral mechanisms to higher levels of the health system are often ineffective and there is a lack of effective monitoring and evaluation. It is clear from the research that the poor service design contributes significantly to the provision of low-quality services and a resulting low demand for services, even when few alternatives exist.

d) Service delivery

“The major problem that we face every day is the acute shortage of staff. We have to keep spreading ourselves thin to deal with the patients in accordance to their diverse needs. Because of the shortage of staff, a patient who comes in at 8am may even leave after 2 o’clock.”

A health worker in Uganda

After developing effective policy and designing appropriate services, the final step in the delivery of high-quality primary healthcare is the provision of efficient services within the community. However, the country research identified that the primary healthcare services provided are often of a low quality, partly due to the ineffective service design and partly due to the weak health systems. The latter created three key problems, which greatly impacted upon the delivery of services, namely: the shortage of skilled health workers; inadequate infrastructure and equipment; and inefficient supply chain management. Without significant improvements in each of these key areas, alongside meaningful community participation, primary healthcare services will not be able to provide services that communities will want to use, let alone deliver on universal access to HIV services.
Summary of recommendations

ActionAid recommends that:

- primary healthcare should be recognised as key to meeting the target of universal access to HIV and AIDS services, and prioritised by aid donors and national governments.

Investment

- Investments made by governments in primary healthcare should be increased and improved.
- Investments made by aid donors in primary healthcare should be increased and improved, through long-term, predictable, coordinated funding to help strengthen health systems, which work within international principles to ensure aid effectiveness.

Policy

- Health policies should be evidence-based, developed after meaningful consultation with community groups and women in particular, integrated with HIV policy, and supported by the necessary staff capacity and resources to implement the policies effectively.

Service design and delivery

- Primary healthcare services should be high quality, comprehensive, integrated, gender sensitive, affordable and provided close to the community.
- The design of primary healthcare services should allow for effective monitoring and evaluation, as well as meaningful community participation in the design, management and monitoring of the services.
- The delivery of primary healthcare services should be supported by sufficient skilled female and male health workers, adequate infrastructure and equipment and effective supply chain management.
- Health workers should be trained in gender issues, and in stigma and discrimination issues.
1 Introduction

Many poor people living with HIV still don’t get the services they need. Health systems in poor countries are frequently under-funded, under-staffed and lack the drugs and equipment required to treat people effectively, particularly at the primary healthcare level in rural areas. Previous ActionAid research identified inadequate primary healthcare as a significant barrier to meeting the target of universal access to HIV prevention, treatment, care and support, especially in poor, rural areas. Although the need to strengthen health systems has been gaining increased attention from donors, civil society and multilateral organisations, limited emphasis is placed upon the importance of primary healthcare in meeting the universal access target.

The objective of this report is to demonstrate the importance of primary healthcare in meeting the universal access target by bringing both communities’ priorities and the barriers they face in accessing comprehensive, local healthcare to the international debate around health system strengthening. In addition, the report will be used at national and community levels as a tool to advocate for improvement to HIV and AIDS services, as well as primary healthcare in general.

1.1 Structure of the report

The report is structured into six parts, with recommendations for action highlighted at the end of each section. Section 2 begins by presenting the case for the importance of primary healthcare in achieving universal access to HIV and AIDS (and related) services. Drawing on our country research, the report goes on to consider ways in which primary healthcare should be improved to increase access to healthcare services, especially by poor and excluded people. Section 3 presents the case for improved financing, not only in terms of available resources, but also in terms of improved accountability and the timely release of committed funds. In contrast, sections 4, 5 and 6 focus on the best use of the available resources and consider policy, service design and service delivery. Conclusions and a full set of recommendations can be found at the end of this report.

1.2 How the research was done

This report draws together desk-based research on the international context, with country-specific research commissioned by ActionAid country programmes in India, Nigeria, Pakistan, Sierra Leone, Tanzania and Uganda. The country-specific research took place between October and November 2008, and included both national and local-level research. At the national level, the research was based upon interviews with key government officials, donor agency staff and national NGOs, as well as desk-based research. At the local level, a range of research methods were utilised including: focus group discussions with community members, particularly women and people living with HIV and AIDS, along with those who are particularly vulnerable to infection; visits to healthcare facilities; interviews with facility users and non-users, health workers, local government staff and NGO staff. The local level research sites were selected to provide a representation of different parts of the country and reflect the reality in both urban and rural settings. Further details of the research sites included can be found in the appendix.

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Table 1: HIV and AIDS indicators for the countries participating in the research

<table>
<thead>
<tr>
<th>Indicators</th>
<th>India</th>
<th>Nigeria</th>
<th>Pakistan</th>
<th>Sierra Leone</th>
<th>Tanzania</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV and AIDS</td>
<td>2,400,000</td>
<td>2,600,000</td>
<td>96,000</td>
<td>55,000</td>
<td>1,400,000</td>
<td>940,000</td>
</tr>
<tr>
<td>Adult HIV prevalence rate</td>
<td>0.3%</td>
<td>3.1%</td>
<td>0.10%</td>
<td>1.7%</td>
<td>6.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Women as a percentage of those living with HIV and AIDS</td>
<td>38%</td>
<td>58%</td>
<td>29%</td>
<td>59%</td>
<td>58%</td>
<td>59%</td>
</tr>
<tr>
<td>ARV coverage rate</td>
<td>38%</td>
<td>26%</td>
<td>3%</td>
<td>20%</td>
<td>31%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: 2007 Data from www.globalhealthfacts.org
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A focus group discussion with women in the village of Makrandpur, Bihar, India.

PHOTO: SIDHARTH JAIN/ONASIA/ACTIONAID
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A rights-based approach to health and HIV and AIDS

Human rights refer to the basic rights and freedoms to which all humans are entitled. These rights are inherent in all people from birth, and cannot be voluntarily given up or taken away. However, while these rights are enshrined in the Universal Declaration of Human Rights and subsequent international covenants and declarations, they are not always promoted, protected or fulfilled and they are often abused.

ActionAid has a commitment to human rights and a rights-based approach to its work. We believe that it is through a rights-based approach to international development that the poor can challenge those in power and hold them to account, whether at the community, national or international level, to ensure their rights are realised. The rights-based approach identifies rights-holders (and their entitlements) and corresponding duty bearers (and their obligations). The primary duty bearer is the state, which is responsible to rights-holders, its citizens, who can claim their rights and entitlements. In an increasingly globalised world, donor governments and international institutions can also be duty bearers. Internationally agreed human rights instruments should provide the basis for the chain of accountability that flows from donors and international institutions to the citizens of all countries.

1.3 A rights-based approach to health

Health is defined by the World Health Organization (WHO) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”24 The WHO constitution states that: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” Every country in the world is now party to at least one human rights treaty that addresses health-related rights.25 ActionAid believes that the provision of primary health care is an essential pillar for realising the right to health, especially for poor and marginalised people who are often excluded from accessing other levels of healthcare.

A rights-based approach to HIV and AIDS

The violation of basic human rights including the rights to health, privacy, education, information and freedom from violence fuels the spread of HIV. Furthermore, people living with HIV and AIDS are often more vulnerable to rights abuses, such as social exclusion, discrimination and violence.26 These intrinsic links between HIV and human rights were formally recognised by world leaders in 2001 at the United Nations General Assembly Special Session (UNGASS) dedicated to HIV and AIDS, when they stated that: “The global epidemic is a global emergency and one of the most formidable challenges to life and dignity, to the enjoyment of human rights, and to economic development” and committed to dedicate national budgets to realise the human rights of those living with and affected by HIV and AIDS.

ActionAid’s work on HIV and AIDS takes a rights-based approach. Importantly, such an approach recognises that the failure to promote, protect and fulfil women’s and girls’ rights and abuses of their rights sustain the global HIV epidemic and undermine attempts to respond to it, thereby building upon previous government commitments to protect the rights of women, including The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979.
Women's rights and health

The WHO highlights the links between women's rights and health, stating that: “Human rights provide a framework within which to respond to gender-based discrimination and other social determinants that have a significant impact on women’s health. In many cases, women's ill-health is the direct result of violation of the principle of non-discrimination based on sex and of many other fundamental human rights, such as the right to education and information, the right to participate in decision-making, equality in employment and the right to the highest attainable standard of health.”

The Cairo Declaration of the 1994 International Conference on Population and Development recommended that all countries should make primary health care universally available, reduce health disparities and promote the equal participation and equitable representation of women and men at all levels of economic, political and cultural life. Furthermore, it was the first international conference document to explicitly affirm reproductive and sexual rights. Its Programme of Action noted for the first time that reproductive rights are included in existing human rights principles and recommended that reproductive healthcare be made accessible through the primary healthcare system.

Building on the CEDAW and the Cairo Declaration, the 1995 Beijing Platform for Action had the empowerment of women as its primary objective. While it endorsed women’s right to the highest attainable standard of physical and mental health, it also recognised that in practice women and girls often experience “inequalities and inadequacies in and unequal access to health care and related services” and identified this as one of its critical areas of concern. And, it recognised that the deterioration of public health systems, alongside increased privatisation, has reduced the availability of affordable healthcare. This has not only limited women’s access to healthcare, but has also increased the care-giving burden placed upon them by the family and community. Significantly the Beijing Platform for Action recommended that governments and other actors implement a policy of gender mainstreaming across all policies and programmes, to ensure that an analysis of the effects for both women and men inform decision making.
2 Somewhere to turn – why PHC is important for universal access to HIV and AIDS services

“A primary healthcare approach is the most efficient, fair, and cost-effective way to organize a health system. It can prevent much of the disease burden, and it can also prevent people with minor complaints from flooding the emergency wards of hospitals. Decades of experience tell us that primary healthcare produces better outcomes, at lower costs, and with higher user satisfaction.”

Dr Margaret Chan, Director-General of the World Health Organization

Developed countries take primary healthcare for granted. Yet in developing countries, where health problems are so much greater and where HIV is often prevalent, even this basic level of healthcare is far from universal. And where it does exist, it may be of such poor quality that people can’t or won’t use it. This situation must change if we are to provide everyone with the required HIV and AIDS (and related) services.

2.1 The goal of universal access to HIV and AIDS services

Despite substantial evidence about how to prevent and treat HIV infection, the AIDS pandemic continues to have a devastating impact on global health. In a quarter of a century, HIV has spread relentlessly from a few scattered locations to almost every country in the world. In 2007, 2.5 million people were newly infected with HIV and 5,700 people died every day from an AIDS-related illness. Today, more than 33 million people are HIV-positive, including more than 15 million women. In sub-Saharan Africa, where the impact of the AIDS pandemic is most strongly felt, women account for 61% of those living with HIV.

A number of bold targets set by governments have sought to galvanise the global response to this growing pandemic. In 2000, the Millennium Development Goals committed governments to halt and reverse the spread of HIV and AIDS by 2015. In 2001, UN member states unanimously adopted a series of time-bound targets in the Declaration of Commitment on HIV/AIDS. More recently, in 2006, governments committed to achieve universal access to HIV prevention, treatment, care and support by 2010. Achieving the country-defined targets for universal access to HIV prevention, treatment, care and support by 2010 could save 1.3 million people’s lives and prevent 2.6 million people from becoming infected with HIV between now and 2010.

As we approach the 2010 deadline, some significant progress has been made. For example, the number of AIDS-related deaths has fallen substantially as access to antiretroviral treatment (ART) has increased. In addition, 34% of HIV-positive, pregnant women received ART to prevent mother-to-child transmission in 2007, almost double the percentage in 2005, and awareness on the part of policy makers of the women’s rights aspects of HIV and AIDS is increasing.

Nonetheless, despite this progress, access to essential HIV services continues to fall woefully short of what is actually needed, leaving an estimated 6.7 million people still unable to access life-saving drugs, for example. Furthermore, UNAIDS estimates that for every two people put on treatment, five more are newly infected and currently just one in five people at risk of infection can access comprehensive HIV prevention services. Moreover, the ‘war chest’ of the AIDS response, the Global Fund for AIDS, TB and Malaria, has faced chronic under-funding and currently faces a shortfall of almost US$5 billion. With 2010 now just one year away, it is clear that the rate of progress needs to be stepped up. ActionAid believes that the provision of comprehensive primary healthcare, alongside the integration of HIV programmes, could play a key role in achieving universal access to HIV services, as well as ensuring that the broader health needs of all, particularly poor people, are met.

At present, the impact of the global financial crisis on the AIDS response remains to be seen, but there are concerns about its impact on the funding available for HIV and AIDS. If funding were to diminish, the sustainability of existing AIDS programmes would be at risk, new programmes may not be introduced and the long-term funding required to strengthen health systems would not be made available.
2.2 Primary healthcare and the goal of ‘health for all’

In 1978, at the Alma-Ata conference, representatives from more than 130 countries, 60 international organisations and representatives of civil society committed to achieve ‘health for all’. In doing so, they emphasised the importance of primary healthcare to achieving this goal. The Alma-Ata declaration defined primary healthcare as “essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families … and at a cost that the community and country can afford”. It also identified primary healthcare as the first level of contact individuals, families and members of the community have with the national health system. As a result, primary healthcare should be brought as close as possible to where people live and work, and address the main health problems of the community.

Key features of primary healthcare

- Well-trained, multidisciplinary workforce
- Properly equipped and maintained premises
- Appropriate technology, including essential drugs
- Capacity to address all aspects of prevailing health problems at community level
- Comprehensive integration with other health services and effective referral systems
- Institutionalised systems of quality assurance
- Sound management and governance systems
- Sustainable funding streams aimed at universal coverage
- Functional information management and technology
- Community participation in the planning and evaluation of services provided
- Collaboration across different sectors (e.g. education and agriculture)
- Continuity of care
- Affordable healthcare

Source: Adapted from Stephen Gillam, Is the declaration of Alma-Ata still relevant to primary healthcare?
Although Alma-Ata highlighted the importance of comprehensive primary healthcare, a number of initiatives were subsequently developed with a focus on selective healthcare, as they were considered to be “more feasible, measurable, rapid and less risky”. The 1980s and 1990s were characterised by Structural Adjustment Programmes that restricted social spending, and polarised debates about the merits of comprehensive versus selective healthcare. These debates came to a head recently in relation to HIV interventions, which have often been set up in parallel with existing structures and in the worst cases have drained resources away from the wider health system. However, more recently there has been a move towards combining the strengths of both approaches, including the use of selective interventions to strengthen health systems over time.

Thirty years on from Alma-Ata, the current international environment is favourable to a renewal of primary health and the 2008 World Health Report noted that values of “equity, people-centredness, community participation and self-determination... have become widely shared social expectations for health that increasingly pervade many of the world’s societies”. Alongside the social expectations, evidence also suggests a focus on primary healthcare is more likely to deliver better health outcomes and greater public satisfaction at lower costs. It is also thought that effective primary healthcare can deal with the majority of health demands, significantly reducing the burden on district hospitals and instantly making many healthcare services more accessible. For those health demands not met at primary care level, effective primary healthcare provides a pivotal link between communities and hospital care or specialist services. It essentially acts as ‘gatekeeper’ to the health system, ensuring a coordinated health response tailored to patients’ needs, subsequently monitoring their care and preventing inefficient use of valuable resources.

Cuba: A revolutionary approach

Over the past 40 years, Cuba has invested heavily in community based primary healthcare services. With modest GDP per capita of US$12,700 and per capita expenditure on health of US$333, Cuba is achieving health indicators that rival the USA, with a significantly higher per capita health expenditure of US$6,350. For example, Cuba’s life expectancy is 77, only one year less than the USA, and its infant mortality rate is 5.93 per 1000 compared to 6.30 in the USA.

Cuba’s focus on primary healthcare was established before the Alma-Ata declaration and the national health programme now addresses the needs of over 95% of the population. Primary healthcare is delivered through polyclinics serving specific geographical areas and populations of up to 30,000. Recent innovations within the polyclinics include providing new services previously only available in hospitals such as x-ray, ultrasound and family planning. The polyclinics avoid a uniform approach and adapt their services; this involves capacity building and quality control for programmes addressing the specific needs of their community.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

2.3 Harnessing primary healthcare to deliver HIV and AIDS services

Achieving universal access to HIV prevention, treatment, care and support hinges upon meeting the health needs of the poorest and most vulnerable members of society. The country research findings and previous ActionAid research highlight that primary healthcare is often the only option available to the poor and excluded, particularly women who frequently cannot afford private healthcare or the transportation and loss of earnings incurred by visiting secondary or tertiary healthcare facilities. If these people are going to get any healthcare at all, it is going to be at the primary level.

Even for those who are able to access secondary and tertiary facilities, primary healthcare is an essential entry point. According to the Alma-Ata Declaration, primary healthcare is “the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work”.

With these factors in mind, ActionAid believes that if more high-quality HIV services were provided at primary care level, by well-trained and sensitised health workers, the number of people accessing those services would increase. Moreover, the integration of HIV and AIDS, sexual and reproductive health (SRH) and gender-based violence (GBV) response services into the primary healthcare system would increase opportunities for the provision of HIV prevention services, as well as providing a more comprehensive, efficient and gender-responsive health service.

For people living with HIV and AIDS, primary healthcare can provide treatment, care and support, close to their homes, or, when the required services are unavailable, can provide the patient with a referral to another healthcare facility. In addition, the provision of comprehensive and integrated services ensures that important diseases or infections often linked to HIV, such as TB, can be easily diagnosed and treated, and that other services, such as family planning, can be tailored to the needs of people living with HIV and AIDS.

Importantly, primary healthcare can also provide vital HIV and AIDS (and related) services for those who may be at risk of infection, both in terms of prevention services and in the provision of voluntary counselling and testing. Ensuring these interventions are available at primary care level would both improve the chances of people remaining HIV negative, and would increase the likelihood of early diagnosis, thereby allowing rapid interventions for treatment as well as counselling to support positive people to use prevention methods to enjoy safe sex and mitigate re-infection and transmission.

Finally, the required improvements to primary healthcare facilities and services necessary to provide HIV and AIDS services can have a beneficial impact on primary healthcare in general.

Improving AIDS prevention and treatment reinvigorated primary healthcare in Dominican Republic

Partners in Health began providing integrated AIDS prevention and treatment at a public health centre in the Dominican Republic in 2002. The records in the following 14 months show greater demand for services, with numbers of patient attendances, prenatal care visits and vaccine administration all increasing. In addition, an evaluation of the project highlighted that “other collateral benefits, though less readily measured, include improved staff morale and enhanced confidence in public health and medicine. We conclude that improving AIDS prevention and treatment can help to reinvigorate flagging efforts to promote universal primary healthcare.”
2.4 How is poor primary healthcare preventing universal access to HIV and AIDS services?

While primary healthcare is the best way to increase access to HIV services for the poor and excluded, this will only work if the services are good enough.

The ActionAid research found that some form of primary healthcare already exists in each country. In all of the countries studied, primary healthcare networks, infrastructure and workers are in place, but are frequently under-resourced. As a consequence, primary healthcare facilities are often inadequate, and thus impede access to HIV and AIDS (and related) services in a number of ways. Firstly, poorly resourced facilities that lack trained staff and equipment will often be unable to offer comprehensive HIV services, which can prevent people, particularly the poor, from accessing vital health services. Furthermore, people seeking alternative healthcare might choose to use ‘quacks’ (unqualified doctors) or private chemists, or they might choose traditional healers, whose remedies may or may not be effective. Moreover, where facilities are perceived to be of poor quality, uptake is likely to be low, meaning that there are fewer opportunities to promote HIV counselling and testing and to build basic HIV awareness. This can mean that stigma around HIV persists and, coupled with poor availability of drugs after diagnosis, this can deter people from testing. As identified in the Sierra Leone report, “if health facilities are equipped with quality equipment, supplies, drugs and staff, more people will visit these facilities, and in turn the proportion with access to HIV and AIDS related services will increase.”

The country research also highlighted that inadequate primary healthcare provision can create inefficiencies within the broader health system. For example, in Nigeria, there were reports of pregnant women registering for maternal care twice in different rural primary health centres to increase their chances of accessing all of the services that they needed. Furthermore, poor primary healthcare can also force people to go straight to secondary or tertiary facilities for quality care, thereby overwhelming the specialist facilities with patients whose problems could have been treated at primary facilities. For example, in the Oron Local Government Area in Nigeria, people choose to go directly to the general hospital and not to the primary healthcare facilities in the area. This is explained by the limited service provision (such as the lack of HIV and AIDS services), the poor availability of health workers and the inconvenient location of the primary healthcare facilities, which makes them expensive to reach. Due to the increasing number of patients, the hospital has now had to assign visiting days for each community, thereby restricting the access to services. In addition, the limited facilities and staff have been overwhelmed. In the words of a laboratory attendant at the general hospital: “I am waiting for the year to end. I will work out my transfer from this place; the workload is unbearable, besides [no-one] compensates me for the extra work I do.”

The poor provision of primary healthcare prevents the efficient use of limited resources. From a pragmatic point of view, in the long term it is clearly more efficient to top-up spending and utilise the existing infrastructure and health workers rather than start again. Investments made within a single organisation can enjoy economies of scale and scope. Economies of scale occur when the costs of service provision decrease as the quantity of services provided increases. For instance, greater buying power can lower the costs of essential equipment or drugs. Economies of scope, in contrast, arise when it is cheaper to provide a range of services together than individually. For example, it is cheaper to provide a range of services at one health centre than to use multiple health centres, due to the shared use of infrastructure, trained health workers or the supply chain management system. Yet what is also clear is that in each country, the opportunities presented by the primary healthcare system’s ability to make use of economies of scale and scope in stepping up access to HIV and AIDS services have been missed.
Pakistan’s Lady Health Worker programme could be extended to provide HIV and AIDS information

Pakistan’s 100,000 Lady Health Workers (LHWs) have an outreach of more than 20 million households across the country, and act as a vital link between the community and primary healthcare facilities. The LHWs are recruited from the local community and receive 15 months of training (3 months full-time and 12 months in-service training). Once trained, LHWs provide health information, treatment for minor ailments and encourage referrals to health facilities when appropriate. The LHW programme strengths have been described as the income generated for the women involved, the high levels of acceptability within the community and the increased access to healthcare and information, especially for women, who for cultural reasons may find it difficult to travel to a health centre. However, even though family planning makes up a significant portion of their work, LHWs do not currently receive any training on HIV and AIDS, STI management or gender-based violence screening and response. It is clear that an opportunity to extend the LHWs’ training to include these modules exists and that such a development could have a considerable impact across the whole of Pakistan, thanks to the already significant outreach of the LHWs.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

2.5 How should primary healthcare be improved and which HIV and AIDS services should be included?

Given the current poor state of primary healthcare in many countries, there are legitimate concerns that shifting HIV services from other levels of the healthcare system would overburden the primary healthcare system. Therefore in order to deliver HIV services at primary care level, significant improvements to the primary healthcare system are needed.

Primary healthcare should be improved by increasing both the supply and the demand for services. In order to increase the supply of primary healthcare, additional resources are required, as well as improvements in the use of the available resources. Such improvements would also contribute to progress in tackling other health conditions, and to realising the right to health more broadly. The demand side issues are more complicated and will take time to overcome. Partly the demand for services is linked to the quality of the supply, and as quality improves, the demand for services should increase. However, previous ActionAid research highlighted additional, more complicated factors, such as social and cultural issues, and stigma and discrimination.

But what are the essential health services that should be available at primary care facilities in relation to HIV and AIDS? The findings from all of the research countries concluded that voluntary counselling and testing and basic HIV prevention should be available in all primary healthcare facilities. In some cases, the research concluded that it would also be appropriate to provide ART, PEP and PMTCT services at primary healthcare level, although associated services such as CD4 and viral load testing, as well as management of severe side effects and treatment failure, may be delivered at higher levels of the health system. Furthermore, these services should be integrated with other key services and facilities, for example SRH and GBV response services. Which services are provided will depend on the needs of patients and of the community, levels of HIV prevalence, as well as on the resources available.

The World Health Organization does not currently provide policy guidelines on this issue, although information is provided regarding the roles and responsibilities of clinical teams at primary healthcare level in resource-limited settings. The International HIV/AIDS Alliance’s guidelines on essential HIV treatment in resource-constrained settings highlights that the majority of prevention, treatment, care and support activities can be carried out at the primary healthcare level, alongside support from secondary healthcare services. Comprehensive HIV services include elements of both clinical management and community care and support.

Clinical management
- initial assessment
- prophylaxis and management of opportunistic infections
- antiretroviral therapy (ART)
- palliative care and symptom control

Community care and support
- HIV counselling and support
- adherence support
- nutritional and daily living support
- positive prevention

Although primary healthcare is key in providing HIV services, it is important to recognise that it is only one part of a broader health system. In order to meet the health needs of the community, all parts of the health system need to be functional. For instance, effective primary healthcare requires a working referral system to higher levels of the health system and adequate numbers of skilled health workers. Finally, primary healthcare provision is also linked to broader infrastructure requirements, such as a road or public transport network, as these will determine the accessibility of a particular healthcare facility to the community it serves.

Finally, it is important to emphasise that a functioning health system, with a particular focus on primary healthcare, is a long-term goal that will enable a more strategic response to the HIV epidemic in the future, especially given its ability to increase access to HIV prevention services. However, progress must also be made in the short or medium term and flexible solutions are needed to deliver such progress. Dr Peter Piot, the previous UNAIDS Executive Director, highlights the risks of waiting for long term change: “One of the main lessons of providing antiretroviral therapy to millions of people is that we should not wait
Primary concern: why primary healthcare is key to tackling HIV and AIDS

Until systems are fixed before acting, because I know what would have happened to the three million people on ART today if we had waited: most would be dead by now. The funding available for HIV and AIDS programmes should not all be committed to long-term programmes to develop robust health systems, at the expense of other programmes. Instead a broad array of programmes should be designed and implemented, with varying time horizons, to ensure that prevention efforts are continued and that people living with HIV and AIDS receive the best possible care in both the short and the long term.

**Improvements made to primary healthcare to achieve universal access to HIV and AIDS services will have a broader impact on the health of the community**

One important argument for investing in the provision of HIV and AIDS (and related) services through the existing health system is that improvements made for HIV and AIDS or other diseases can have benefits across other interventions. In this way, resources can be efficiently utilised and improvements in healthcare generally will assist with meeting a broader array of health targets, such as the health-related Millennium Development Goals (MDGs). 67

For example, in Sierra Leone, better primary healthcare could have a significant impact on maternal mortality, thereby meeting the aims of MDG5. Sierra Leone has one of the worst maternal mortality ratios at 2,100 per 100,000 live births in 2005. According to preliminary results of the recently completed DHS (2008), more than 85% of pregnant women attend ANC services at least once, but only 42% actually deliver in a health facility. Primary healthcare is inadequate as there are too few health facilities equipped and staffed to provide emergency obstetric care. There is no functional referral system in many districts, leading to delays in the provision of comprehensive emergency obstetric care. Furthermore, HIV-positive women are at 1.5 to 2 times at greater risk of maternal mortality than HIV-negative women. Improvements in primary healthcare could bring down maternal mortality rates by increasing the provision of obstetric care, alongside greater access to HIV and AIDS services.
2.6 Recommendations

- Governments, donors, and international organisations should recognise that investment in primary healthcare is key to meeting the target of universal access to HIV and AIDS services.

- Governments, donors, and international organisations should prioritise primary healthcare in health system strengthening initiatives.

- The World Health Organization (WHO) should continue to champion primary healthcare in the international arena and should persuade donor governments and developing countries to put a greater emphasis on PHC in their health and HIV strategies.

- The WHO should develop guidelines for what HIV and AIDS, SRH and GBV response services should be available at primary care level.

- Civil society should work with communities to put pressure on governments to promote and respect the health commitments they have made.
In order to improve primary healthcare to increase universal access to HIV and AIDS services, the country research identified that more funds should be allocated to the health sector, budget processes should be improved and accountability should be strengthened.

The availability of adequate funding is an essential prerequisite to an effective, efficient and sustainable health system, which will allow for the provision of comprehensive, high-quality services across the country. However, a lack of financial resources was identified as a key factor limiting the ability of the public sector to provide high-quality healthcare in all of the countries included in the research. The health expenditure per person in Tanzania, for example, was over 150 times less than the equivalent spending in the USA in 2005.

<table>
<thead>
<tr>
<th>Country</th>
<th>Health expenditure per capita (government and private) in 2005 (PPP int.$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>$40</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>$41</td>
</tr>
<tr>
<td>Nigeria</td>
<td>$45</td>
</tr>
<tr>
<td>Pakistan</td>
<td>$49</td>
</tr>
<tr>
<td>India</td>
<td>$100</td>
</tr>
<tr>
<td>Uganda</td>
<td>$130</td>
</tr>
<tr>
<td>Cuba</td>
<td>$333</td>
</tr>
<tr>
<td>UK</td>
<td>$2,597</td>
</tr>
<tr>
<td>USA</td>
<td>$6,350</td>
</tr>
</tbody>
</table>

This underfunding has created major financing gaps in the health sector. To raise the funds necessary to address these gaps will require significant funding increases, from governments, as well as from international donors.

**Uganda’s funding gaps in healthcare**

In Uganda, the funding gaps are significant: 85% of funds required for effective health promotion and education, 74% of funds required for basic equipment and maintenance, and 59.6% of funds required for primary healthcare drugs were not made available in 2007-08.

<table>
<thead>
<tr>
<th>Funds required (UGX)</th>
<th>Funds available (UGX)</th>
<th>Funding gap (UGX)</th>
<th>Funding gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary healthcare drugs</td>
<td>278.9bn</td>
<td>113bn</td>
<td>165.9bn</td>
</tr>
<tr>
<td>Basic equipment &amp; infrastructure maintenance</td>
<td>33.07bn</td>
<td>8.6bn</td>
<td>24.47bn</td>
</tr>
<tr>
<td>Health promotion and education for PHC</td>
<td>16bn</td>
<td>2.4bn</td>
<td>13.6bn</td>
</tr>
</tbody>
</table>

Unsurprisingly, these funding gaps have a significant impact on service delivery and the Uganda country report documented numerous reports of drug stock-outs, inadequate equipment, and a limited focus on health promotion and education activities. The Uganda report argues that such severe underfunding will undermine the country’s target of achieving universal access to basic healthcare services by 2015.
3.1 Increasing the national government funding for health

Government funding for health is essential to ensure that the public health sector is functional. Adequate funding also serves to demonstrate the government’s commitment to the health sector. However, all of the countries in the study highlighted a lack of government funds as a key limiting factor in the provision of quality healthcare. For example, the India country report identified the low government investments in health as one of the main constraints faced by the public health sector, resulting in insufficient operating funds, weak health management and inadequate staff incentives.72

Evidently the low amounts of government funding for health available in the countries included in the study is linked to their overall low levels of wealth.

<table>
<thead>
<tr>
<th>Country</th>
<th>Government expenditure on health per capita in 2005 (PPP int. $)73</th>
<th>GDP per capita in $ (2007 estimates)74</th>
<th>Infant mortality rate (2008), per 1,000 live births75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>9</td>
<td>2,400</td>
<td>66.94</td>
</tr>
<tr>
<td>Nigeria</td>
<td>14</td>
<td>2,100</td>
<td>95.74</td>
</tr>
<tr>
<td>India</td>
<td>19</td>
<td>2,600</td>
<td>32.31</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>21</td>
<td>600</td>
<td>156.48</td>
</tr>
<tr>
<td>Tanzania</td>
<td>23</td>
<td>1,300</td>
<td>70.46</td>
</tr>
<tr>
<td>Uganda</td>
<td>37</td>
<td>1,000</td>
<td>65.99</td>
</tr>
<tr>
<td>Cuba</td>
<td>302</td>
<td>11,000</td>
<td>5.93</td>
</tr>
<tr>
<td>UK</td>
<td>2,261</td>
<td>35,000</td>
<td>4.93</td>
</tr>
<tr>
<td>USA</td>
<td>2,862</td>
<td>45,800</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Please note that international dollars account for the purchasing power of different national currencies.

How much national governments can spend on health also depends on how much tax they collect.

Developing countries have much lower tax revenue levels than developed countries; their average overall tax revenue is only 20% of GDP, compared to around 35% in developing countries.76 For example, in Uganda tax revenue represents only 10.7% of GDP, while in Pakistan it is only a little higher at 12.8% of GDP.77 A smaller tax base, limited administrative capacity, along with generous tax breaks for foreign companies and losses through tax evasion and
avoidance all contribute to lower tax revenue in developing countries. This has important implications for how much governments can spend on recurrent costs such as additional health workers. Donors and governments alike are reluctant to use aid money to fund doctors’ and nurses’ salaries because aid is unpredictable over the medium-term. Therefore, to hire additional health workers, developing countries are forced to rely more heavily on tax revenue than on aid, and consequently, raising additional revenue has to become a priority if developing countries are to build sustainable primary healthcare systems.

In 2001, the heads of state and government of the Organisation of African Unity (OAU) met in Abuja, Nigeria, and committed to allocating at least 15% of their annual budget to the improvement of the health sector. However, as can be seen in the table below, the African governments included in the study are not meeting this target, although progress varies significantly.

<table>
<thead>
<tr>
<th>Country</th>
<th>Government health expenditure as a percentage of total government expenditure (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>3.50%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>7.80%</td>
</tr>
<tr>
<td>Uganda</td>
<td>10.00%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>12.60%</td>
</tr>
</tbody>
</table>

The two Asian countries included in the research have even lower proportions of government expenditure allocated to health, namely 3.5% in India and only 1.5% in Pakistan. These low proportions of government spending are much below developed countries, such as the UK (16.2%) and the USA (21.8%).

Although the percentage of government spending committed to health provides some level of indication of the political commitment to the health sector, it can be misleading to consider percentages, because a high percentage of a low budget may still not provide enough resources to adequately fund the health system. Governments can increase their budgets by making improvements to the tax system, as well as preventing tax evasion.
Poor investment in the public sector healthcare in India has resulted in a two-tier health system

The proportion of private sector health spending in India ranks among the highest in the world. Since the mid-1980s, following structural adjustment reforms, the public sector’s role has been confined to preventive care while the bulk of the curative services are provided by the private sector. The private health sector accounts for over 70% of all treatment sought and over 50% of all hospital care. The effect of the expansions to the private healthcare sector is that those who can afford expensive services from the private sector tend to opt out of public healthcare. This has led to the emergence of a two-tier healthcare system in India, in which the poor receive lower quality health services through the under-staffed and under-funded public health facilities, while those that can afford it receive expensive, high-quality healthcare from private providers. Due to inadequate public healthcare provision, the poor also use private providers, often getting into debt in order to find the money needed to access them, as evidenced by Vikash Kumar’s story in section 5.
3.2 Increasing and improving development assistance for health

3.2.1 Increasing donors’ funding for health

Developing countries account for 84% of the global population and 90% of the global disease burden, but only 12% of global health spending. Given these disparities in financing, development assistance for health is required to support health systems in poor countries. Official Development Assistance (ODA) for health has seen considerable increases in recent years, in line with increased donor commitment to meet aid promises. However, the increase in aid funding continues to fall short of donor commitments. In 2007, ODA fell to 0.28% of the gross national income (GNI) of Development Assistance Committee (DAC) members, significantly below the intermediate target of 0.5% of GNI by 2010 and the final target of 0.7% of GNI.

Financing gaps for health are jeopardising the achievement of the Millennium Development Goals and leaving poor women and men without even basic healthcare. In 2009, the OECD DAC reported that the disbursements for health and population more than tripled from US$3.5 billion in 2002 to US$10.8 billion in 2007. However, the Commission on Macroeconomics and Health (CMH) estimated that the level of donor funding required for health interventions was US$27 billion per year in 2007 and US$38 billion per year by 2015. Comparing these figures for 2007 reveals a shortfall of US$16.2 billion in 2007, highlighting the need for significant increases in both the levels of overall ODA and the proportion of ODA allocated to health in order to meet the 2015 target. It is clear that if the international community is serious about the health of people in poor countries, significantly more and better quality aid is required.

3.2.2 Increasing donors’ HIV and AIDS funding for health system strengthening

There is increasing recognition among leaders of the global AIDS response regarding the importance of a functioning health system for an effective, long-term strategy to tackle the HIV epidemic. The Global Fund states that “inadequate health systems are one of the main obstacles to scaling-up interventions to secure better health outcomes for HIV, tuberculosis, and malaria.” This recognition is important given the comparatively significant resources which have been invested in HIV and AIDS programmes and their potential for health system strengthening.

Donor funding for HIV-related activities in low and middle-income countries has increased tenfold in less than a decade to $10 billion in 2007, while per capita domestic spending on HIV in low and lower-middle income countries has more than doubled between 2005 and 2007. However, it is important to note that, even given the significant increases made to HIV and AIDS funding in recent years, UNAIDS estimates that available financial resources for the global AIDS response must increase by US$11.3 billion to US$25 billion by 2010 in order to meet the goal of global universal access in low and middle-income countries.

New initiatives, such as the International Health Partnership, seek to address some of the problems experienced by developing countries receiving development assistance for health, by increasing national ownership and improving donor coordination. It is hoped that these initiatives will provide new and innovative ways of integrating HIV and AIDS programmes into national health plans and programmes.

A number of HIV and AIDS donors are already committing funds to developing stronger health systems. For example, DFID’s 2008 HIV strategy commits £6 billion over the next seven years to “health systems and services”, rather than to disease specific interventions. Similarly, the Global Fund committed almost 20% of Round 7’s total approved funding to health system strengthening interventions. While there is now an appreciation of the importance of health systems to the HIV and AIDS response, a similar recognition of the particular importance of primary healthcare in meeting the universal access targets for HIV and AIDS has not been made.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

The International Health Partnership and Related Initiatives (IHP+)

The International Health Partnership (IHP) was launched in September 2007 by UK Prime Minister Gordon Brown and Norwegian Prime Minister Jens Stoltenberg, to establish a coordinated approach to the challenges presented by the MDGs on health and universal access. The IHP has partnered up with related initiatives, such as the Global Health Workforce Alliance, and this coordinated effort is referred to as IHP+.

The IHP+ work plan aims to scale up and coordinate financial, technical and political support, and build on existing initiatives to achieve global health targets. The IHP+ is country focused and country led, with a focus on establishing country compacts between donors and individual countries to ensure long-term, predictable funding on broad health objectives, alongside clear performance indicators for all parties.

To date, 10 countries are signatories to the IHP+ and country compacts have now been signed in Ethiopia and Mozambique. However, the scale of the task ahead is demonstrated through the case of Ethiopia, which has made the most progress but which also has a funding gap of US$2.8 billion to scale-up primary healthcare and meet the health MDGs.

The Task Force on International Innovative Finance for Health Systems

The task force was established in Doha at the UN Financing for Development Conference in December 2008 and brings together heads of states from a number of IHP+ member countries, UK Prime Minister Gordon Brown, Director General Margaret Chan of the WHO, and President Robert Zoellick of the World Bank. The task force was set up to respond to the “inadequacy of existing donor arrangements to respond to the financing gaps in national health plans to scale-up services so as to reach the health MDGs. Of particular concern were those health MDGs not showing significant progress, in particular MDG 1c, 4 and 5, all of which require a functioning health system and focus on primary healthcare in order for progress to be made.”

The task force will consider how best to mobilise additional resources, increase the financial efficiency of health financing and improve the use of funds. Its initial recommendations are due at the G8 in July 2009 and its final report in September 2009.
What are the key organisations doing on primary healthcare?

- The WHO remains a major proponent of primary healthcare and has championed it in its current programme of work and strategic plan, as well as in the latest World Health Report entitled ‘Primary healthcare – now more than ever’.

- The World Bank has traditionally supported vertical initiatives over primary healthcare, but is beginning to recognise the importance of systems strengthening and equitable access to services.

- UNAIDS recognises that health systems strengthening is a key part of the AIDS response, although there is no particular focus on primary healthcare. The new executive director, Michel Sidiblé, noted the links between achieving universal access, primary healthcare for all and the MDGs. In a letter to partners in February 2009 he stated that “the opportunities afforded by the drive to universal access must be seized to ensure... progress on all Millennium Development Goals and primary healthcare for all”.

- UNFPA has prioritised access to reproductive health services and to HIV services, both of which will require robust primary healthcare systems.

- The current African Union health strategy explicitly prioritises a primary healthcare approach to health service delivery.

- Various UK government (DFID) strategies and reports highlight the need for equitable health service delivery, health systems strengthening and integration, but do not reference primary healthcare specifically.

- The Global Fund is increasing funding on integrated health system development, but without an explicit focus on primary healthcare.

- The President’s Emergency Plan for AIDS Relief (PEPFAR) is supporting diagonal programmes that have broad effects on the health system and the specific disease but does not prioritise primary healthcare. Under the Obama presidency there have already been dramatic changes to the US approach to HIV and AIDS, but it remains to be seen whether Obama’s promise of “best practice, over ideology” will reach as far as prioritising primary healthcare.

In addition to HIV and AIDS funding spent directly on health system strengthening, HIV and AIDS programmes, if appropriately designed, can have a beneficial impact on the health system. According to Dr Peter Piot, the previous Executive Director of UNAIDS, “there is now growing evidence that AIDS action has become a true engine for strengthening health systems.” A recent report by the HIV/AIDS Monitor identified numerous opportunities for HIV investments to be leveraged to bring benefits for the whole health system. However, the report also highlighted the negative impact that HIV and AIDS programmes could have on the health system when they are not appropriately designed, including the potential to draw away health workers and burden countries with additional reporting requirements. The key recommendations from the report centre round the need for more robust joint HIV and health planning, coordination and management in order to achieve the desired HIV outcomes, alongside health systems strengthening.
Impact of macro-economic policy restrictions

The research from Tanzania and Uganda, alongside previous ActionAid research, highlights the problems caused by restrictions on fiscal space resulting from macro-economic policies. For example, the Tanzania report found that the government, with the support of the International Monetary Fund, blocked the implementation of expansionary macro-economic policies. This contributed to a restricted national budget, which further translated to a limited health sector budget. These claims are supported by a large body of evidence showing that excessively low inflation targets, budget deficit restrictions and resulting low public wage bill ceilings have prevented countries from scaling up their investment in health, particularly on health workers. Therefore, even if the government wanted to spend more of its tax revenue to recruit additional doctors and nurses, it could not.

The governments are responsible for the macro-economic policies they choose to implement, but the IMF continues to influence macro-economic policies in many of the world’s poorest countries. All countries included in the study, except for India, have an arrangement with the IMF. In these arrangements, governments agree with the Fund to adhere to a set of economic conditionalities. In many countries, these economic policies are in line with governments’ own policies. The common economic thinking is to keep inflation targets low, at around 5%, and to decrease budget deficits to between 0 to 3%. For example, in December 2008, the Ugandan government said it was targeting inflation at less than 5% and expected the fiscal deficit level to fall below 3% of GDP by 2010. To meet these targets, governments have to constrain their spending, including on the public sector wage bill.

While governments and the IMF now claim that they are protecting the health sector from budget cuts, restrictive macro-economic policies prevent the scaling up that would be necessary, including the hiring of the additional 2.4 million health service providers and 1.9 million support workers that the World Health Organization estimates are required globally. Furthermore, the failure to improve the quality and reach of healthcare services has meant that communities increasingly rely on informal healthcare, thereby shifting the costs of healthcare provision from the state to the household. Women and girls are disproportionately affected as the burden of care primarily falls upon female members of the household, resulting in fewer opportunities for them to seek formal employment or attend school.

Developing macro-economic policies requires a discussion of the trade-offs that come with meeting restrictive monetary and fiscal targets and the resulting constraints on government spending. These trade-offs should be openly debated between government and citizens.

Please see www.actionaidusa.org/what/imf_project/ for more information on ActionAid’s work on the IMF.
3.2.3 Improving development assistance for health

Continual investment by governments and donor agencies in building up the public health sector provides the best long-term, sustainable solution. Yet, development assistance is often provided in short funding cycles and the resulting unpredictable nature of aid flows creates difficulties in long-term planning, and often has a negative impact on the sustainability of donor funded projects. Predictability of health aid is especially important, given the high proportion of recurrent costs, such as staff salaries, and the provision of long-term drug therapies, including ART. Another problem with donor funding is the lack of coordination. The National AIDS Control Organisation in India has 32 large donor agencies working across the states and focusing on different programmes, resulting in significant transaction costs for the government.

Donors are increasingly aware of the difficulties associated with development assistance and this recognition has been translated into a number of international agreements to improve aid effectiveness, such as the Paris Declaration in 2005 and the Accra Agenda for Action in 2008. Yet, as the monitoring of these agreements shows, governments have been woefully slow at improving the predictability of their aid.

Despite the international agreements, the country research also demonstrated that the lack of long-term predictable funding often challenges the sustainability of HIV and AIDS projects. For example, in Pallisa district in Uganda, the assumption often made by the development partners is that when they phase out support, the site will continue to provide the services. A health worker highlighted the problems of sustainability, “the donors even try to help us out by training our staff members. But I tell you, the programmes end with them. The activities need a budget. You cannot start if there is no budget.” Even when donor funds are channelled through the public sector, sustainability is not guaranteed. In Akwa Ibom state, Nigeria, the primary healthcare budget is used for administrative purposes, whereas the other aspects of the programme are left to donor agencies. If these agencies were to withdraw from the area, it would threaten the provision of primary healthcare in the area.

Although public sector investments provide the preferred long-term, sustainable solution, it is also important to recognise the significant role which is already played by NGOs and the private sector in the delivery of health services, particularly when people prefer to access certain types of services outside the public sector. For example, in Sierra Leone, commercial sex workers in Bo and Kenema explained that they prefer to buy condoms from the pharmacies than go to a public sector facility, even though the condoms are provided free of cost. As one sex worker in Kenema explained, “I am ashamed to go for free condoms.” Similarly, in Karachi, Pakistan, NGOs rather than public health services were providing prevention services for specific at risk groups such as male sex workers, female sex workers, truck drivers and injecting drug users, as well as providing care and support for people living with HIV and AIDS.

In addition to developing a sustainable health system, the public sector should provide a comprehensive selection of services, based on the needs and demands of the communities it is serving. In contrast, NGOs may only be able to provide services for which funding is available and the private sector will choose to provide the services on which it can generate profit. For example, no private primary healthcare facility in Nigeria or India was found to provide gender-based violence response services. In the specific case of HIV and AIDS service provision, it is unlikely that private providers will focus on prevention. However, as highlighted by Dr Margaret Chan, Director-General of the World Health Organization, prevention services can have a significant impact: “When the emphasis is placed on specialized or commercialized care, providers have no incentive to invest in prevention. This is a failure with huge consequences. WHO estimates that better use of existing measures could prevent as much as 70% of the global disease burden.”

In summary, although NGOs and the private sector can and do currently play significant roles in meeting the needs of people who feel unable to attend public facilities, this should only be viewed as a short or medium-term solution. In the longer term, the aim should be to address the root causes of why particular community members feel unable to utilise public sector facilities. For example, they may be of a poor
quality, or not gender sensitive. If addressed appropriately, groups such as the sex workers in Sierra Leone would feel able to discuss their needs with their health workers without fear of stigma. Moreover adequately trained health staff could tailor their care and advice to these groups’ needs, and ensure their access to the full range of services required.
3.3 Improving budget processes and accountability

Once funds are committed to the health sector, it is also critical that the allocated funds are distributed throughout the health system on time and reflect the full amounts committed. The research from Nigeria and Uganda reported problems in this area. For example, in Nigeria, there were reports of funds to Local Government Areas (LGAs) not being released in full. This prevented the LGAs from purchasing all the necessary equipment and facilities for primary healthcare centres. In Uganda, the funds allocated to some of the primary healthcare facilities were not released on time or had not been paid in full by the end of the financial year. Evidently, such inefficiencies in the distribution of funds have a negative impact upon service delivery (see section 6 for more information).

The research from India, Nigeria and Tanzania highlighted the need for improved accountability and transparency at all levels in the health system in order to tackle inefficiencies and corruption. For example, the Nigerian report highlighted the “lack of accountability of the government to the people”. The India report stated that accountability mechanisms further down in the health system should be strengthened in order to address issues such as corruption, negligence and absenteeism among health staff. Community participation is one method through which accountability and transparency can be improved and is discussed further in section 6.5.
**ActionAid’s ELBAG programmes help communities to hold governments and institutions to account**

Economic Literacy and Budget Accountability in Governance (ELBAG) is a process which enables communities to demand accountability from governments and international institutions and to reclaim rights and challenge injustice. The objective is to facilitate community learning in order to bring about changes in favour of poor and marginalised people, increase their participation in economic and budgetary processes, reduce inequality and poverty and promote transparency, accountability and basic rights. ActionAid and our partners currently support ELBAG processes across Asia, Africa and South America. In Nigeria, for example, ELBAG groups successfully advocated for improvements to school facilities and greater numbers of teachers in Sokoto, Kebbi and Zamfara states. ActionAid Pakistan’s ELBAG programme was able to play a central role in developing a People’s Charter on Budget, a statement that outlines how budget processes and government policies should be improved to meet the needs of all of the citizens, including poor and excluded groups.

Please see www.elbag.org for more information.

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**ActionAid’s STAR programme**

Societies Tackling AIDS through Rights (STAR) is a participatory approach which facilitates the mobilisation of people and communities affected or living with HIV by providing a system for mutual reflection, planning and collective action on HIV, Sexually Transmitted Diseases and gender issues. The programme creates ‘circles’ – groups of 25 to 30 people in a particular community, whose members come together on a weekly basis for joint planning, reflection and collective action. For example, in northern Nigeria, circles of people living with HIV demanded that ART supply centres be located closer to the community. As a result, the government commissioned a STAR project partner to distribute ARVs and related commodities within and outside circles.

3.4 Recommendations

• National governments should honour their health commitments, including universal access to HIV and AIDS services, by:
  – increasing investment in health systems, particularly primary healthcare, in line with the Abuja Commitment where relevant;
  – developing macro-economic plans that will enable them to scale-up primary healthcare provision;
  – improving monitoring and evaluation systems to ensure that all funding invested in the health system is allocated as effectively as possible;
  – ensuring representative community participation in decision making on health budgets to increase transparency and accountability;
  – ensuring funds are released in a timely manner, at all levels of the health system, to allow for effective planning and distribution of funds.

• Aid donors should:
  – provide more funding for health systems as part of reaching 0.7% of GNI in aid;
  – meet their Paris Declaration commitments to provide long-term, predictable, coordinated funding, and in 2011 at the Fourth High Level Form on Aid Effectiveness commit to more ambitious targets to improve the quality of their aid;
  – untie their aid to IMF loan arrangements, giving developing countries full ownership of their macro-economic plans so that citizens and governments can openly debate the costs and benefits of scaled-up health provision.

• International coordinating mechanisms and efforts, such as the IHP+, should work with developing countries to ensure that health plans include a strong focus on primary healthcare as a means to deliver HIV services, and reach out to women, the poor and other marginalised groups. This should be achieved through ongoing meaningful community and civil society participation.

• The IMF should ensure that all advice it provides to developing countries is based on country-specific information, rather than global averages, and reflects commitments to improving healthcare that governments have already made.

• Civil society should, where possible, monitor government spending through budget tracking, to ensure effective and adequate spending on health, particularly primary healthcare, and HIV.
Adequate investment in primary healthcare is essential to provide high-quality primary healthcare. However, available resources must also be spent in a cost-effective manner so that they bring the greatest benefit. The 2008 World Health Report highlighted that, although greater spending on health is associated with better health outcomes, there are also significant differences in health outcomes between countries that spend similar amounts, particularly when health budgets are low. The report noted that “in countries where the envelope for health is very small, every dollar that is allocated sub-optimally seems to make a disproportionate difference”.

Inefficient use of health resources has three main causes: ineffective policy, inappropriate service design and inefficient service delivery. Each will be discussed in the following chapters.

The development of policy is the first step towards achieving targets on health improvement. The main policy shortcomings identified in the country research can be translated into three areas for action:

• developing effective policy
• ensuring integration between HIV and AIDS policy and policy regarding health service delivery
• improving the implementation of policy in practice.

4.1 Developing effective policy

First, policy needs to exist, and then people need to know about it. In Nigeria, the absence of effective policy and clear targets at national, state and local levels is hindering the HIV and AIDS response. In Kebbi state, for example, none of the policy makers interviewed at the state and local levels could provide information relating to any HIV and AIDS policy in the state.

The impact of the lack of policy is described as follows by Dr David Magwi, Director of Systems Management at the National Primary Healthcare Development Agency in Nigeria: “The absence of a National Health Act to back up the National Health Policy has been a fundamental weakness which needed to be tackled head on. This weakness means that there is no health legislation describing the national health system and defining the roles and responsibilities of the three tiers of government and other stakeholders in the system. This has led to confusion, duplication of functions and sometimes lapses in the performance of essential public functions.”

Effective policy will also take into account the competing priorities for health resources. For example, the research in Sierra Leone identified that the government and partners’ focus on reducing high infant and maternal mortality rates, coupled with the relatively low HIV prevalence, resulted in the underfunding of HIV services.

Finally, effective policy must also take into account the needs of the people affected. The country research highlighted that marginalised groups, people living with HIV and women are often excluded from policy development. As noted by Dr Reema Nanda, the Director of Public Health at the American India Foundation: “There is a medicalisation of policies… There are only ‘experts’ relating to policies on maternal, reproductive health and the promotion of breastfeeding. Most of these ‘experts’ are men.”

4.2 Ensuring integration between HIV and AIDS and health department policies

India, Sierra Leone, Tanzania and Uganda all provided information regarding the good integration of HIV and AIDS and other health departments, at least at the policy level. Successes include the example of Sierra Leone where, according to Dr Momodu Sesay, the National HIV/AIDS Coordinator: “HIV/AIDS services have been widely scaled-up during the past two years, and this has been mainly due to the integration of services within primary healthcare.” However, challenges were also described by Dr Sesay regarding the implementation of such policies in practice. These will be discussed in section 6.1.1.

The lack of integration between HIV and AIDS and health department policies, as evidenced by the absence of an HIV policy in the Ministry of Health, was identified as a significant problem in Pakistan. The research highlighted limited coordination and integration between the National and Provincial AIDS Control Programmes, the Ministry of Population Welfare and the Ministry of Health. Consequently, primary healthcare centres are not providing any HIV...
Discarded syringes at a primary healthcare centre, Dhaiahat, Bihar, India.

PHOTO: SIDDHARTH JAIN/ONASIA/ACTIONAID
and AIDS services and there is inadequate training in HIV and AIDS, STI management and gender-based violence response services. One possible reason for the lack of integration could be the relatively low HIV prevalence rates, which, according to UNAIDS, is 0.1% in Pakistan. While the provision of HIV and AIDS services should be tailored to the local epidemic, there remains an important role for primary healthcare in the provision of HIV prevention services to provide services for people living with HIV and AIDS, as well as to stop the HIV epidemic spreading in the general population.

4.3 Improving the way policy becomes practice

In India, Sierra Leone, Tanzania and Uganda, policy provisions are well developed, but their implementation remains a challenge. In India, research found that, although the third National AIDS Control Programme policy outlines the types of HIV and AIDS services to be included at each level of the health system, the study of 96 health facilities across five states found that these services are not being provided in accordance with national policy. This was because of inadequate infrastructure, institutional capacity and administrative support on the ground.

There are also examples of specific policies failing in their implementation. In Edo state, Nigeria, few health workers and health service users are aware of the 2006 Law against Stigma and Discrimination, meaning it is not enforced. Similarly, in Uganda, there is a policy on Post Exposure Prophylaxis (PEP), but health workers still don’t have information on how to manage cases of occupational post-exposure, because they have not seen the protocol or had appropriate training.

The research also highlighted challenges in the implementation of policies. For instance, in Sierra Leone, the National HIV/AIDS Coordinator described those experienced when integrating HIV and AIDS services into the health system. Some healthcare workers still consider HIV and AIDS programmes as external to their core work, and demand extra remuneration for implementing them.

In India, policy implementation is challenging because, while healthcare provision is the responsibility of each state, health policy is developed at the national level. Similar issues were also identified in Nigeria, where decentralisation has resulted in three levels of government – federal, state and local government areas (LGAs). Each of the government levels has some responsibilities in the provision of healthcare and this creates challenges in policy implementation. For example, the federal government sets overall policy goals; however, the relative independence of the states means that pursuing consistent national policies across the country is problematic. Furthermore, Local Government Areas have responsibility for financing and service delivery at primary healthcare levels. Particular problems were identified regarding the lack of knowledge of the Supervising Councillors for Health at the LGA councils, who need not have a health background in order to be appointed. This has led to a poor understanding of health policy and primary healthcare in the LGA council, and an inability to drive health priorities forward in the LGAs.
4.4 Recommendations

National governments should:

• review and revise policy based on the recognition that primary healthcare provision is essential to meeting the target of universal access to HIV and AIDS services;

• ensure that all health policies are based on sound evidence and have been developed after meaningful consultation with representative community groups, including people living with HIV and AIDS, women and poor people;

• ensure that all health policies are based on a robust analysis of the ways in which women are vulnerable to ill health and the barriers they face in accessing healthcare, developed after meaningful consultation with women, including women living with and affected by HIV and AIDS;

• integrate HIV and AIDS policy with national health policies, particularly those relating to primary healthcare, SRH and GBV;

• ensure that policy developments are supported by the necessary staff capacity and resources to implement the policies effectively;

• monitor and evaluate the implementation of policy and take action to improve the process where necessary.
5 What healthcare do people want? Improving PHC for universal access to HIV and AIDS services through appropriate service design

Once effective policies are in place, the next stage in providing healthcare is designing appropriate services. The country research found that primary healthcare services should be:

- comprehensive, integrated and high-quality
- gender sensitive
- located close to the community
- evenly distributed across rural and urban areas
- affordable
- linked to higher levels of the health system through effective referral mechanisms
- regularly monitored, evaluated and improved.

5.1 Provision of comprehensive, integrated and high-quality services

Primary healthcare facilities should provide comprehensive services in order to meet the needs of the entire community, irrespective of gender, age or socio-economic status. According to the World Health Organization, comprehensive and integrated healthcare builds greater trust of the health services, improves patient satisfaction and facilitates the early detection of health problems, leading to improved health outcomes. The provision of comprehensive services is even more important where primary healthcare is the only option for healthcare within the health system. For example, a focus group participant in Akwa Ibom state, Nigeria, explained that: “Where there is no money to go to the hospital, either you stay at home and die, or adopt self-medication, or rather revert to the Church as the last resort.”

People often prefer integrated services as it is less costly, confusing and time consuming to visit a single health facility for a range of services. This is especially true for poor people, where the potential cost of extra time spent away from work may deter them from accessing healthcare at all.

The research findings highlighted three key areas for improvement in the design of HIV services at primary level, namely

- increased provision of HIV and AIDS services
- greater integration with sexual and reproductive health services
- further integration with gender-based violence response services.

5.1.1 Provision of HIV and AIDS services

The full range of HIV services includes prevention, treatment, care and support. The results of the country research, particularly in India, suggest that HIV and AIDS services are often considered to be ‘add-on’ services at the primary healthcare level, and highlighted the need for them to be integrated with other services such as tuberculosis testing (a major HIV-related infection) and treatment and maternal care.

All of the countries concluded that HIV and AIDS services should be provided at the primary healthcare level. However, the range of services should depend on the local HIV epidemic and the available health resources. In areas where HIV prevalence is low, services should focus on prevention and voluntary counselling and testing, alongside treatment for simple opportunistic infections. In areas where prevalence is higher, more specialised services should also be included, such as Prevention of Mother to Child Transmission (PMTCT) services, or treatment for more complicated opportunistic infections. Moreover, primary healthcare facilities should always provide referrals to higher levels of the health system for HIV services not locally available, including more complex services, such as viral load testing.

Anti-retroviral treatment (ART) saves lives, encourages HIV testing, lowers viral loads and reduces stigma. However, its provision at primary healthcare level remains an area of debate. The case for providing ART at primary health centres is based on providing it as close to the patient as possible in order to increase take-up and adherence to the regime. An HIV counsellor in Karnataka state, India, explained one of the risks of not doing it: “More than 80% of people who get tested positive do not go to the ART centre at the district hospital. Usually, they think that as their status is already revealed to a few people, including the [HIV] Counsellor at the Community Health Centre (CHC), they do not want to go to the district hospital and reveal their status for the second time. They also think that in the district hospital one might come...
Primary concern: why primary healthcare is key to tackling HIV and AIDS

Across twice as many people as in the CHC. Integrating CD4 tests and ART at the CHC would help to reduce this fear. Thus, coverage of ART will be much higher.137

The case against such provision is that ART requires specialist skills and lab equipment that may not be available in health centres, some of which may not even have a doctor. An alternative and more feasible option is to use primary healthcare facilities as an ARV re-filling centre, whereby patients are initiated on ARV and monitored at intervals by a specialist, but receive their monthly prescriptions at the local health centre from clinical officers and other lower level health workers. This is currently occurring in parts of Uganda.138

Finally, HIV and AIDS services should be integrated with other services. This provides opportunities to refer patients to and from other linked services, thereby ensuring that they receive the full range of services they require. For example, patients who visit a primary healthcare facility for family planning would also receive information about HIV to inform their choice of contraceptive method; or those who are diagnosed with tuberculosis would also be referred for an HIV test. The research in Nigeria highlighted that these links are often not made. For example, in Edo state, primary health centres are delivering babies without providing women with information about HIV, or offering them a test. The health officials interviewed confirmed that it is only at secondary and tertiary facilities that antenatal services are combined with HIV counselling and testing.139

5.1.2 Integration of sexual and reproductive health services with HIV services

Sexual and reproductive health (SRH) services include family planning, maternal and infant care, management of sexually transmitted infections and other SRH problems.141 The World Health Organization identifies a number of benefits of linking SRH with HIV and AIDS services, at both programme and policy levels, namely:142

- People use more of these services when they are integrated, so they have greater impact. For example, there is more use of methods that provide dual protection against unintended pregnancy and sexually transmitted infections (STIs) including HIV, and more uptake of HIV counselling and testing.
- Reduced stigma and discrimination against people living with HIV and AIDS and those seeking HIV counselling and testing.
- Better access for people living with HIV to SRH services tailored to their needs including reproductive choices, family planning, antenatal care, STI services and sexuality counselling.
- Improved scope and quality of care, so programmes are more effective, efficient and cost effective.

It is important to note that the integration of SRH and HIV has to be gender sensitive (see section 5.2, page 48).

Research in all countries identified shortcomings in the design of primary healthcare services dealing with SRH and HIV. For example, in Nigeria, the research highlighted that HIV and AIDS services are not sufficiently mainstreamed into family planning activities.143 However, there are signs of increased integration in Kebbi state, where HIV and AIDS counselling has been integrated into antenatal activities in the facilities visited.144

However, even where these services are integrated and free of cost, people may continue to face difficulties in accessing them. For instance, the Ugandan report highlighted the need to ensure that the distribution of condoms is designed according to the local context. At Kibale Health Centre III in Pallisa district, a facility with a target population of 8,800 adults, the records show that only 80 people had received condoms between January and October 2008.145 And in Mityana district, it was found that teenagers in particular are reluctant to come to collect them. In contrast, a woman from Bundibugyo district commented: “Whenever we come here, the health worker offers to give us condoms to take home, but we don’t take them. Those condoms are for boys... no mother should lie to you that she can carry condoms from the health centre; we only see condoms with youth, especially the boys.”146
Vikash Kumar’s story

Vikash Kumar is 35 and married with a two-year-old daughter and a four-year-old son. The family lives at his parents’ home in Patna, Bihar state, India. His story highlights the difficulties people living with HIV and AIDS face in accessing affordable, high-quality, confidential and local treatment, even when they are aware of the services they need.

“In 2005 I became very sick - I had a fever, I was losing weight and coughing. I was diagnosed with TB and the doctor who was treating me advised me to have an HIV test at Patna Medical College Hospital (PMCH). At the time, I was very ill, but when I could walk, I went. PMCH is 30km away and I had to go by bus and auto-rickshaw on poor roads. It takes two and a half hours to make the journey.

At PMCH, I had to pay for tests. I received no pre-test counselling and some post-test counselling. At the time my wife was six months pregnant and the counsellor didn’t inform us about preventing the child from becoming infected, and I was not told that my wife should also be tested. After the delivery, I saw messages on TV and in the paper that told me that I should get my wife tested. She is also HIV-positive.

I was given a prescription to buy medicines to increase my immune system at a cost of 3,000 (US$58) rupees per month. I was only earning 50 to 100 rupees (US$1 to 2) per day from my phone booth. My family gave me money for a few months, but then stopped. The doctor said that I must not stop taking the medicines and prescribed a different drug at a cost of 4,500 rupees (US$87) per month. I started taking out loans to pay for them.

The doctor connected me with the ART centre at the government hospital (PMCH) when ART became available [for free] in 2006. Once a month, I had to travel to PMCH at a cost of 150 rupees (US$3) for travel, which takes 2.5 hours. I then had to wait for four or five hours. It cost 250 rupees (US$5) to do a CD4 count test at the government hospital, and 800 rupees (US$15) to do an ECG and a haemoglobin test at a private facility.

When my wife became pregnant again, we wanted to abort the child, but our doctor told us about medication to prevent the baby from becoming infected. However, at PMCH, no-one wanted to deliver the child as my wife was HIV-positive. My wife was told to have a Caesarean and to give the child Nevirapine, but all of the doctors refused to help her. In the end, my wife had a normal delivery, with the help of her mother in PMCH. I kept searching for Nevirapine and it was eventually given to the baby after four or five hours, not immediately.

When I have opportunistic infections, PMCH give me a referral for the local primary health centre. But even though the primary health centre is closer, I prefer to be treated at PMCH, as there is greater confidentiality and better availability of doctors.

In March 2008, I kept getting sick and doctors told me that the first-line ARVs were no longer working and that I needed second line ARVs, but these are only available in two places in the whole of India. One of the places is Bombay, so I travelled to Bombay to get the ARVs, but I was sent home and told to buy them privately. I took out more loans, and sold some land to pay off the interest on the loans, so that I could buy them as they cost 7,000 rupees (US$135) per month.”
5.1.3 Integration of gender-based violence response services with HIV services

Gender-based violence (GBV) is defined as violence (physical, sexual, or psychological) that is perpetuated against a person because of that person’s gender, gender identity, or gender performance, or the perpetrator’s understanding of gender roles or expectations. It is often, but not always, violence against women and girls. GBV is endemic across the countries included in the research, though it is often under-reported because of fear of reprisal, discrimination and lack of response from state authorities. In India, for example, recent estimates suggest that nearly 40% of women who have ever been married faced domestic violence.\(^{147}\)

Health services can play an important role in the detection, prevention and mitigation of GBV in the community, particularly as healthcare settings are often the first point of contact for women experiencing violence and women living with HIV. Therefore these settings should provide integrated services so that if a woman presents as HIV-positive she is also screened for violence, and if a woman presents with an injury from violence, she is also screened for HIV.

The research found that, despite the high incidence of GBV across the countries included in the research, the full range of GBV response services (such as those provided by the Rainbow Centre – see box on opposite page) are provided infrequently and inconsistently throughout all countries included in the research. For instance, the Indian research found that GBV is not considered to be a health issue and response services do not form part of the National AIDS Control Organisation’s service provisions.\(^{149}\) Furthermore, post-exposure prophylaxis (PEP) is often not provided to survivors of sexual assault. A medical superintendent in Bundibugyo district, Uganda, highlighted the problems resulting from the delays in reporting sexual assault: “We receive police forms and fill them. It happens long after the problem has happened. Therefore post-exposure prophylaxis is not offered since it would be too late and a waste of time.”\(^{150}\) The lack of training of health workers on PEP was reported to be preventing access in Sierra Leone and Nigeria. A health worker in Kebbi state explained that: “We have been able to treat all the rape cases that were reported to us. We counsel them on unplanned pregnancy. We do not know about PEP, we only counsel them.”\(^{151}\) However, there are also some examples of success, as highlighted by the Rainbow Centre in Sierra Leone.

The country research concluded that the range of GBV response services provided at primary healthcare levels should depend on the local context, particularly the availability of resources and trained health workers. However, at a minimum, primary healthcare facilities should provide survivors of GBV with initial counselling and medical treatment, alongside referrals to higher levels of the health system or specialist facilities.
The Rainbow Centre, Sierra Leone: providing integrated GBV response services

The Rainbow Centre provides integrated GBV response services at Kenema Government Hospital, Sierra Leone’s eastern regional referral hospital, and the only hospital in the country providing GBV response services. The Rainbow Centre of the International Rescue Committee (IRC) provides services for survivors of sexual violence, while Action Plus focuses on domestic violence. The services are all free of charge and include:

• counselling, including for parents and relatives
• medical examination and assistance
• pregnancy tests
• HIV counselling and testing
• provision of post-exposure prophylaxis
• provision of emergency contraception
• STI examination and treatment
• endorsement of a medical certificate for legal support
• support for clients at court
• advocacy
• community sensitisation about services and how to get referred.

The Rainbow Centre also assists clients with the legal process. Sister Theresa Banya, a midwife at the Rainbow Centre, reported that: “In the year 2008, eight perpetrators were charged for rape cases reported at the facility.” The convicted perpetrators paid a fine of Le 250,000 (US$83) and the minimum sentence is two years in prison.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

5.2 Provision of gender-sensitive services

In order to provide gender-sensitive services, service design needs to ensure that they are geared to meet the specific needs of women and men, and are provided in a way that upholds their rights.

The disproportionate impact of HIV and AIDS on women and girls is now well documented, as are the many social, cultural and economic barriers women face in attempting to access information and HIV and AIDS services. Yet previous ActionAid reports have highlighted that health systems are often gender blind, and these findings have been reinforced by this research. For example, while women face particular barriers in accessing healthcare, because they have limited decision making authority or financial resources, this is not often reflected in the way that HIV services are provided. A woman interviewed for previous ActionAid research in South Africa commented that a woman is often “shouted at and dismissed easily when they are late for medication. If the medication is not available they are told to go home, not considering the distance that they have travelled to get there.”

A UNICEF report used demographic and health survey data to estimate that 73% of women in Nigeria, 39.5% of women in Tanzania and 37.6% of women in Uganda said their husbands made the decisions regarding their health. Similarly, the Sierra Leone report highlighted that “social roles and expectations, and norms and values of behaviour, mean that women are more vulnerable to ill health, yet have fewer resources and opportunities to protect their health or to utilise healthcare”. For some of these women, the local primary healthcare facility may be their only source of healthcare; therefore it is essential that these facilities provide them with a broad range of high-quality services. Furthermore, HIV services must also be integrated with other key related services such as antenatal care, sexual and reproductive health and gender-based violence response services to increase the opportunity for women to access all the services they need. Services should also be provided promptly and privately so that women can access them without having to explain themselves to their partner, family or friends.

Primary healthcare services must also meet the needs of men. Ensuring the take-up of integrated primary healthcare services, including HIV services, would ensure that men can access the full range of services they need. However, a number of the countries involved in the research project highlighted that men often believe that the primary healthcare facilities exist solely to meet the needs of women, given their focus on maternal and child health. For example, a man in Enugu state, Nigeria, stated that “I don’t use the health centre because it is filled and made for women. Any time you visit the health centre you see a lot of pregnant and nursing mothers moving in and out of the health centre.” Furthermore, men often choose to opt out of primary healthcare, preferring to access hospitals or private facilities instead, as they believe that the primary healthcare services are of a low quality. Accessing private facilities could prevent men from accessing the full range of services they require, while directly accessing hospitals creates inefficiencies in the health system. Women, however, may not have this choice. A female facility user in Nigeria highlighted how her husband’s and her choice of healthcare differs: “My husband does not like the health centre, he is afraid because they do not have a doctor here, I am coming here because of the free maternal and child care provided in the centre.”

The low uptake of primary healthcare by men is also reflected in the worryingly low uptake of HIV services. For example, Ogur health centre IV in Lira district, Uganda, provides HIV counselling and testing services and ART – 75% of its 969 registered clients are female. Similar results were highlighted in Sierra Leone by Mr Koyama Saffa, a VCCT counsellor in Bo district: “The patients they get for VCT services are mainly women and especially pregnant women who come to join the PPTCT services. Very few men opt for VCT services.” It is hoped that, if more men access comprehensive and integrated primary healthcare services, the take-up of services, including HIV and AIDS services, would increase.

The country research in Pakistan and India also highlighted that both female and male health workers are needed. The introduction of Lady Health Workers in Pakistan, for example, has extended health services...
and referral mechanisms to villages, and provided vital links to women who, for cultural reasons, may find it difficult to travel to a health centre. The country research also highlighted that where only either male or female health workers are available, care can be compromised. In Bihar state, India, for instance, the lack of female doctors at primary health centres forces female patients to travel to the district hospital for STI services, located a significant distance from their homes. A woman from a Muslim community in Bihar complained that male doctors prescribe medicine without any clinical examination for gynaecological problems, whereas male patients in Bihar complained that the lack of male health workers makes them uncomfortable when accessing counselling and treatment for STIs.

Health workers must also be trained to deal with gender issues. This should include the specific challenges faced by women, such as gender-based violence, economic dependence on men, and lack of control over their own bodies and choices around child bearing, particularly within marriage. An understanding of these challenges should underpin the way in which a whole range of HIV services is provided, including prevention of mother to child transmission, voluntary counselling and testing and SRH services. At present, many women and girls affected by HIV face double discrimination within the health system on the basis of both their HIV status and their gender. Such discrimination and stigma can result in women being blamed for infecting their children or partners with HIV, receiving poor treatment and being denied accurate information. A woman in Nepal interviewed for previous ActionAid research described her treatment by a nurse when she went to collect her medicines from a hospital as follows: “She looked at me from top to bottom and made a comment: ‘You look so pretty, you must have been involved in some immoral behaviour, that’s why you got this virus.’” Moreover the International Community of Women living with HIV has highlighted examples of pregnant women being tested for HIV without their permission being sought and the results relayed to their husbands and in-laws without their knowledge.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

5.3 Provision of services close to the community

Services must be close to the community to ensure access, particularly by the poor. In Pakistan, for example, viral load and CD4 count tests are being provided in only seven hospitals (mostly teaching hospitals) and sometimes the patients have to travel a distance of more than 600 kilometres in order to access them, making them inaccessible to the poor. Furthermore, services should be located according to need. However, in Bihar state, India, the research found that the provision of primary healthcare facilities is often limited in areas with a high proportion of Muslims or people considered to be of a lower caste. Distance from the facility also proved to limit access to ARVs in Tanzania, due to the need for numerous visits to the secondary health centre. One health worker in Kibaha district commented that: “The policy is good, but the process is too long as it makes the patient go for adherence counselling, CD4 check and ARV initiation. This involves several appointments which are affected by the economic status of patients, as most PLHIV are living under absolute poverty.”

However, even once services are provided physically close to the community, this does not guarantee that they will be utilised by the community, particularly if they are inconveniently located. Ugbor primary health centre in Oredo Local Government Area, Nigeria, is one such example. Although it was described as a ‘model’ primary health centre since being rebuilt, furnished and equipped by the National PHC Development Agency, it remains underused. At the time the research team visited it, there were no patients there and the centre register showed that no patients had attended in the previous two weeks. The research attributed this to both the inconsistent attendance of health workers and the lack of consultation during planning, which resulted in the centre being located in an area where public transport is lacking and private transport is expensive. A female focus group participant said that: “People from far-away communities have to charter a bike to come here and the bike has to wait for them and take them back to their village, which will cost them N300 (US$2) each way. To avoid this high cost and the possibility of not meeting a trained health worker, they would rather go to the central hospital in Benin City, which only costs N100 (US$0.70) and they are sure of meeting a doctor.”

The situation is still more complex. People’s choice of health facility is also influenced by fear of stigma, discrimination and rights violations, as well as location. The research documented a number of cases where a person living with HIV would choose to go to a facility that was located further from their home due to a fear that their HIV status would be disclosed. In Bundibugyo district, Uganda, a woman commented that: “When a person is tested HIV-positive we say that ‘he is dead’. Many people fear this label and are forced to go to Nyahuka [a more distant facility] where people may not know them.” The country research found that poor confidentiality and low-quality primary healthcare services resulted in some patients preferring to receive ART at locations further away from their home. The Indian and Nigerian research

**Christine Akello and her hopes for a village health centre, Uganda**

“I have to walk 24 kilometres every two weeks to get the [ARV] drugs. I am not alone; there are also other women in my village walking a long distance to get the drugs. I walk so many hours and get tired by the time I reach the health centre, so I sleep at a friend’s home and go back the following day. My husband has missed his drugs; he has given up walking the long distance to get his ARVs and he has resorted to drinking alcohol. He drinks alcohol every day, and said he waits for his day to die. I can’t get his ARVs – the doctors say my husband should come for them personally. I pray to God so that a health centre is brought nearer to our village to help HIV-positive people in the area.”

Primary concern: why primary healthcare is key to tackling HIV and AIDS

Innovations in service design

Even when it is difficult to provide services within the community, there are examples of innovative service design that have provided the community with access to remote services, either by providing transport or by running outreach services, such as the use of transportation, radio communications or the introduction of other information or communication technologies. The country research identified several examples. For instance, in Kebbi state, Nigeria, the Local Government Area provides transportation by bus each month for people living with HIV to access treatment at Zuru town. In a maternal and child health post in Sierra Leone, VCT services are provided with the help of a lab technician who came from the local hospital to carry out testing once a week. If they are HIV-positive, the patient is referred to the local hospital. However, more could be done to introduce additional mobile services and to improve the sustainability of these innovative projects. In Pallisa district, Uganda, for example, HIV outreach activities by health workers on bicycles are constrained by the meagre budget for bicycle maintenance.

highlighted that the choice of location was greatly influenced by health workers’ and the community’s stigmatising and discriminatory behaviour, irrespective of distance and cost implications. However, it is important to note once quality issues are resolved and the design of services is improved, it is anticipated that the demand for local HIV services within primary healthcare would increase.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

5.4 Even distribution of services across rural and urban areas

There were far more resources available for healthcare in urban than rural areas. Primary healthcare services in rural and urban areas varied in terms of the amount of health facilities, the number of skilled health workers, and the quality and quantity of equipment and facilities. In Nigeria, for instance, the report stated that “at the urban level we have more service providers who are more qualified than we have at the rural level, [as well as] more and better facilities”. In Uganda, there are only 3.3 doctors per 100,000 of the rural population compared to 59.3 doctors per 100,000 of the urban population (see section 6.1 for more information).

The differences in healthcare provision are also reflected in the distribution of HIV services. For example, in Sierra Leone, the research highlighted that there are more HIV and AIDS services provided through primary healthcare in the urban than rural areas. The Tanzanian report described the difficulties in accessing ART in rural areas due to the greater distance to the health facility, lack of food and the out-of-pocket expenses incurred by patients.

These geographical variations are being increasingly recognised by policy makers. For example, in India, the government launched the National Rural Health Mission in 2005, whose objective is to improve the availability of and access to quality healthcare in rural areas, especially for the poor, women, and children. Similarly, there are also examples of rural support programmes in Pakistan, such as the PRSP (Punjab Rural Support Programme).

5.5 Provision of affordable services

Sierra Leone is the only country included in the research that charges user fees for basic primary healthcare consultations, and the findings highlighted that the user fees were negatively impacting the demand for services. Mariama Swarray, a woman with four children living in Sierra Leone, explained that: “The cost of health services is very high and we cannot afford to visit the facility for every disease we suffer from”. Health outcomes were also impacted. For example, it was identified that poor access to condoms and the high cost of STI treatment (US$3 to 5) may be related to the high level of STI cases among outpatients.

Even though the rest of the countries included in the research did not charge user fees for primary healthcare consultations, many hidden costs of healthcare were identified by the research. People are unable to access the services they need due to associated costs, including transport, formal fees for consultations and tests, informal bribes or the cost of drugs or essential equipment, such as gloves. For instance, costs were found to prevent poor and excluded people from accessing health services in Kebbi state, Nigeria, where all tests and drugs have to be paid for (with the exception of the HIV test and ARV drugs), and patients are required to buy their own gloves, syringes and pads when they run out in the health facilities.

Another example of hidden costs is in India. Although the government hospitals in India are meant to provide tests at subsidised rates to the general population (and free of cost to those below the poverty line), in reality, patients need to buy disposable syringes from unlicensed medical shops to get these tests done at primary health centres. Similarly, the research from Sierra Leone highlighted that, even though healthcare services are meant to be free for children, pregnant women and the elderly, this is often not the case. As health workers’ salaries are often not paid, they resort to misusing their power to charge informal fees for services.

The research also identified significant costs in accessing a number of HIV and AIDS services. In Gadchiroli district, India, the transport cost of obtaining ART ranges from 60 to 500 rupees (US$1.20 to US$10), depending on the distance. The cost of having a CD4 count test is over 1,000 rupees (US$20) per visit because the patients have to stay overnight to collect the test reports the next day. Similarly, there are also costs incurred in Lira district, Uganda, for CD4 tests. A local leader highlighted that “CD4 count is also done every Wednesday but you have to pay 11,000UGX (US$5.60), if you don’t have [the money] then you cannot have a CD4 count. They say it is for transport because the machine is in Lacor Hospital in Gulu district, but ours is a regional hospital, it should have this machine!” There were also
hidden costs identified in Tanzania, where a VCT counsellor remarked that “it is not possible for PLHIV to access all of the HIV/AIDS and related services for free, because most of the public health facilities’ opportunistic infection drugs have been regularly out of stock.”

There were also some success stories. In Kebbi state, Nigeria, PMTCT programmes were reported to be successful. The key success factor was that the service was led by women for women. In addition, the policy of free treatment for all pregnant women increased the utilisation of the facilities.

5.6 Functional referral mechanisms

The countries report mixed evidence regarding the provision of effective referral mechanisms. In Nigeria, the referral process for HIV-positive people to secondary or tertiary healthcare facilities appeared to be functioning effectively, although the overall referral system was weak due to the decentralisation of the health system. In Nigeria, the provision of primary healthcare services is the responsibility of LGAs, while secondary healthcare services fall under the State Hospital Management Board’s responsibility. However, there are very few links between the two and as a result, the referral system is weak and hospitals are not providing support for primary healthcare facilities. In Uganda, the referral mechanism was also described as poor due to the high likelihood that patients referred for service will drop out, because of a lack of follow-up, the distances to facilities or the uncertainty of finding the service at the referral facility.

5.7 Effective monitoring and evaluation of primary healthcare services

Effective monitoring and evaluation of primary healthcare services should lead to continual service improvements and can be achieved through transparent and public monitoring, alongside regular impact evaluation. However, in Nigeria, there were no structures in place at either the state or the local levels to carry out effective monitoring and supervision of HIV and AIDS (and related) services in primary healthcare facilities. Furthermore, most of the facilities and government officials interviewed lack performance targets, which are vital for evaluating the impact and success of healthcare services and assist with programme planning. A potential solution to this is the greater involvement of service users in the management and monitoring of primary healthcare services (see section 6.5 for more information on community participation).
5.8 Recommendations

- Governments, donors, and international organisations should recognise that each country’s situation on HIV and health is unique, and design or support services tailored to that unique context, rather than taking a one-size-fits-all approach.

- National governments should review and revise service design based on the recognition that primary healthcare provision is essential to meeting the target of universal access to HIV and AIDS services.

- National governments should provide primary healthcare that is:
  - comprehensive, integrated and high-quality
  - gender sensitive
  - located close to the community
  - appropriately distributed across rural and urban areas
  - affordable
  - linked to higher levels of the health system through effective referral mechanisms
  - regularly monitored, evaluated and improved.

- National governments should improve rural health services in particular, through increased investment, the recruitment and retention of trained health workers, the provision of mobile services and exploring the use of innovative healthcare delivery methods, such as telemedicine.

- National governments should provide an adequate level of training in gender issues for health workers, including recognising and responding to signs of gender-based violence.

- National governments should provide stigma and discrimination training for health workers, and should enact and enforce laws that prevent stigma and discrimination in the health system, as well as in other spheres.

- Civil society should invest time and resources in building communities’ awareness of community participation structures in order to increase their meaningful involvement in the design, management and monitoring of primary healthcare services.

- International non-governmental organisations should implement practices that contribute to building public health systems. The NGO code of conduct for health systems strengthening may provide useful guidelines – see http://www.ngocodeofconduct.org/pdf/ngocodeofconduct.pdf
After developing effective policy and designing appropriate services, the last step in the delivery of high-quality primary healthcare is the provision of efficient services. The country research found that primary healthcare services should satisfy the needs of the community and be supported by:

- enough skilled health workers
- adequate infrastructure and equipment
- efficient supply chain management
- community participation

6.1 Provision of skilled health workers

6.1.1 Availability of health workers

As well as the global health worker shortage, health workers are also inequitably distributed worldwide, with sub-Saharan Africa facing the greatest shortage. The shortage of health workers is recognised as one of the key constraints to the provision of essential, life-saving interventions such as childhood immunisations, safe pregnancy and childbirth services for mothers, and access to treatment for AIDS, tuberculosis and malaria. All of the countries included in the research identified a lack of skilled health workers as a significant problem, but the extent of the problem varies. In Uganda, 79% of the approved posts are currently filled by appropriately qualified personnel. However, the situation is worse in Tanzania, with only 35% of positions filled.
Primary concern: why primary healthcare is key to tackling HIV and AIDS

The countries also reported a shortage of health workers specifically qualified to provide HIV and AIDS (and related) services. In Nigeria, there is a shortage of trained HIV counsellors in most health facilities. According to the health workers, “we are not able to test many people since we do not have enough trained counsellors.”199 Similarly, Dr Momodu Sesay, the coordinator of Sierra Leone’s National HIV/AIDS Control Programme, noted that “administering of antiretrovirals requires trained personnel but they are lacking in the country”.200 With a population of more than six million,201 Sierra Leone only has 95 medical doctors employed across the entire public health system,202 therefore providing ARVs is challenging, particularly to people in rural areas.

In addition to the failure to meet official government staffing levels at primary healthcare facilities, there were also reports that the staffing levels are inadequate in relation to their catchment areas. For instance, a nursing officer at Health Centre IV in Uganda suggested that “the government policy of having two clinical officers and one medical officer for such a site should be revised. They are not enough to serve people from ten parishes”.203

The reasons provided for the health worker shortage included the migration of skilled health professionals, inadequate pay, lack of housing available for health workers (particularly in rural areas), the long time taken to find replacement staff and the poor, or even dangerous, working conditions. The latter often resulted from overworking or from a lack of adequate infrastructure and/or ineffective supply chain management. One medical superintendent in Uganda commented that: “The working environment is not good in these government facilities; you lack the things to use. If you are in a place where when you receive a night call to attend to an emergency, you must use your own torch or lamp because the hospital has no lights.”204

The health worker shortage affects the quality of services provided, by preventing the provision of services, limiting the opening hours of the facilities or increasing waiting times. A health worker in Uganda commented that: “The major problem that we face every day is the acute shortage of staff. We have to keep spreading ourselves thin to deal with the patients in accordance to their diverse needs. Because of the shortage of staff, a patient who comes in at 8am may even leave after 2 o’clock.”205

Similarly, a facility head in Enugu state in Nigeria stated that “this facility does not render 24-hour service due to inadequate staff. This has made some of them to decline their usage of the health centre in cases of emergencies during labour.”206

### Table 6

<table>
<thead>
<tr>
<th>Staff/position</th>
<th>Established position</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical officers</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Nursing officers</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Midwives</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Public health dental officer</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy technician</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Anaesthetist assistant</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>7</td>
</tr>
</tbody>
</table>
In addition to inadequate staffing levels, there were some reports of late reporting or of absenteeism. In Karachi, Pakistan, the community reported that staff are only available for two to three hours per day and are not available on the weekends.207

A woman described the situation in Bundibugyo district in Uganda. “When we were coming here [to the health centre] we met the midwife attached to this facility. She was going away and we got worried, because now there will be no one to attend to those in labour or those who need ANC services. You can also see that person is there [pointing at the expectant mother who had come for delivery services] but there is no one to attend to her. This is not the first time a pregnant mother has not had a midwife to attend to her at the time of giving birth. Have you ever seen a health centre or an antenatal ward without a midwife? And yet almost every day a woman must give birth at this centre. That is why we go to the birth attendants in the village who can easily help us.”208

Health worker migration creates shortages in the poorest countries209

Health workers migrate to improve their working conditions as a result of ‘pull’ and ‘push’ factors. ‘Pull’ factors include better remuneration, job satisfaction and training and promotion prospects, whereas ‘push’ factors include political instability, conflict, inadequate salary or poor working and living conditions. Migration can take place within a country, from poorer rural areas to the richer cities, or between countries, where health workers migrate to a higher income country. For example, according to the WHO, on average, a quarter of doctors and a twentieth of nurses trained in Africa are working in OECD countries. Although the impact of health worker migration on poor countries can have some positive consequences, such as the remittances generated by the migrants, it can also have a devastating impact on health systems already suffering from severe health worker shortages. In recognition of this and the broader issues resulting in health worker shortages, the Global Health Workforce Alliance convened the first-ever Global Forum on Human Resources for Health in March 2008. The resulting Kampala Declaration calls upon richer countries to “give high priority and adequate funding to train and recruit sufficient health personnel from within their own country” and all countries to “put appropriate mechanisms in place to shape the health workforce market in favour of retention”. At the same time, previous WHO reports on the recruitment of health workers from the developing world210 have highlighted the need for:

• strategies at national level to counteract migration and enhance retention of health workers
• the adoption of international codes of conduct on international health worker recruitment
• the development of mechanisms to compensate countries that lose skilled health workers to developing countries, including recoupment of investments in health worker training

The WHO is currently working on a code of practice on the international recruitment of health personnel.211
6.1.2 Health workers must respect the rights of people living with HIV and AIDS

The research showed that people living with HIV and AIDS continue to experience rights violations including a lower quality of care because of stigma and discrimination. This was identified as a significant issue in India and Pakistan. The Indian research found that in Belgaum district, medical officers refuse to perform minor operations for people living with HIV and AIDS; hospital beds are denied to women living with HIV after delivery of their babies and confidentiality of HIV patients is usually not maintained by the health workers.212 Women living with HIV or AIDS were also denied beds or discriminated against by health workers in Karnataka and Maharashtra states in India.213

The research in Pakistan highlighted that stigma, discrimination and rights violations within the health system acted as significant barriers to access for people living with HIV and AIDS.214 This sometimes led them to conceal their status from health workers, thereby undermining their own health and potentially increasing the health workers’ risk of infection, where protection methods, such as gloves, are not routinely utilised. In Pakistan, all medical officers at the basic health units included in the research reported that they were not aware of any HIV-positive person ever having visited their facility, whereas the NGOs working in the local areas confirmed that cases do exist.215

There were also reports about the lack of confidentiality maintained by the health workers. For instance, Saada Said Saaduni, secretary for ZAPHA+ in Pemba, Tanzania, recounted the following example: “One of our members one day heard in the neighbourhood: ‘Do you know one woman who has HIV and lives in this area?’ The neighbours were then in discussion on who that person was, and after some time the community home-based carer said I think she is called Ms X, and after some time, they told them where she lives. The home-based carer went to the house and found Ms X already furious, for she had revealed her status without consent and without reason.”216

6.1.3 Action to tackle corruption in health systems

The corrupt practices of some health workers and people in positions of power were identified as a barrier to access by each country included in the research. For example, a health worker at a primary healthcare centre in Edo state, Nigeria, commented that: “World Development System gave eight motorbikes so that those in the interior could have access to vaccinations. The supervisor said he needs one of the bikes, the chairman says he needs one too. Someone called and asked if I want to lose my job, I was instructed to hand over two bikes. The other six bikes I have now assigned to various PHCs.”217

The community in Gadchirol district, India, reported that the auxiliary nurse midwife at one of the primary healthcare centres deducts up to 10% of reimbursements given under various government schemes under the pretext of photocopy charges.218 In Nigeria, health workers were reported to be re-selling the drugs provided to the primary healthcare facilities. A male community member in Enugu state claimed that: “When the government sends drugs to the PHC facilities, the providers don’t use it for the people, they sell it on their own to make money out of it.”219

Corruption also manifests itself in the levying of informal fees on drugs, equipment or services that are meant to be provided free of charge. In Turbat, Pakistan, there are reports that condoms are being sold at BHUs by the Lady Health Visitors, even though they are provided free of cost to them.220 The research from Sierra Leone highlighted that for health workers who are not being properly remunerated by the government, the only way for them to make ends meet is to charge illegal fees for drugs and treatment services at the facilities.221

While low salaries and poor working conditions play a significant role in encouraging corruption among health workers, an additional problem is the lack of monitoring, evaluation and sanctions, which allow corruption to continue. Dr. Bassey Okposi, the South-South Zonal Coordinator of the National Primary Healthcare Development Agency in Nigeria asserted that: “Some of the health workers are not serious because of the lack of discipline, especially at Local Government Areas where the Local Government Chairman are not experienced administrators. They are not assertive, so the workers do whatever they please.”222
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6.2 Adequate infrastructure and equipment

There were reports of inadequate infrastructure and equipment in all countries included in the research. Reports from Uganda, India and Nigeria all highlighted the lack of available space, particularly for counselling, which is often not carried out in private. The head of facility at a primary health centre in Nigeria recounted the problems facing the facility: “We use this one room for consultation, pharmacy, laying ward. The other room is the labour ward.”

A 2007 survey in Uganda found that only 3% of health centre IIs (HC-II), the lowest level healthcare facilities, had all basic client amenities, as well as regular supply of electricity and water. Similar results were reported throughout the rest of the primary healthcare system, with the next two levels only achieving 7% (HC-III) and 11% (HC-IV) coverage. There were also reports of low-quality equipment and inadequate maintenance, frequently occurring due to a lack of budget allocated to the maintenance of equipment.

At a health centre IV in Pallisa district, Uganda, the facility in-charge commented: “We have a facility vehicle; as a health sub-district, we oversee the other health units and we also have to distribute the drugs to them so we need the vehicle to do the work. It is new but we have to use our own funds to ensure that it is on the road. When the central government gives you a vehicle, they do not remit maintenance fees.”

There were frequent reports of a shortage of basic equipment, such as HIV-testing kits and syringes. A medical officer working at a district headquarters hospital in Tamil Nadu commented that “We are not provided with even the basic equipment like gloves.”

6.3 Efficient supply chain management

Ineffective supply chain management was reported across all of the countries included in the research. Health facilities frequently run out of medicines (including ARVs and drugs needed to treat opportunistic infections) as well as essential equipment such as gloves or syringes. For instance, in Uganda, there were reports of ARV stocks running out in Pallisa, Mityana and Lira districts. A woman living with HIV described what happened in Mityana district: “Sometime back, our facility ARVs went out of stock, and they used to give us a few tablets to share and a telephone number to call to find out if the medicine had come. At some points we had a complete stock out of ARVs yet we were not supposed to miss any days.”

When supplies run out, patients are asked to purchase their own drugs and equipment from the private sector. A facility manager explained that: “We run short of drugs like Cotrimoxazole. In such cases, when the patients come, we tell them to go and buy. But we have patients who are very poor and we know they will not buy.”

Other countries, such as India, highlighted the inefficiencies created in the supply chain when the drug supplies are not tailored to the specific needs of the community. Auxiliary nurse midwives interviewed for the country research explained how they frequently experienced shortages of the drugs in high demand, and surpluses of drugs not required by the community.

The lack of drugs and essential equipment evidently hinders the performance of the primary healthcare facilities, which in turn reduces demand for the services. As one elderly woman commented in Nigeria, “people don’t come because they know that there are no drugs in the facility. Instead of coming just to get a prescription, they go straight to the chemist and buy [the drugs].”

The inefficient supply chain management also leads to further inefficiencies in the health system. In Uganda, for example, there were reports of community members overwhelming a health facility whenever they learned that drugs had arrived. The Ugandan report stated that it “is alleged that community members come out and claim all kinds of illnesses so as to take the drugs away because they know that if they come after some time, they might not find the drugs in the health facility. And so they keep them for future use.”

In Pallisa district, Uganda, a health worker described other inefficiencies generated by the pressure on the health workers to treat the patients without the necessary drugs: “We attend to patients but cannot treat them when there are no drugs. So what do you do? You refer a patient even when you know that there are no drugs where you are asking them to go.”
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6.4 Satisfied communities

The community’s satisfaction with primary healthcare services greatly influences the demand for services, and our research showed that it is affected by both the community’s awareness of the range of services available and their perceptions of the quality of care provided. The Ugandan report highlighted that: “Glares disparities exist between community awareness and available services at nearby health facilities. Partly due to intermittent supply of drugs and irregular availability of facility staff, people often do not know when (and which) services are readily available at the nearest PHC facility at a particular point in time. Many will try self medication, pay for drugs at the nearest shop, or simply stay home, even when services could be available at the PHC facility for free.”

There were also examples of particular groups being unaware of services. For example, women in Bihar state in India were not aware of the voluntary counselling and testing facilities provided at the local primary health centre. In addition, many male focus group participants in Nigeria thought primary healthcare only provided services to pregnant women and their babies. The men were not aware of other services rendered by the PHC in their community, and did not know that they could make use of the services. For example, Mr John Odiagbe, a university student and footballer who lives opposite Uujuolen PHC remarked that: “I never knew I could come here and be treated. I thought only women are welcome here. I will start coming.”

Even when the community was aware of services, community members frequently complained about the quality of care provided. For example, a woman in Bundibugyo district, Uganda complained that: “The most disappointing moment is when we spend the five to six hours at the facility and in the end we are told there is no medicine”. The chairperson of MWAVIUM, a network for people living with HIV and AIDS in Mikuranga district, Tanzania, highlighted that the “services provided by the district hospital are poor, compared to those in the private centres”.

Uganda rejects free ARVs until supply chain improves

In 2008 the Ugandan government’s main supplier of drugs, Uganda’s National Medical Stores (NMS), incinerated US$1.3 million worth of expired drugs, including ARVs. Consequently, in January 2009, the NMS decided to reject some of the donations of ARV medication in a country where only half of the ARV need is currently being met. Moses Kamabare, the general manager of the NMS, commented that “in Uganda we have more drugs expiring than is acceptable because procurement is uncoordinated in the entire health sector”.

The expiration of such large quantities of drugs has been attributed to a rapid scale-up of ARV distribution that has not been supported by adequate growth in the number of health facilities able to redistribute the drugs, as well as ineffective supply chain management. The NMS plans to improve its internal management processes and increase information sharing between dispensing sites to reduce the value of expired drugs to US$1,000 per year.
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6.5 Effective community participation

The country research found that greater community participation in the management and monitoring of primary healthcare services could help to improve service provision, particularly in relation to the attitude of health workers. Local health committees and other structures could also help mobilise and educate the community about the range of services available at the primary healthcare centres. As one government health official from India put it: “The community should be aware of their health rights. The system is so corrupt that often during elections the local politicians turn a cow-shed into a sub centre [the lowest level primary health care facility in India] and the villagers cannot do a thing about it. The communities should be sensitised to demand sub-centres and also non-negotiable service guarantee at all levels.”

In many of the countries included in the research, community participation structures already exist. For example, Pakistan has health committees, India has village health and sanitation committees in nine states in selected areas and Tanzania has health committees at facility levels. Similarly, the research from Sierra Leone described the role of the village development committees which assist in the coordination of activities at the health facilities, including HIV and AIDS-related activities. A number of other community groups also facilitate the provision of HIV and AIDS (and related) services, including the district AIDS committees, community-based organisations, religious groups, schools and the police partnership board, whose work includes activities relating to GBV. In Nigeria on the other hand, community participation in primary healthcare was noted to be very limited. Even though village development committees exist, in practice they rarely function effectively.

The challenges of incorporating community participation mechanisms into the primary healthcare system are also recognised. Dr Umesh Chawla from the India HIV/AIDS Alliance noted that the scale of such a programme is significant, and asks a key question: “How to get voices of so many people into a programme [in a way] that is digestible, understandable and workable?” Furthermore, even once community participation programmes are developed and committees created, it still does not guarantee actual community participation. In some cases, while community participation is taking place, its potential impact on the design, management and monitoring of services at primary healthcare level is currently not being fully realised because of a lack of resources. The Ugandan report provides examples where a management committee is doing good work, but could do more. A nursing officer in Lira district stated that: “There is a management committee and they supervise the health centre. Even last week there was a meeting because some staff had started absenting themselves. The meeting is supposed to be monthly, though because of poor funds it is usually not possible.”

Furthermore, to ensure true participation, the membership of committees needs to accurately reflect the diversity within the community. The Tanzanian research found that health committees are not voted in, do not have voting rights and often do not include female members or people living with HIV and AIDS. Similarly, the Indian report found that gender and caste often limit participation of particular groups of people and highlighted that: “Even when committees are formed, the majority of the members are local government officials, politicians or members of the facility itself. The corollary to this situation is that the members of the community rarely hear of such committees, let alone participate in the management.

“The mobilisation of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to addressing social inequalities and determining priorities for action.”

World Health Report, 2008
6.6 Recommendations

- National governments should ensure that the delivery of primary healthcare services meets the needs of the community, including people living with HIV and AIDS where appropriate, by ensuring the provision of:
  - enough skilled male and female health workers, by improving the working conditions, providing adequate remuneration, ensuring appropriate accommodation, providing sufficient training for health workers and where necessary developing targeted education policies to recruit more female health workers;
  - adequate infrastructure and equipment, by making the appropriate investments in primary healthcare;
  - a continuous supply and delivery of essential medicines, and basic equipment such as gloves and syringes, particularly in rural communities, by developing effective supply chain management systems;
  - the necessary resources and legal and policy framework, to enable representative and meaningful community participation.

- National governments should revise or implement policies to treat, train and retain health workers, in accordance with the WHO’s strategy.

- National governments should ensure the monitoring of health workers at the primary healthcare level and introduce sanctions where necessary.

- Donor governments should ensure that their health worker recruitment policies and practices do not contribute to or worsen the health worker shortage in developing countries. They should also develop means to compensate developing countries for the cost of training health workers who have then been recruited to work in the health sector in developed countries.
7 Conclusion

With only one year to go until 2010, the policy makers, health workers and community members that participated in this research have identified significant shortcomings in the provision of HIV services across the research countries. In order for all of the people affected by HIV and AIDS to have access to essential HIV, SRH and GBV response services, functioning health systems are required in developing countries, particularly primary healthcare facilities and services.

To facilitate this, greater investments in the health system, with a focus on primary healthcare, are essential. Moreover, in the broader context of limited resources and the current financial crisis, available resources must be directed where they are most needed, through effective policy, appropriate service design and efficient service delivery.

The changes in funding, policy and service provision need to respond specifically to factors that determine whether or not people affected by HIV in developing countries access primary healthcare services. Furthermore, attention needs to be directed at the poorest and most vulnerable, in this case those living in rural communities, and must respond to the specific needs of women and girls. In summary, although there remains much more to be achieved if the international target of universal access to HIV prevention, treatment, care and support is to be met by 2010, there is also a lot at stake, not least the million lives that could be saved and the three million new HIV infections that could be prevented.
8 Recommendations

Overarching recommendations

Governments, donors, and international organisations should:
- recognise that investment in primary healthcare is key to meeting the target of universal access to HIV and AIDS services;
- prioritise primary healthcare in health system strengthening initiatives;
- recognise that each country’s situation on HIV and health is unique, and design or support services tailored to that unique context, rather than taking a one-size-fits-all approach.

(a) Recommendations for national government: investment

National governments should honour their health commitments, including universal access to HIV and AIDS services, by:
- increasing investment in health systems, particularly primary healthcare, in line with the Abuja Commitment where relevant;
- developing macro-economic plans that will enable them to scale-up primary healthcare provision;
- improving monitoring and evaluation systems to ensure that all funding invested in the health system is allocated as effectively as possible;
- ensuring representative community participation in decision making on health budgets to increase transparency and accountability;
- ensuring funds are released in a timely manner, at all levels of the health system, to allow for effective planning and distribution of funds.

(b) Recommendations for national governments: policy design and implementation

National governments should:
- review and revise policy based on the recognition that primary healthcare provision is essential to meeting the target of universal access to HIV and AIDS services;
- ensure that all health policies are based on sound evidence and have been developed after meaningful consultation with representative community groups, including people living with HIV and AIDS, women and poor people;
- ensure that all health policies are based on a robust analysis of the ways in which women are vulnerable to ill health and the barriers they face in accessing healthcare, developed after meaningful consultation of women, including women living with and affected by HIV and AIDS;
- integrate HIV and AIDS policy with national health policies, particularly those relating to primary healthcare, SRH and GBV;
- ensure that policy developments are supported by the necessary staff capacity and resources to implement the policies effectively;
• monitor and evaluate the implementation of policy and take action to improve the process where necessary.

(c) Recommendations for national governments: service design

National governments should:
• review and revise service design based on the recognition that primary healthcare provision is essential to meeting the target of universal access to HIV and AIDS services;
• provide primary healthcare that is:
  – comprehensive, integrated and of a high quality
  – gender sensitive
  – located close to the community
  – appropriately distributed across rural and urban areas
  – affordable
  – linked to higher levels of the health system through effective referral mechanisms
• regularly monitored, evaluated and improved.
• improve rural health services in particular, through increased investment, the recruitment and retention of trained health workers, the provision of mobile services and exploring the use of innovative healthcare delivery methods, such as telemedicine;
• provide an adequate level of training in gender issues for health workers, including recognising and responding to signs of gender-based violence;
• provide stigma and discrimination training for health workers, and enact and enforce laws which prevent stigma and discrimination in the health system as well as in other spheres.
(d) **Recommendations for national governments: service delivery**

National governments should:

- ensure that primary healthcare services are able to meet the needs of the community, including people living with HIV and AIDS where appropriate, by ensuring the provision of:
  - enough skilled male and female health workers, by improving the working conditions, providing adequate remuneration, ensuring appropriate accommodation, providing sufficient training for health workers and where necessary developing targeted education policies to recruit more female health workers;
  - adequate infrastructure and equipment by making the appropriate investments in primary healthcare;
  - a continuous supply and delivery of essential medicines, and basic equipment such as gloves and syringes, particularly in rural communities, by developing effective supply chain management systems;
  - the necessary resources and legal and policy framework, to enable representative and meaningful community participation.
- revise or implement policies to treat, train and retain health workers, in accordance with the WHO’s strategy;
- ensure the monitoring of health workers at the primary healthcare level and introduce sanctions where necessary.

**Recommendations for aid donors**

Aid donors should:

- provide more funding for health systems as part of reaching 0.7% of GNI in aid;
- Meet their Paris Declaration commitments to provide long-term, predictable, coordinated funding, and commit to more ambitious targets to improve the quality of their aid in 2011 at the Fourth High Level Forum on Aid Effectiveness;
- untie their aid to IMF loan arrangements, giving developing countries full ownership of their macro-economic plans so that citizens and governments can openly debate the costs and benefits of scaled-up health provision;
- ensure that their health worker recruitment policies and practices do not contribute to or worsen the health worker shortage in developing countries. They should also develop means to compensate developing countries for the cost of training health workers who have then been recruited to work in the health sector in developed countries.
Recommendations for international organisations and initiatives

- The World Health Organization (WHO) should continue to champion primary healthcare in the international arena and persuade donor governments and developing countries to put a greater emphasis on PHC in their health and HIV strategies.

- The WHO should develop guidelines for what HIV and AIDS, SRH and GBV response services should be available at primary care level.

- The International Monetary Fund should ensure any advice it provides to developing countries is based on country specific information, rather than global averages, and reflects the commitments to improving healthcare that governments have already agreed to.

- International coordinating mechanisms and efforts, such as the IHP+, should work with developing countries to ensure that health plans include a strong focus on primary healthcare as a means to deliver HIV services, and reach out to women, the poor and other marginalised groups. This should be achieved through ongoing meaningful community and civil society participation.

Recommendations for civil society

Civil society should:

- work with communities to put pressure on governments to promote and respect the health commitments they have made;

- where possible, monitor government spending through budget tracking, to ensure effective and adequate spending on health, particularly primary healthcare, and HIV;

- invest time and resources in building communities' awareness of community participation structures in order to increase their meaningful involvement in the design, management and monitoring of primary healthcare services.

International non-governmental organisations should:

- implement practices that contribute to building public health systems. The NGO code of conduct for Health Systems Strengthening may provide useful guidelines. http://www.ngocodeofconduct.org/pdf/ngocodeofconduct.pdf
Appendix

Research sites by country

India
- Villupuram district, Tamil Nadu state
- Gadchiroli district, Maharashtra state
- Belgaum district, Karnataka state
- Shimboga district, Karnataka state
- Muzaffarpur district, Bihar state
- Patna district, Bihar state
- Ganjam district, Orissa state

Nigeria
- Kaltungo local government area, Gombe state
- Yamaltu local government area, Gombe state
- Oredo local government area, Edo state
- Esan West local government area, Edo state
- Rafin Zuru district, Zuru local government area, Kebbe state
- Rikoto district, Zuru local government area, Kebbe state
- Sakaba local government area, Kebbe state
- Essien Udim local government area, Akwa Ibom state
- Oron local government area, Akwa Ibom state

Pakistan
- Peshawar city, North West Frontier province
- Mansehra, North West Frontier province
- Faisalabad, Punjab province
- Multan, Punjab province
- Sukkur, Sindh province
- Karachi, Sindh province
- Turbat (recently renamed Kech district), Baluchistan province
- Quetta, Baluchistan province

Sierra Leone
- George Brook Community, Freetown, Western area
- Ogoo Farm Community, Freetown, Western area
- Allen Town Community, Freetown, Western area
- Bo Town, Bo district, Southern province
- Tikonko Community, Bo district, Southern province
- Sahn Community, Bo district, Southern province
- Blama Community, Kenema district, Eastern region
- Kpeteme Community, Kenema district, Eastern region
- Kenema Town, Kenema district, Eastern region
- Senekedugu Community, Koinadugu district, Northern region
- Yagala Community, Koinadugu district, Northern region

Tanzania
- Newala district, Mtwara region
- Pemba Island, Zanzibar
- Mikuranga district, Pwani region
- Singida Rural district, Singida region
- Kibaha district, Coast region

Uganda
- Bundibugyo district, Western region
- Mityana district, Central region
- Lira district, Northern region
- Pallisa district, Eastern region
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