A gateway for capacity development

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Fighting disease or strengthening health systems?

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The road to Busan

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The Fourth High Level Forum on Aid Effectiveness will take place in Busan, South Korea later this year. How will the question of capacity development be addressed in the forthcoming debates?

Since 2003, the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) has organised three forums to assess the effectiveness of development aid. The fourth, which will take place between November 29 and December 1, will be a political, multi-stakeholder event with up to 2000 participants from over 150 countries.

Organisers would like it to mark a milestone in international development cooperation and represent a culmination of the collective efforts of donors, partner countries and other stakeholders to tackle the question of managing the aid process. But how and where will capacity development feature in the forthcoming debates on aid effectiveness?

Certainly, capacity development will be one of the themes being debated in Busan, and one of the questions being tackled will be how to forge a South–North consensus on approaches to capacity development – a question that no one is naïve enough to believe will be easy to answer.

A stronger Southern voice

Over the past two years, a partnership comprising the OECD, the Learning Network on Capacity Development (LenCD) and a nascent Southern political advocacy group, CD Alliance, has been working with other partners to highlight priority areas. Their aim is to move the capacity development agenda from the donor–donor discussion that has characterised it over the last 50 years to an agenda with a stronger Southern voice – perhaps even the voice of leadership. Key to this partnership has been Talaat Abdel-Malek, senior economic advisor to the Egyptian Minister of International Cooperation. Dr Abdel-Malek is co-chair of both the CD Alliance and the Working Party on Aid Effectiveness (WP-EFF), the body tasked with organising the Busan process.

This partnership is not the only group intent on enlarging the circle of Southern involvement. The New Partnership for Africa's Development (NEPAD), an African Union programme, is a radically new intervention pursuing new priorities and approaches to the political and socio-economic transformation of Africa. The African Capacity Building Foundation (ACBF) has a memorandum of understanding with NEPAD to help implement the principles of the Capacity Development Results Framework. The Capacity Development for Development Effectiveness (CDDE) Facility for Asia-Pacific is implementing the Paris Declaration and the Accra Agenda there. And the Task Team on South–South Cooperation (TT-SSC) has a strong anchor in Latin America.

Together, these partners have the potential to raise the visibility of Southern perspectives in Busan, foster better support for capacity development and translate collective knowledge about capacity development into local action. More partner country ownership will foster better donor support. Capacity is the flip side of ownership – and ownership is a precondition for capacity development.

On the horizon

It is too soon yet to be clear about what to expect from Busan, but already, the principles of good capacity development have helped to influence the direction of the aid effectiveness agenda: greater partner country ownership and leadership of aid; greater donor interest in using and supporting country systems; greater attention to the strengthening of local capacity as the foundation of sustainable development action.

It is almost certain that after Busan, capacity development will be more strongly Southern-focused than before – and will present a range of political and strategic opportunities. Already on the horizon are:

- The placement of Southern leadership at the forefront of capacity development
- Agreement on a more 'joined-up' approach to capacity development – a vision, language and approach that are common to both North and South
- Greater agreement to use the principles of capacity development in all key aid agency business processes, and to encourage mutually supportive learning
- Making reforms to technical cooperation that are sensitive to capacity development
- Making sectors a primary entry point for joint approaches to capacity
- Agreement to better link capacity development thinking on fragile situations with the leadership of the g7+ International Dialogue on Statebuilding and Peacekeeping
- Reforming international donor business systems to be more in line with capacity development principles: more collaborative strategic planning and results measurement; more flexible project implementation; the sending of more resources into the field; and a reduction in agency fragmentation

Using the Busan process, it may be possible to call upon emerging Southern voices to seek more joined-up and united (North and South) learning and action in some of these areas. <

Strengthening health systems

Many developing countries have health systems that are ailing – and well-intentioned development aid is contributing to the problem. Between 2000 and 2010, annual development assistance for health surged from US$10.5 billion to US$27 billion. Most of this was channelled through donor-driven programmes targeted at specific diseases, most prominently HIV/AIDS. Such 'vertical' programming has undermined the development of strong national health systems and drawn resources away from countries' other health priorities.

This problem has been on the international agenda for many years. In 2007, the International Health Partnership (IHP) was established to put the principles of the Paris Declaration on aid effectiveness into practice in the health sector. Unfortunately, little progress has been made.

Vertical funding

In this issue of *Capacity.org* we illustrate some instances where vertical funding has drawn resources away from other diseases and health priorities and produced adverse effects. For example, Maurits van Pelt and Chean Men tell us that in Cambodia, diabetes is responsible for many deaths – but because it is a non-communicable disease, it is largely ignored by external funders. And Carolien Aantjes and Fikansa Chanda describe how vertical funds have contributed to the fragmentation of Zambia's health system, leaving it increasingly difficult for the government to manage. In Zambia, sections of health facilities have been 'taken over' by foreign-directed programmes focused on specific diseases.

One of the significant negative effects of aid is countries' internal brain drain. Wendy Johnson of Health Alliance International speaks about the dilemma faced by many NGOs. Under pressure from donors to deliver results for specific disease programmes, they find themselves forced to compete with other NGOs to recruit the best local health professionals. In doing this, they undermine the very organisations whose capacities they are supposed to strengthen. In a bid to find a way out of this dilemma, a group of NGOs drafted a code of conduct pledging to refrain from practices, including employee compensation schemes, that are harmful to developing countries. But NGOs do not have the power to change the rules of the game and such a code of conduct will work only when the big funders acknowledge that they are part of the global health system, and that only they have the power to impose 'do-no-harm' rules.

A diagonal approach

This issue of *Capacity.org* also addresses the question of what can be done at district government level and in primary health care to strengthen health systems and align vertical programmes. Such programmes can be structured to help develop the capacity of primary health care systems in a way that allows a much broader spectrum of health issues to be addressed. Thomas Gass describes how the Swiss health development organisation, SolidarMed, experimented with a 'diagonal' approach which allows disease-specific interventions to support other elements of primary health care.

District governments have a key role in coordinating the activities of all local health players, including those running vertical programmes. In his guest column, Abdul Ghaffar argues that most district health authorities are poorly equipped to take on this leadership role and that little is done to strengthen them. Peter Lochoro, Rogers Ayiko, and Giovanni Dall'Oglio describe how, in Uganda, the partnership of Italian-based organisation Doctors with Africa, Cuamm, and UNICEF engages in strengthening such systems and enhancing the leadership capacity of district health offices.

Patients as participants

One persisting weakness of health systems, particularly in remote areas, is the lack of capacity to train, recruit and retain health care workers. One way of addressing this problem is to involve patients as active participants in health systems. Thomas Gass describes how patients work as HIV/AIDS counsellors in sub-Saharan Africa. Van Pelt and Men tell how diabetes sufferers in Cambodia run networks to help others cope with the disease and to find their way through the country's complex health system.

For solutions to gain momentum at district and local levels, a change of policy and practice is needed at national and international levels. Representatives from 91 countries due to meet at the Fourth High Level Forum on Aid Effectiveness in Busan in November must surely address the huge backlog of work that needs to be done on applying the principles of the Paris Declaration to health development aid.

The big funders who signed the IHP Global Compact are ideally placed to change the rules of the game and prevent the consequences of setting narrow targets focused on a small selection of diseases. A results-oriented approach should strengthen the capacities of health systems at all levels, and Busan provides a unique opportunity to stop development aid's unwanted outcomes. It is an opportunity that should not be wasted.

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Cover photo

Lineair / Mark Edwards
Medical assistants in Ivory Coast villages take blood samples to test for the parasites that cause sleeping sickness

Exploring a diagonal approach

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Programmes aimed at fighting single diseases have helped many, but they have also weakened public health systems. This does not have to be the case. Individual disease programmes can help to develop the capacity of primary health care systems.

Health is a fundamental requirement for development. If farmers, teachers, housekeepers and nurses are ill and cannot do their jobs, it affects a community's access to nutrition, education, safe drinking water and health care – all of which can increase vulnerability to disease and lead to more illness in society. When the United Nations launched the Millennium Development Goals (MDGs) in 2000, they made a commitment to break the vicious circle of poverty and ill health by making health a priority for development cooperation. Financial development assistance for health increased from US$10.5 billion in 2000 to US$27 billion in 2010.

And considerable improvements have been made. For example, antiretroviral treatment (ART) has been introduced for the treatment of HIV/AIDS. Before ART was available in rural Africa, almost two million people died every year. Most deaths occurred at home, imposing a huge burden on families, who were frequently unable to continue paying for treatment. Often, patients were abandoned and left to die alone because primary health care networks were overstretched and hospital wards were already crowded with AIDS patients.

Changing picture

This picture has changed. ART has had a huge impact on African families, communities and society as a whole. Now that treatment is available, more and more people are ready to learn more, to talk about HIV, to protect themselves better and to show up for testing and counselling.

In parallel with this good news, a controversial debate has emerged on the drawbacks of the MDG approach and on global health policy in general. Yet critics argue that HIV/AIDS interventions absorb too big a share of the resources allocated for improving health. According to a report jointly published by the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD) and the World Bank, 32% of all official development assistance for health since 2000 has been spent just on HIV/AIDS intervention. And some countries in sub-Saharan Africa, including Kenya and Uganda, spend more than half their health budgets on alleviating HIV/AIDS.

This contrasts sharply with what is spent on, for example, acute respiratory infections. Such infections, according to an article published in the *British Journal of Medical Practice* in 2008, represent 26% of the communicable disease burden in the developing world, but attract only 2.5% of direct funding. Perhaps the strongest criticism in the debate comes from Roger England, who argued in the *British Medical Journal* in 2008 that the 'international HIV/AIDS industry' – under which umbrella he includes Western companies, consultants and HIV/AIDS bureaucracies – usurps precious resources. He even goes so far as to suggest that UNAIDS should be closed down because its mandate is harmful.

While most critics might not be prepared to go this far, there is a consensus that in their mission to achieve the health-related MDGs, global health initiatives have encouraged disease-specific or 'vertical' health programming. And there is widespread agreement that such vertical programmes have led to a fragmentation of primary health care. Staffing, equipment, infrastructure and data management have been planned, designed and allocated according to the budgets and requirements of various disease-specific programmes rather than according to the local disease burden and the requirements of the local health service providers.

Many vertical ART programmes have funded new laboratory equipment and supplies of reagent, and established protocols for laboratory-based routine monitoring of ART patients. Yet, according to one of the largest studies on antiretroviral treatment in sub-Saharan Africa, the DART Trial (Development of Antiretroviral Treatment in Africa), routine laboratory monitoring of ART patients is ineffective in settings where resources are limited – and this is so from a clinical as well as from an economic point of view. The trial highlighted instances where funding and personnel were deployed to carry out non-essential testing of HIV-positive patients who were doing perfectly well on ART, while essential diagnostic tests were not available, or affordable, for patients with other acute illnesses. The DART Trial showed that ART patients could be monitored effectively without laboratory equipment. It recommended that where laboratories and personnel are limited, they should be allocated in such a way that they deliver high-quality care to all patients, not just to those with HIV.

'Do no harm'

The human resources crisis is another sensitive area where vertical ART programmes have adversely affected health systems. Parallel management structures and monitoring and reporting schemes have diverted well-qualified doctors and nurses away from looking after patients to administer projects. A study in *McKinsey Quarterly* revealed that in Tanzania, a district medical officer spends 100 days a year writing reports for international organisations. And in his commentary in *The Lancet*, former Mozambican Minister of Health, Paulo Garrido, wrote that 'in many countries, funds are not needed specifically for AIDS, tuberculosis, or malaria. Funds are firstly and mostly needed to strengthen national health systems so that a range of diseases and health conditions can be managed effectively.'

With the aim of stemming the brain drain from the public health sector, 50 international institutions have signed the NGO Code of Conduct to 'do no harm' to public health systems – that is, to limit the unintended negative effects of their health programmes. (For more information on this, see the interview with Wendy Johnson on pages 10 and 11.)

The experiences of SolidarMed, a Swiss health development organisation, are a good example of how to put the do no harm principle into practice in primary health

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care. Long before the advent of ART, SolidarMed had been collaborating with district hospitals on primary health care development plans, targeted investments, support for nursing schools, improved housing for health workers, community-based mother and child health care, and initiatives for the prevention of malaria and tuberculosis.

SMART

In 2005, SolidarMed started running an HIV/AIDS treatment and prevention programme called SMART in ten district sites in Tanzania, Mozambique, Lesotho and Zimbabwe. The organisation learned that the key to fighting HIV/AIDS was to build the capacities of local health systems – it does not work the other way round. Certainly, managing HIV/AIDS requires money for drugs, but what is much more important is a strong health workforce, reliable health services that reach out to rural communities and adequate district health management capacities.

In an effort to mitigate the drawbacks of vertical health programmes, SolidarMed pursued three strategies:

- It integrated SMART into existing SolidarMed primary health care programmes and long-standing hospital partnerships.
- It harmonised SMART with existing HIV/AIDS programmes and brought it in line with national health policy. From the beginning, SMART was designed to complement government ART programmes and to be in line with national policy on HIV/AIDS. In memorandums of understanding, SolidarMed and district health authorities defined the terms of a harmonised and multi-stakeholder approach.
- It used some of SMART's budget lines to strengthen capacity. A number of budget lines are earmarked for general capacity building interventions, such as infrastructure and salary top-ups, that are not specifically related to HIV/AIDS services.

As a result, SMART pursues a 'diagonal' programme approach – one where ART-specific interventions are embedded in wider primary health care support. However, as the following examples show, the SMART project has been a learning experience for SolidarMed, and there have been adverse as well as positive effects on local health systems.

Outcomes

Bricks and mortar: SMART provided funding for the substantial reconstruction and renovation of hospital out-patient departments and peripheral health facilities at all ten of its sites – providing primary care to a population of roughly two million. SMART created more and better space for all patients as well as more housing for health personnel. However, extending and renovating out-patient departments have often been tailored to the particular needs of HIV/AIDS clients and patients to the exclusion of patients with other chronic diseases. Sometimes, these efforts have not anticipated the integration of treatments for HIV/AIDS and tuberculosis.

Laboratories and pharmacies: Antiretroviral treatment requires improved diagnostic means and laboratory-based patient monitoring. Upgrading laboratories with new equipment and additional staff training remains one of SMART's priorities. At some sites, this capacity building component has been beneficial for all areas of primary care. For example, the improvement of blood chemistry and haematology facilities has meant that patients suffering from anaemia now receive adequate treatment. However, in terms of the regular supply of essential chemical reagents and drugs, it is again the HIV-positive patients that benefit most from the vertical funding schemes. At times, hospitals have large quantities of antiretroviral drugs and CD4 test reagents while the paracetamol shelf in the pharmacy is empty. Also, while clients on ART are getting routine lab tests done free of charge even when they feel perfectly well, seriously ill patients not infected with HIV cannot afford a laboratory test. In 2009, in one of the SMART partner hospitals, it was noted that more than 80% of all laboratory tests performed were for HIV patients.

Human resources: ART has been a great relief not only for patients, but also for health workers. Prior to SMART, the only treatment options primary care nurses could offer AIDS patients were painkillers, antibiotics, hospital referral or registration in a home-based care project. We saw with SMART that the roll-out of ART to primary

health facilities had a positive impact on the motivation of rural health workers. Seeing patients recover from opportunistic infections, gain weight and resume their everyday lives enhanced job satisfaction. SMART also provided a wide range of training opportunities for all health workers.

In addition to various training sessions related to the clinical management of HIV/AIDS and opportunistic infections, SMART has reinforced the clinical mentoring and supportive supervision of peripheral health workers by consultants and district hospital outreach teams. By investing in buildings, furniture, equipment and means of transport and communication, SMART has had a positive impact on working conditions – a key factor in attracting and retaining personnel. Unfortunately, the positive effects of SMART on the health workforce are undermined by severe staff shortage in remote areas. In understaffed areas, the decentralisation of ART and the steadily growing number of patients is a heavy burden on the small numbers of health workers struggling to provide essential primary health care with extremely limited resources.

Maternal and neonatal health: The roll-out of antiretroviral treatment has had both positive and negative effects on maternal health. On the positive side, pregnant women now have free access to HIV testing and counselling, and if they test positive, they can protect their babies from HIV infection. The care and treatment of babies exposed to HIV/AIDS has been an important focus at all SMART sites. As a result, the general quality of paediatric primary health care has improved. Also, because one in five maternal deaths globally is attributable to HIV/AIDS, ART programmes have a direct effect on maternal health.

SolidarMed observed that in Chiure in north-eastern Mozambique, where large parts of the SMART budget went to strengthen the local primary health care system, the programme has prompted more women to give birth in a health facility rather than at home. The percentage of births attended by skilled health personnel increased from 28% to 72% during the course of the programme.

The Chiure experience was not replicated throughout all SMART sites though. It has always been an objective of SMART to prevent the transmission of the HI virus from an HIV-positive mother to her baby. To this end, SMART promoted HIV testing and counselling as part of antenatal care as well as the prophylactic antiretroviral treatment of both mother and baby. Yet, at many SMART sites, such vertical measures have had little effect on maternal and neonatal health in general. Many women are still dying during pregnancy and childbirth, and infants are still dying from neonatal complications. A comprehensive package of emergency obstetric care is an imperative for maternal health, but ART programmes may have diverted scarce resources away from maternal and reproductive health to HIV/AIDS services.

Tuberculosis: In sub-Saharan Africa, HIV/AIDS has caused a massive spread of tuberculosis (TB). This is because TB is the most frequent opportunistic infection among AIDS patients, and the most common cause of death. Despite knowing that the two diseases were so closely interlinked, SMART missed the chance to pursue a collaborative approach in the early stages of the programme. Only recently has training on HIV/AIDS included the management of TB. TB patients are tested for HIV and people living with HIV/AIDS are screened for TB. To date, across the SMART sites, one in ten ART patients receives TB treatment as well. This is a proportion that is well below the expected case load of co-infected patients. From what is now known as a result of the SMART programme, starting to treat TB and HIV concurrently can have a positive effect on the quality of clinical care.

Community health workers: Because there is a chronic shortage of doctors and nurses and because ART has been extended into the primary health care arena, lay members of the community have become involved in prevention and first contact health care. These community health workers have attracted growing recognition as an integral component of the health workforce. In the past, community health schemes had proved unsustainable because of a lack of support, supervision and training. But more recently the WHO, in collaboration with the Global Health Workforce Alliance, has reviewed the concept of community health workers and issued recommendations on how to integrate them into health systems.

Recent studies show that community health worker schemes have considerable

	Births	Proportion
2006	2588	28%
2007	3604	39%
2008	4946	54%
2009	5786	63%
2010	6684	72%

Source: SolidarMed, based on data from the Mozambique Ministry of Health

Table 1 – Births attended by skilled health personnel in Chiure District, Mozambique between 2006 and 2010

SMART outcomes

- Approximately 200,000 clients tested (including pregnant women)
- 15,800 patients on treatment (8% of whom were children)
- 21% of patients decentralised to primary health facilities
- 72% of patients retained on ART
- Just 28% of ART patients dropped out or died

Health-related MDGs

Three MDGs address health and illness directly: MDG 4 and MDG 5 aim to improve the health of mothers and children. MDG 6 targets the fight against HIV/AIDS, malaria and tuberculosis. Other MDGs are indirectly related to health. For example, MDG 1 is aimed at fighting malnutrition – an underlying cause in one out of three child deaths. Health is also a key aspect of environmental sustainability (MDG 7). In many low-income countries, drinking-water and sanitation facilities are so poor that diarrhoea remains a leading cause of childhood illness.

With only five years to go on the MDG countdown, there is both good news and bad news to report.

On the positive side, it can be reported that:

- As a result of immunisation coverage in 81% of countries worldwide, the annual number of child deaths from measles dropped from 733,000 in 2000 to 164,000 in 2008.
- Antiretroviral treatment (ART) has now reached more than 5.2 million people living with HIV/AIDS, the majority of whom live in sub-Saharan Africa. Globally, 35% of those in need now receive ART.
- Malaria initiatives have resulted in 71% children under five in sub-Saharan Africa sleeping under mosquito nets. And as a result of the scaling-up of artemisinin-based combination drugs, the coverage of malaria treatment has substantially improved.

However, there is also some bad news:

- Of all the MDGs, least progress has been made in maternal and neonatal health – particularly in sub-Saharan Africa, where 52% of all maternal deaths occur. Globally, 940 women die every day during pregnancy or delivery. More than half of these deaths are due to preventable and manageable haemorrhage and hypertension. In sub-Saharan Africa, the poor health of mothers means that 880,000 babies are stillborn every year, and more than 1.2 million die during the first 30 days of their lives.
- In contrast to the progress made in the fight against measles, other preventable and treatable diseases still kill more than 24,000 children under five every day. In sub-Saharan Africa, one child in seven dies before their fifth birthday – most commonly from pneumonia, diarrhoea, malaria or AIDS.
- The HI virus is still spreading: In 2009 alone, 2.6 million people were newly infected, 72% of them in sub-Saharan Africa. For every two individuals who start ART, five people are newly infected – and 40% of the new infections occur in the 15-24 year age group.


Hollandse Hoogte / Deloche

SMART's impact on health systems		
	Positive	**Negative**
Primary care delivery	• HR developed • Infrastructure improved • Equipment provided • Quality of care enhanced • Facility utilisation improved • Health centres strengthened • Health centres supervised	• HR support not embedded in a plan • Off-site training caused absenteeism • More advantages given to SMART staff and patients • Lab equipment used primarily for HIV/AIDS patients • Data management capacity building exclusively for HIV/AIDs patients
Community health	• Community health workers mobilised • Health promotion supported • Community initiatives promoted	• Community schemes fragmented by inconsistent remuneration • Ineffective competitive performance
Health system management	• Supply-chain management enhanced • Mentoring and support revitalised • Health information system improved • Leadership strengthened	• HR training fragmented and inefficient • Competition for 'sitting allowances' • Parallel schemes for budgeting, reporting, and monitoring and evaluation • Parallel outreach and supervision undermined district teams • Geographical focus limited

Table 2 – SMART's impact on health systems

potential. For example, a systematic review concluded that a combination of outreach and community care could reduce neonatal mortality by 37%. A report in *The Lancet* in 2007 showed that regular contact (18 visits over five years) between community health workers and mothers and their children during the first five years of the children's lives was the most effective preventive intervention in ensuring survival of children under five. Community health workers can also improve the survival prospects of severely ill children by administering basic case management before referral to hospital. Two million children die of pneumonia every year. A study published in the *Bulletin of the WHO* in 2008 concluded that community case management of pneumonia by community health workers is a feasible, effective strategy to complement facility-based management.

Lay health workers and 'expert patients' – ART patients volunteering as HIV/AIDS counsellors – have become driving forces in the decentralisation of SMART. In Zimbabwe, SMART collaborates with the NGO Batanai, which runs community-based advocacy, training and service programmes for people living with HIV/AIDS. SMART and Batanai have established a network of village-based community HIV/AIDS support agents, who are ART patients themselves, and who provide adherence counselling and facilitate mutual support between patients. These support agents have a unique role in linking communities with first contact health facilities. In Lesotho, SMART trains and pays the salaries of HIV lay counsellors who have no medical background, but are based at rural health clinics to help with HIV/AIDS clients and patients. Carefully recruited, trained and supervised, they are becoming an important pillar of primary health care that extends beyond simply providing antiretroviral treatment.

Assessing local impact

The impact that SMART has had on local systems of primary health care is difficult to assess. Its effects over the years have been both positive and negative, and while many of the consequences were desired outcomes, some were unintentional and unanticipated. We also need to examine the extent to which non-HIV/AIDS patients have benefitted from SMART's substantial investments in HIV/AIDS treatments.

The impact of SMART on the local health system has not been systematically evaluated yet. Its monitoring and evaluation efforts have been largely focused on the outcome of ART projects. SolidarMed visualises a health system comprising three interlinked domains. First, the delivery of primary care services through district hospitals and primary health care facilities; second, the realm of various kinds of community-based health activities; and third, a health system management scheme that is under the leadership of the district health authorities.

The table above proposes a structure for discussing possible impacts of disease-specific programmes such as SMART on the local primary health care system.

Relaunching primary health care

Of the 22.5 million people living with HIV/AIDS in sub-Saharan Africa, about ten million have reached an advanced stage and need ART. Despite steady up-scaling, 65% of the patients in urgent need of ART do not have access to it – some are not even aware they are HIV positive. And many more people who have been newly infected will need the treatment in the near future. This backlog of patients in need of treatment is a colossal challenge for fragile local health systems in rural Africa. The SolidarMed experience shows that decentralised ART provision works only when it is based on the foundation of a solid primary health care system, one where the health workforce – doctors, nurses and community health workers – is the core element.

Primary health care is multidimensional. It depends on self-determined community capacities, strong and durable infrastructure and equipment, and the comprehensive management of health workers, supply chains and health data systems. There is now a consensus between governments, civil society and global health initiatives that health systems should be people-centred rather than disease-centred.

A number of international organisations have adapted their funding criteria to accommodate disease-specific interventions that also strengthen the horizontal system of primary health care. In 2008, the WHO relaunched primary health care as one of the guiding principles of global health. In a reworking of the Alma-Ata Declaration, the WHO proposed health care reforms that would:

- Give universal access and social health protection
- Provide people-centred services
- Incorporate community-based public health policies
- Encourage participatory health management

A primary health care approach to ART will have to deal with growing numbers of patients. And in order to prevent resistance to antiretroviral drugs from developing, it will also have to ensure quality of care and ensure that patients on ART adhere to the treatment programme. At the same time, if ART programmes are designed in a diagonal rather than in a vertical way, primary health care will also benefit. <

Thanks to Jochen Ehmer of SolidarMed for his valuable contribution to this article.

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Applying the Paris Declaration to Zambia's health sector

Case study – Zambia

Earmarked and vertical funds are often at odds with commitments to strengthen health systems. Can such funding be tweaked to prevent a negative impact on health systems?

In 2007, a concerted international effort was made to rationalise the way in which health development aid was being deployed and to ensure that the health-related Millennium Development Goals (MDGs) would be reached.

More than 20 governments, bilateral and multilateral partners, and donor organisations such as the Bill and Melinda Gates Foundation, came together to reform the ways in which they delivered and managed aid. Calling themselves the International Healthy Partnership (IHP), the partners signed a global compact that was to be a key step in putting the Paris Declaration on Aid Effectiveness into practice in the health sector. The emphasis was to be on building and using recipient countries' own health systems and fostering harmonisation to reduce fragmentation and the duplication of donor aid.

But have such efforts proved effective? This article looks at Zambia's health system, as it was in 2008 and again as it is today, to see if a synergy now exists between disease-specific projects and the strengthening of the country's overall health system.

Donor funding constitutes a significant portion of health financing in Zambia. In 2007, Official Development Aid made up 32% of the total health budget. Government allocation of public expenditure for health increased from 7.5% in 2005 to just over 11.5% in 2008 – still far short of the 15% to which African heads of state committed in Abuja in 2001.

Midterm review

A midterm review of Zambia's National Health Strategic Plan 2006–2010 was carried out in 2008. The review was led by a senior consultant from ETC Crystal. Carolien Aantjes, one of the authors of this article, was a member of the multidisciplinary review team. It was found that there was still much to be done to put the principles of the Paris Declaration into practice in terms of donor support. Some donors – among them the Dutch government – provide budget support under a sector-wide approach, others earmark their funding, and some do both. The midterm review revealed that most of the health budget came from earmarked funds.

This situation was further compounded by the large funds from the various global health initiatives that were set aside for programmes targeting specific diseases. These initiatives included the Global Alliance for Vaccines and Immunisation (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, the Clinton Foundation and the World Bank Booster Program for Malaria in Africa. Calculating funds from PEPFAR and GFATM alone, public per capita expenditure rose from US$11 to approximately US$34 between 2004 and 2006.

Earmarked funds caused serious distortions in funding priorities in Zambia. The global health initiatives overloaded government systems and structures with their separate planning processes, financing, implementation, accounting and reporting systems – none of which was necessarily linked to strengthening the country's National Health Strategic Plan. The proposal-writing processes caused similar frustration. Out of seven comprehensive attempts to secure GFATM funding, the Zambian health ministry was successful with just three.

Some direct funding agencies had carved up the country into geographical zones, balkanising the health sector. They withheld information on these activities from government and other actors in the sector, thereby increasing the duplication of efforts. And in addition, global health initiatives attracted scarce skilled health workers away from priority areas such as reproductive health, children's health and nutrition.

The diversification of donor instruments also changed the financial support mechanisms for public and private actors in the Zambian health sector. Donors such as USAID, PEPFAR, the World Bank and GFATM provided significant support to vertical programmes and to faith-based organisations, non-governmental organisations, community-based organisations and the private sector. As a consequence, the private not-for-profit sector was able to increase its support to the health sector. But the other side of the coin was that reporting and monitoring and evaluation overheads contributed to an increased workload at district, provincial and

Types of funding

There are two broad categories of funding – earmarked funding and basket funding (also known as sector budget support). Earmarked funds are provided for very specific interventions or items such as drugs and vaccines. This funding comes with its own application procedures, timetables and monitoring requirements. It often bypasses the policy and coordination processes of the recipient country because it rarely addresses priorities across a sector. Excessive earmarking leads to fragmentation in a health system and undermines countries' capacities to lead a development cooperation process. Earmarked funds are often seen as being at odds with the principles of the Paris Declaration, which advocates alignment, harmonisation, management for results, mutual accountability and ownership.

With basket funding, development agencies pool their funding for a particular sector into a joint bank account. This is then channelled directly to particular ministries, rather than going through the accounts of the finance ministries in the recipient countries. Basket funding often goes hand-in-hand with sector-wide approaches (SWAps). A SWAp is a partnership between governments and development agencies which allows project funds to be tied to a specific sector and sent directly to that sector. The aim is to provide all or a major share of funding for that sector as part of the government's unified policy and expenditure programme. This strengthens government ownership and leadership. SWAps were introduced in the 1990s because development agencies were being repeatedly criticised for each funding their own self-contained projects, leading to fragmentation and duplication. SWAps are more in line with the principles of the Paris Declaration.

national levels, and coordination became more problematic.

Urban health facilities in particular were so overrun by externally managed and funded programmes that provincial and district managers often no longer knew what was happening in their facilities. The coordination of the myriad HIV/AIDS initiatives proved difficult for the health ministry because of its limited capacity and the fact that some programmes did not seek to be coordinated or streamlined into the existing health service.

The midterm review also demonstrated that the expansion of services, particularly free services, had created an overwhelming demand and moved the congestion from hospitals to the AIDS service delivery points. This was seen as compromising the overall quality of care and the assurance of proper case management because the time per patient was severely reduced. The Zambian Network of People Living with HIV/AIDS reported that up to 70% of patients faced waiting times of more than three hours, and that 66% did not regularly go for essential testing. Links between the various services had been built, but tended to be one-way. For example, the antenatal clinic would refer an HIV-positive patient to the antiretroviral treatment (ART) clinic, as would the tuberculosis (TB) clinic for its patients. But the ART clinics did not routinely refer their patients to sexual and reproductive health services or for TB screening. The review concluded that there was still much room for improvement in the areas of integration and offering a comprehensive health package to the patient.


Reuters / Thierry Roge

A Zambian health care worker tests for malaria

Progress since 2008

Now, three years on, has anything changed? Has Zambia's health system been strengthened and is the way funding is being deployed resulting in better integration and a harmonisation of donor assistance? Below are two examples of 'diagonal' programming under which vertical funding for HIV/AIDS has been used to benefit the broader health system in Zambia.

The Churches Health Association of Zambia (CHAZ) is a national network of mission hospitals and health centres, operated by sixteen churches. It provides approximately 30% of Zambia's health services. GFATM and PEPFAR provide funding to CHAZ as part of the AIDS relief programme executed by Catholic Relief Services (CRS). This funding is assisting in the renovation of laboratories and pharmacies and is helping to purchase essential equipment.

Certainly, better labs, pharmacies and equipment have accelerated access to ART for HIV-positive Zambians – and at the same time they have helped to strengthen health institutions' capacity to investigate and treat other medical conditions.

Public health institutions in Zambia have also been supported to upgrade their structures. Family Health International (FHI), has used PEPFAR funding to renovate laboratories, pharmacies and counselling rooms and procured laboratory equipment in seven provinces. It has also been assisting in improving the data management capacity of health facilities, the integration of HIV/AIDS services with other clinical areas, the coordination between health facilities and community health services, and in developing the capacity of the workforce.

Yet despite these and other examples of successful diagonal programming, the Zambian picture does not show dramatic improvement since the midterm review in 2008. This is particularly the case in terms of donor harmonisation and alignment, two of the key principles of the Paris Declaration. Funding structures have remained vertical. International organisations and funders decide on allocations and priority areas in reference to the national strategic framework on HIV/AIDS. There is no initial joint planning between the ministry and international organisations such as FHI and CRS, which are implementing the diagonal programmes discussed above.

A new mindset

On a positive note, the international debate on disease-specific programmes versus health system strengthening seems to have influenced a shift in thinking. Partners are more aware that integrating HIV/AIDS services and strengthening the health system are both priorities.

The decision to invest in the health system and to institutionalise country-led responses has been agreed in the 2011–2015 partnership framework between the governments of Zambia and the United States. The partnership between the Zambian government, GFATM, PEPFAR, FHI and CRS has now resulted in the establishment of permanent positions for among others, psycho-social counsellors and data clerks, within the ministry. While planning and budgeting remains vertical, there is much more integration at the health facility level. The transfer of skills from international non-governmental organisations to staff at the health ministry and CHAZ is being carried out successfully. Laboratory equipment, such as haematology analysers, is being used not just for HIV testing, but for a wide range of disease investigations.

Now that donor policies are explicitly stating the objective of strengthening the health system, those implementing them have more leeway to use the funding beyond the scope of one or two diseases. So there has been modest progress. However, much remains to be done to harmonise efforts, to build a more robust health system, and to implement aid effectiveness principles in Zambia. <

Further reading

- Topp, M., et al. 2010 Strengthening Health Systems at Facility-Level: Feasibility of Integrating Antiretroviral Therapy into Primary Health Care Services in Lusaka, Zambia. In *PLoS ONE* (5)7:e11522.

Giving substance to pretty words

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Promoting 'country ownership' in aid-dependent countries is central to the debate on aid effectiveness – but global health initiatives have often encouraged the opposite. In 2008 a code of conduct was drafted to address this trend.

Since the 1990s, the dramatic expansion in the amount of development aid being donated to the health sector has enabled undeniable progress in many areas – and not least in the fight against HIV/AIDS. But there is a fear that aid programmes can undermine national health systems in the long term.

The 2008 NGO Code of Conduct for Health Systems Strengthening asked international non-governmental organisations (NGOs) operating in the health sector in developing countries to scrutinise their practices. The organisers behind the code of conduct were concerned that some NGO practices, such as paying high salaries in low-income countries and luring qualified people away from national health systems, might actually weaken the management capacity of health ministries.

The management burden of government health systems has been increasing rapidly, partly as a result of the myriad health initiatives led by the NGOs – each of which requires health ministry attention. The drafters of the code of conduct realised that unless something changed in the way international health NGOs operated, their achievements would be overshadowed by the harm being done to countries' own capacity to provide health services.

Capacity.org talked with Wendy Johnson, director of new initiatives with Health Alliance International (HAI), who was one of the architects of the code of conduct.

Wendy, what motivated you to become involved in drafting the code of conduct?

Anyone who has worked in low-income countries where there is a large concentration of NGOs has seen how they compete for small pools of highly trained local staff and health personnel. I saw this in Mozambique, where the Ministry of Health cannot compete with the salaries that NGOs offer. So you get a brain drain of doctors, nurses and other clinicians from front-line ministries and local institutions to the non-governmental organisations.

Because they do not go abroad, this internal brain drain is not reflected in data on the migration of health workers. And to make matters worse, professionals that move to NGOs generally leave clinical or public health jobs for project administration positions, and most never go back to the national health systems.

When it comes to building local capacity, this brain drain is a huge problem. Building capacity means ensuring that health ministries can work efficiently – and for this, they need trained professionals. I can understand the pressure that NGOs are under from donors to provide results quickly. Their argument is that they compete with other organisations who pay high salaries, so they have to pay high salaries too. And they do not want to bring in expats to do the work; they want to work with local people.

I am sympathetic to that and understand that the various principles can be at odds from an individual NGO's point of view. However, the whole system gets subverted as a result of this salary 'arms race'.

The 22 initial signatories of the code of conduct were all engaged in capacity building and in partnerships with local institutions. They struggled with these issues and developed solutions that were not really getting well publicised. So we thought that a code of practice, (which included the practices that NGOs should try to avoid), might help other groups to find a way of doing some non-traditional work in health development that would help to build capacity in the long term.

Not all of those involved in drafting it became signatories to the code of conduct. Some organisations felt that they could not comply with a number of the articles, particularly those that dealt with human resources. We did not want to write a code of conduct that was so general and vague and non-specific that everyone could sign up comfortably and feel good. We wanted to be a bit more challenging about the way we wrote it – to really make NGOs think about the way they operate in developing countries.

Which parts of the code of conduct were the most controversial and made the NGOs reluctant to sign?

Article 2 says that 'NGOs will enact employee compensation practices that strengthen the public sector'. In that article signatories pledge to 'attempt to create pay structures that acknowledge differences in expertise and training, irrespective of the employee's nationality'.

Article 1 was also an issue for some people. Section 1 of this article says that 'in areas where trained personnel are scarce, NGOs will make every effort to refrain from hiring health or managerial staff away from the public sector, thus depleting ministries and their clinical operations of talent and expertise'.

NGOs argue that if they are to follow the labour laws in, say, Mozambique, they have to treat everybody who applies for a job equally. The law requires that they advertise everything locally before advertising it internationally. So if they find a qualified Mozambican, they are obliged to employ that person.

Although I believe there are solutions to these dilemmas without skirting countries' labour laws, I acknowledge that these are valid issues. Of course we cannot discriminate against local staff in our recruitment practices. But health NGOs can work to support salaries and programmes within the ministry structure.

Do you supervise whether NGOs adhere to the code of conduct, and do you monitor what impact it has had?

The code of conduct does not have an enforcement mechanism. There are codes of conduct that, while not legally enforceable, are so widely accepted that non-compliance would cause embarrassment. But this code of conduct has not acquired that status.

A year after we launched the code of conduct, we conducted a survey to find out whether it was being adhered to. We did not find that health NGOs had changed their practices because of the code of conduct. But that was because the organisations that had signed up were the ones that had already

Bill and Melinda Gates visit a hospital in Mozambique

been committed to what the code of conduct advocated.

It is not the case that all the non-governmental organisations who have signed up adhere one hundred percent to the code. Rather, those who sign up like to find innovative ways of getting close to complying with the code. What was valuable in the early stages was the sharing of information and insights as part of the drafting process. The result is a knowledge product. The code of conduct functions as a way of publishing some of these practices in a way that would not have happened otherwise. So although we do not have hard evidence that it changed practices, I do believe it is a valuable resource for NGOs that want to engage in creating similar policies and procedures.

Who can sign up for the code of conduct and how do they go about it?

The code of conduct was originally meant for international health NGOs. However, donors and local non-governmental organisations can sign up to it too. Initially, local NGOs were seen as victims of the internal brain drain because they were affected in the same way as their governments. Now many of these local NGOs have become sub-contractors for large international NGOs. The lines have become blurred.

There is a place on the website where local NGOs can apply to become signatories.

How about donors like the Bill and Melinda Gates Foundation? Could such a donor sign up to the code of conduct?

If an international institution such as the WHO or a big donor like the Bill and Melinda Gates Foundation signed up to the code of conduct, it would have a tremendous impact. These big organisations could, for example, demand that all their grantees sign up too. That would really shift the code of conduct from being a knowledge product to becoming a real tool to measure the performance of NGOs.

It would be incredibly valuable even if they were to take the code of conduct and adapt it for themselves. We had some interesting discussions early on with USAID and the International Health Partnership, but unfortunately it never got to the level where they adopted the code of conduct as part of their policy.

The core problem is that while everybody talks about country ownership, donors lack the substance to really change practices. I was working in local public health here in the United States until about 2004, before moving to work in global health. In that time, I have seen the problem getting worse rather than better. There is a lot of talk about strengthening health systems. And there is a lot of talk about building local capacity. But as I see it, it is the big international NGOs – which are getting bigger all the time – who really benefit from the influx of dollars that goes to global health.

In contrast, I was talking to a friend who was taking care of a sick friend in Ethiopia last month. Ethiopia receives about $US400 million a year in development health aid from the United States – yet there is no X-ray machine in the national tuberculosis hospital.

In the countries in which I have worked, I am not seeing a growth in capacity in the public sector. Perhaps there is a little bit more of it in local institutions, but from where I am standing, the public sector still looks pretty anaemic. If the goal is building local capacity, I personally do not see the results in any kind of measurable way.

The challenge for those of us who care about strengthening health systems is to start thinking about how to measure those results. Pretty words such as 'country ownership' and 'local control' are all very well, but the code of conduct offers an opportunity to see what these would really look like in practice. We need to be more serious about shifting development work from charity to a model of solidarity, with the building of local capacity as our primary goal. <

Interview by Heinz Greijn

Links

- www.ngocodeofconduct.org

Inside the district health system

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In Karamoja in northern Uganda, many children do not live to see their fifth birthday. In an initiative to improve child survival, Doctors with Africa, Cuamm has formed a partnership with UNICEF to strengthen Karamoja's district health systems.

Karamoja is the poorest, most remote and least developed part of Uganda. Its population of over 1.2 million people is deprived of basic services including health and access to safe water. For decades, the people here – mostly semi-nomadic pastoralists – have suffered from violence, insecurity and lack of water for their animals. Morbidity and mortality rates are very high. Out of every 1000 live births, 174 children die before the age of five – a death rate that is 27% higher than the national average. And maternal mortality is 72.4% higher than the average figure for Uganda.

Karamoja's health system consists of 101 facilities of different sizes and types: one regional referral hospital, four general hospitals, four health centre IVs (HC IVs), 35 HC IIIs and 57 HC IIs. Of these facilities, 22 are owned by the private not-for-profit sector, while the remaining 79 are public owned. There are hardly any private for-profit facilities in the region.

Karamoja is divided into health sub-districts. Each of these consists of a set of HCIIs, HCIIIs and a referral facility such as an HC IV or a hospital. At the community level, each village is serviced by village health teams, which constitute an HC I. A total of 2910 village health team members work in the Karamoja region. These help to implement community health interventions such as immunisation, nutrition and sanitation campaigns. They are now also being equipped for community case management of common childhood illnesses.

A number of vertical programmes are being run in Karamoja. These include:

- Prevention of mother-to-child transmission of HIV/AIDS (PMTCT)
- HIV/AIDS programmes run by various partners
- Reproductive health programmes
- Nutrition programmes run by various partners
- Expanded outreach programmes
- Neglected diseases programmes, particularly for kalazar (leishmaniasis) and filiariasis (elephantiasis)

These programmes are called vertical because they have their own work plans, management structures, funding and reporting systems – although most do tend to use the same district staff to implement their activities. Vertical programmes have a tendency to cause fragmented planning, fragmented resource mobilisation, and an overlap or even a doubling of funding for certain activities. This is a waste of resources and the increased administration activity it causes takes staff away from their broader health care tasks.

All health activities in Karamoja – public facility, private facility and vertical programmes – are coordinated by the region's seven District Health Offices (DHOs). DHOs are headed by district health officers, who are responsible for the strategic planning and management of health in their districts. Each DHO is composed of district health team members who meet regularly. Civil and political supervision is provided by the chief administrative officer and the district executive committee represented by the Secretary for Health – an elected local politician.

The District Health Management Team (DHMT), a wider stakeholder body, is composed of the district health team members and the heads of health sub-districts, heads of health units and development partners. District health officers have a key role in ensuring that the system delivers a coherent and effective service.

Forging synergy between all these agencies requires strong leadership and governance at the district level. This, unfortunately, is often lacking in Karamoja. Governance and supervision are weak. There is a shortage of highly trained staff. There is little capacity to manage logistics and supply chains and little experience of managing health information systems, infrastructure and equipment. Planning is poor, programme implementation is weak and resources are being wasted. Strengthening capacities at district level is a must if we are to address the high levels of morbidity and mortality.

Obviously, more financial resources are required in order to tackle these health system challenges effectively – and this may not happen in the near future. But even using just the resources currently available, it is still possible to improve outcomes by improving management – in planning, in the use of resources, in the coordination of various partner inputs, in the use of information, in the management of logistics, in the deployment of staff in remote areas, in enhancing skills and improving supervision. The districts need to be strengthened in these capacities and this is the hallmark of the Cuamm intervention in Karamoja. With input from the Ugandan government and other partners, improvements are continuing to be made across Karamoja's districts.

Strengthening the district health offices

Through its partnership with UNICEF, Cuamm is supporting district health systems

Cuamm

Doctors with Africa Cuamm is an Italian-based organisation that has been working on health issues in Africa since the 1950s. It works mainly to improve health among the poorest sections of the population. It does this through strengthening district health systems to make it easier for greater numbers of people to access primary care, by improving the quality of care available and by building the capacity of communities and local systems to recognise the health problems they are facing and find solutions to them.

Uganda is one of seven African countries where Cuamm has maintained a presence for decades. The organisation is also active in Sudan, Ethiopia, Tanzania, Mozambique, Angola and Kenya.

Mothers and their children in a UNICEF-supported hospital

in all seven districts of Karamoja. Since December 2006, Cuamm has been operating a four-phase project, responding to chronic emergency in Karamoja. The object of this has been to provide technical assistance to all DHOs. The need for such assistance was identified by a team from the Ministry of Health, UNICEF and Cuamm in August 2006 when it carried out an assessment of district health sector management. They found a number of capacity gaps.

One of the major recommendations of the assessment was to use technical advisors to support and help to build the capacity of the district health teams. Based on this, Cuamm seconded a technical advisor to each district. These were experienced public health officers, usually medical doctors, who were co-opted as members of the district health teams. They paired up and worked with task officers on the district health teams to help impart essential skills. The advisors organised and continue to be involved in supervision and mentoring within the district health teams. They also participate in technical planning committee meetings with the heads of district departments. Here, they are able to interact with the civil and political leadership of the district as well as with civil society. Their ability to advocate for continuous improvements in service delivery was mainly realised through these forums.

The key roles of the technical advisors are:

1. To support districts to improve their capacities to plan, implement, monitor and report results
2. To support the building of a reliable health information system with demonstrable improvement in information collection, reliability, storage, retrieval, analysis, reporting and use
3. To promote Karamoja's district forums as avenues of cross-district learning and solution sharing
4. To improve capacity to supervise, train and mentor health staff
5. To support enhanced accountability for the resources used and the results derived
6. To support cooperation with other technical heads in the district departments of education, water and sanitation, and planning

The relevance of the advisors in terms of minimising the negative effects of vertical programmes and achieving a synergy between horizontal and vertical programming lies mostly in roles 1, 2 and 5 above. In these roles, they work to prevent fragmentation and duplication, promote comprehensive planning and share information. Cuamm advisors see to it that vertical programmes do not negatively affect the delivery of the other components of the integrated Uganda National Minimum Health Care Package – the country's primary health care package.

Advisors also provide on-the-job training for health information staff and periodic data quality assessments. They also facilitate the promotion of technology such as RapidSMS data collection, coordination and communication during disease outbreaks and disease surveillance. Every quarter, this health information is shared in the health, nutrition and HIV quarterly review meetings, which are attended by many stakeholders including NGOs and UN partners working in Karamoja. These reviews have become crucial in encouraging peer learning across districts and identifying new or persistent gaps in access. A web-based regional data centre has been set up to allow all those concerned to access health information for development.

Results

Through their active participation in the various consultative bodies, the Cuamm advisors have been effective in fostering synergies between stakeholders. This has led to clear improvements in the level of participation, more frequent and more productive meetings, and eventually, a better service for the community. These results are reflected in the performance figures of the various DHOs.

The use of primary health care resources disbursed by central government rose from 56% in 2005 (before the intervention started) to 100% in 2010. There was also an improvement in epidemic surveillance reporting. In 2005, only 49% of reports were submitted to the Ministry of Health on time. But by 2010, this had increased to 82%. This has led to measurable improvements of service delivery on the ground. Coverage of vaccinations against diphtheria, pertussis (whooping cough) and the DTP3 tetanus booster started to rise at the rate of about 3% a year in the region, while the national trend was falling at about the same rate. The outpatient utilisation rate has also been rising, and the trend in mothers opting to give birth in hospital is increasing slightly more steeply than the national rate.

As a result of a more participatory planning process, innovative approaches are beginning to emerge. For example in Kotido district, the tetanus toxoid immunisation given to young women and girls was carried out at the Sunday church service. This brought coverage of the second to fifth doses in that sub-district to 78.4% – well above the Karamoja district regional average of 36.4%, and even higher than the national target of 70%.

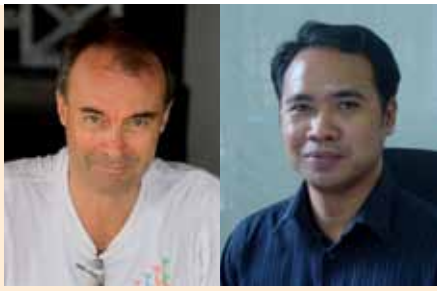
The DHOs in Karamoja are communication and coordination hubs. The professional demands on the district health officers and their teams are very high. The Cuamm project shows that supporting them in their capacity development helps them to improve the way they operate and give better health-service coverage to the people of Karamoja.

Authors' conclusion

Vertical programming has always been a form of fire fighting. Although we often take pride in the quick and clean benefits demonstrated by instruments we have perfected over time, rarely do we measure the opportunity costs of vertical programmes. It will take time to convert every donor – and indeed in certain situations we may still need vertical programmes – but the message we deliver here is that vertical programmes must become increasingly diagonal in order to achieve better results.

In situations where there is deprivation and despair, it is of great value to demonstrate that confidence can be built, capacity can be developed and results can be seen. This was what the Cuamm intervention achieved – this and the ability to achieve a synergy between horizontal and vertical programming. <

Diabetes, Cambodia's silent killer



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In Cambodia, diabetes is a devastating disease. Expensive clinical care is accessible only to the urban rich, while the poor remain untreated and die. The Cambodian organisation, MoPoTsyo, has an innovative solution that has already saved many lives.

In the early nineties, Cambodia's public health system started to be rebuilt after decades of war. Health experts and international donor agencies designed a system in which most resources went to combat communicable diseases. Non-communicable diseases, many of which are chronic conditions, were largely ignored.

A prevalence survey carried out in 2010 showed that as many as 2.3% of rural Cambodians aged between 25 and 60 had diabetes and that 10% had hypertension. While the prevalence of these conditions is not particularly high in comparison with other countries, what is worrying is that a comparatively high number of *lean* Cambodians suffer from diabetes and hypertension. The reasons are unknown, but experts attribute it to a genetic predisposition combined with environmental factors. Cambodia's post-war public health system is not fit for purpose in that it does not know how to deal with patients suffering from chronic diseases such as diabetes. Health reform is needed urgently as the society rapidly modernises and lifestyles change.

Diabetes is one of Cambodia's silent killers – the great majority of patients go undiagnosed. The average reported history of diabetes in a group of more than 500 patients who registered at Kossamak National Hospital was just four years. Only one in ten patients reported a history of more than ten years. This suggests that most people with the disease live for only a short time after contracting the condition.

As well as killing otherwise healthy adults in the prime of their productive lives, the fallout of diabetes drains households of their assets. Parents are forced to take their children out of school to work and supplement the family's income. Livestock and even land are sold to pay for treatment, leaving debts that can never be repaid.

There is little protection against such costs. High-risk debtors – which poor people typically are in the eyes of their creditors – pay the highest interest rates: 2% per day is not unusual. And when interest rates are high, poorer patients lose any assets they might have. Losing land is a growing problem for the rural poor. Landlessness rose from 13% in 1997 to 20% in 2004, and experts speculate that this has already risen to 30%. According to a much-quoted survey, half the rural poor who have lost their land blame it on health care costs. Treatment for diabetes is based on medication and monitoring by clinic-based professionals. But in Cambodia, only well-off city dwellers can afford regular medication – insulin in the private sector costs US$16 for 10 ml, without the syringes.

The MoPoTsyo solution

Cambodian non-governmental organisation, MoPoTsyo, came up with an alternative to expensive clinic-based support. They started involving 'experienced' diabetes patients in the early diagnosis, treatment and education of new patients. This experimental programme started in 2005 in two slum areas in the capital, Phnom Penh. It gradually expanded into five slum areas and by June 2007, the first rural project had begun in Takeo province, about 100 kilometres south of Phnom Penh.

The core of the programme consists of community-based peer educators who have diabetes themselves, but who are managing their own symptoms well. They receive a six-week training course, after which they take an examination. These trained patients form Peer Educator Networks (PENs), and their homes become weekly meeting points for diabetes patients living in the community.

The peer educators visit people at home and help to increase awareness of the disease. For early diagnosis, they hand out urine glucose test strips, and do blood glucose tests. This screening helps to identify who is diabetic. Anyone whose blood glucose levels show diabetes can register with the patient information centre. Membership is free and there are currently 63 peer educators running patient information centres from their homes, with a total membership of 2906 diabetics.

Self-financing

The income needed to run the programme is generated by providing services to registered patients. MoPoTsyo acts as an importer and wholesaler of routine medication, which is sold to the pharmacies in the communities where the peer educators are active. These contracted pharmacies sell the prescription medicines to the registered members and peer educators at the lowest possible price.

The payment scheme for peer educators is innovative too. Peer educators whose patients have the best health outcomes – in terms of knowledge and understanding, blood pressure, blood sugar and weight control – receive higher rewards. Twice a year, peer educators from another province evaluate the work of their colleagues by assessing random samples of patients.

Peer educators also guide patients through Cambodia's often confusing and highly commercialised health system. They help new patients to find the health service provider that gives best value for money. This can be a provider trained by and paid by the PEN, or a recommended affiliated provider. Once detected with diabetes, patients are coached in the ins and outs of the medical system so that they will know how to get what they need from the public service, and be able to recognise the more trustworthy providers.

Peer educators try to protect vulnerable diabetes patients against buying services from untrustworthy health care providers. Patients outside the system continue to pay too much for very poor quality care. But informed patients who are members do not just save money, they are healthier, more confident and better equipped to voice their concerns and improve their situation. The financial advantages of being registered with a PEN help to keep patient retention at about

90% annually. According to a study carried out by Chean Men, a senior researcher at the Center for Advanced Study in Phnom Penh and a member of MoPoTsyo's board, the average monthly spend on routine medication for PEN members is US$4 – before registration, they would have been spending about US$12.

Peer educators run courses to help patients learn about their condition, but for many patients, the personal contact between them and their trusted peer educator is just as important, especially in the early stages. Patients build up a practical understanding of how they can control the disease and slow its progress.

A MoPoTsyo health care worker gives insulin to a Cambodian fisherman with diabetes

Diet and lifestyle

Courses given by the peer educator consists of six sessions:

- An explanation of basic human biology
- How diabetes affects the body's mechanisms
- How to restore and keep the blood–glucose balance (physical activity, food intake and medicines)
- The various types of medicine and their roles
- Nutrition and healthy eating for Cambodians with diabetes
- How to self-test, set targets, self-measure and record progress

The courses emphasise the importance of lifestyle changes. Most Cambodian diabetics do not realise that white rice, particularly Cambodian rice, is highly glycaemic, meaning that the large quantities of glucose in the rice are very quickly released into the blood stream. Average Cambodians take more than 80% of their daily energy from white rice.

MoPoTsyo's food pyramid is a great help for the patients too. Every registered patient receives a poster showing where commonly eaten food items are on the glycaemic index: highly glycaemic foods are shown in red at the top of the pyramid, and foods with a low glycaemic index rating are shown in the green layer at the bottom. The pyramid helps hyperglycaemic (type 2 diabetes) patients to bring their glucose levels down by encouraging them to replace white rice with healthier sources of energy.

Further promising results

In rural Takeo province, over 70% of people diagnosed with diabetes had been unaware of their condition until they were detected by the peer educator. Early diagnosis is a key step in the prevention of complications, especially because the screening activity is combined with access to affordable care.

Independent assessments based on random samples of registered patients show a relatively consistent pattern of health improvements. Despite low levels of literacy, PEN members have a better understanding of their condition and of how to improve their health and lifestyle. Taken together in all random assessments, average blood glucose and blood pressure levels improve significantly after registration. The vast majority report that they are more physically active and are eating less white rice than before. Studies show that there are also fewer episodes of hospitalisation after registration with a PEN. Health expenditure is reduced by a factor of three.

Facing the future

The PEN approach challenges the widespread notions that diabetic patient populations can only be reached effectively through professional health services, and that any strategy aiming to deliver secondary prevention requires investment in clinic-based care and the strengthening of the capacity of professional health service providers. The results achieved by the PENs provide a strong case for attempting to scale up this initiative. There are a number of critical risks factors that need to be considered though:

- *Integration within the wider health system* – Local health authorities need to get involved in governance in order to strengthen the system further. If such a system is allowed to develop on its own without adequate links to other parts of the health system, patients may miss out on opportunities for care that they would have received had they remained within the public system.
- *The status of the peer educator in the system* – At primary care level, confusion can arise about the precise definition of a peer educator in terms of:
  - hierarchy, responsibilities and accountability
  - lines of communication
  - how the PENs can complement the existing primary care system
  - how they are financed (level and mode of payment)
- *Quality of care* – Many community-based peer educators have had little formal education. They are trained only in very specific health problems and have no background in general health care before becoming peer educators. This limits their scope when dealing with the complexity of the chronic cases that they follow up. It is important to bear in mind that peer educators have to remain motivated. A particular challenge will be how to deal with serious complications over time. Members are starting to live longer and develop complications in greater numbers than they would have had there been no programme. There will be a growing demand for core professional health services with the capacity to deal with complex chronic cases. This type of responsibility cannot be shifted to lay health workers.

Possibly these challenges can best be addressed through supervision, by organising training and by elaborating good policies and procedures to govern the system. More research is needed to explore the potential of this innovative approach. But it is already clear that PENs are a worthwhile investment as part of a health system response to the needs of one million Cambodian citizens affected by diabetes and high blood pressure. <

Further reading

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Links

- www.mopotsyo.org

GUEST COLUMN

Why health systems are failing

The forgotten link

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Both 1978 and 2000 were watershed years for world health. The conference of health leaders in Alma Ata in 1978 and the United Nations Assembly in 2000, where the Millennium Declaration was adopted, stand out as the two international gatherings that threw global health into the spotlight and put it on the development agenda.

In Alma Ata, health leaders from around the world vowed to design and build national health systems on the three pillars of equity, intersectoral collaboration and community participation. Yet despite the good intentions and the promises, more than 20 years on, we still have few national health systems based on equity and collaborative community involvement. And sadly, most countries will not meet the health-related Millennium Development Goals (MDGs) by the 2015 target date.

Fatal error

The World Development Report, published in 1993, and the World Health Report, published seven years later, turned out to be highly detrimental to achieving the health systems envisaged at the 1978 and 2000 conferences. These two reports advocated the mapping and measuring of macro indicators – based in most cases on projections. They made one fatal error. They ignored the role, relevance and contribution of district health systems in the performance of any national health system.

The poorly judged focus of these two reports unwittingly undermined the potential of the district health systems – which are crucial to any national health system. This is especially the case in low- and middle-income countries (LMICs). Problems that arose from overlooking the district health systems were further compounded when big funders started distributing millions of dollars to secure their own specific health priorities. No doubt, this funding provided poor countries with additional funds, but in some cases, it seriously undermined and distorted – and in some cases even destroyed – national health systems.

Centralised policies and plans prepared with the assistance of international donors are important – but policy makers did not consider the health workers who run health services at and below district level. They were equally remiss in not visiting primary care facilities to see the situation on the ground. They failed to grasp that it is not possession of the best equipment and the most thoroughly prepared plans that wins wars. In the end, it is the motivation and morale of the troops that determines outcomes. Regrettably, national health leaders in general, and global health players in particular, failed to recognise the role, relevance and contribution of district health systems – and they completely underestimated how important leadership here is to achieving the MDGs.

A precondition

There is sufficient evidence from LMICs that integration and collaboration at the primary health care level has significantly improved access to health services as well as quality and coverage. Improving the performance of *district* health systems, especially their leaders, is a precondition for improving *national* health systems.

It is precisely at the district level that all the vertical programmes naturally come together – and ideally, integrate. This is where community needs should be assessed and translated into actions. And it is the logical level for effectively managing, supervising and supporting primary care services – which range from preventative to curative services.

National health authorities and governments must recognise the significance and potential of district health systems in achieving the MDGs. Just as importantly, they must start to invest in a capable and competent health workforce and provide the financial resources needed to build and maintain a health infrastructure. Without these fundamental elements, the existing vicious circle will persist and millions of taxpayers' dollars will continue to be injected into the fragile health systems of developing nations without obtaining the desired results. And the health-related MDGs will remain beyond our grasp. <

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