STRENGTHENING HEALTH SYSTEMS TO IMPROVE HIV/AIDS PROGRAMS IN THE EUROPE AND EURASIA REGION USING GLOBAL FUND RESOURCES

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ABBREVIATIONS AND ACRONYMS[1]

AED	Academy for Educational Development
AIDS	Acquired immune deficiency syndrome
CAPACITY	Central Asian Program on AIDS Control and Intervention Targeting Youth and High Risk Groups
CCM	Country coordinating mechanism
DFID	Department for International Development
E&E	Europe and Eurasia
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, TB and Malaria
HIV	Human immunodeficiency virus
HSS	Health systems strengthening
IDU	injecting drug user
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSM	men who have sex with men
NGO	Nongovernmental organization
OSI	Open Society Institute
SES	Sanitary and Epidemiological Service
SWAp	Sector-wide approach
SWEF	System-Wide Effects of the Fund
TB	Tuberculosis
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

[1] Most abbreviations are explained at first use, many are used only in tables and figures; some appear only in annexes.

EXECUTIVE SUMMARY

Countries in the Europe and Eurasia region are facing a significant and expanding HIV/AIDS epidemic that is largely concentrated among particularly vulnerable populations. A window of opportunity exists to respond effectively to the epidemic and to halt its spread, both within and beyond vulnerable populations. However, available evidence indicates that this opportunity is being missed. One explanation for this is that significant barriers exist within the region's health systems that prevent rapid scale-up of effective HIV/AIDS programs.

This study seeks to examine these barriers and ways they can be overcome. The study was commissioned by the Europe and Eurasia (E&E) Bureau of the U.S. Agency for International Development (USAID). The report focuses on practical steps that can be taken to produce tangible gains for HIV/AIDS programming in the region.

The timing of this study is opportune. The Global Fund to Fight AIDS, Tuberculosis and Malaria is a significant funding agent of the regional response to HIV/AIDS. To date, the Global Fund has, in five rounds, agreed to commit more than $523 million for HIV/AIDS work in the region. The Global Fund's fifth round of applications, in 2005, differed from those held previously. For the first time, countries were able to apply for funds for health systems strengthening (HSS) purposes as well as for disease-specific components. This change was due to greater international recognition of the need to strengthen health systems to deliver and sustain disease-specific health benefits. This change is not unique to the Global Fund, but it has also occurred in other global health partnerships, like the Global Alliance for Vaccines Initiative; GAVI.

This is a welcome development, both internationally and for the region. Additional financing is welcome to overcome critical barriers within national health systems that are preventing effective program scale-up, not only for HIV/AIDS programs, but also for responses to tuberculosis (TB) and, in a few countries, malaria. Yet, globally, only thirty countries applied for these funds, and only three (10 percent) countries were successful in receiving funds. Only the Republic of Georgia applied from the E&E region. That application was to strengthen second-generation surveillance, but it was unsuccessful. The Global Fund's technical review panel (TRP) has submitted a report outlining the reasons for the low success rate. This is currently being considered within the Global Fund and it is likely that appropriate changes will be made prior to Round 6. It is unclear whether the stand-alone HSS component will be available in the future or whether countries will be encouraged to include initiatives to strengthen health systems in their disease-specific applications. There is a strong argument that this latter approach is the most appropriate one for countries in the E&E region. Regardless of the outcome of this debate, it is clear that there should be a way to include initiatives to strengthen health systems within programs financed by the Global Fund.

If the Global Fund retains HSS as a separate category, action will be needed before Round 6 to make the guidelines clearer, to make the application form more appropriate, and to strengthen the capacity of the TRP to assess applications of this nature. Whatever is decided, countries will need support and advice if applications to strengthen

health systems are to be stronger in Round 6 than they were in Round 5. It is essential that in the E&E region this takes three contextual factors into account.

First, countries must recognize that they are facing a low-level or concentrated HIV epidemic that disproportionately affects particularly vulnerable populations such as sex workers and injecting drug users, and that responding to such an epidemic requires a fundamentally different approach from that needed to address a generalized epidemic. The extent to which this is happening in the region is disputed. Many countries have made statements or policies committing their governments to do the right things. Yet they continue to allocate financial resources for prevention away from where the epidemic is really spreading; for example, spending more on general education programs in schools than on focused prevention among injecting drug users and sex workers. As a result, coverage of effective prevention programs among the most vulnerable populations remains universally too low to make a difference. It is essential that any initiatives to improve HIV/AIDS programming by strengthening health systems in the region address this key issue.

Second, for the E&E region, it is essential to recognize that strengthening health systems will involve substantial policy changes and not just incremental improvements to existing systems. This may be significantly different from other regions where the essential elements of a health system may be weak or even absent. On the contrary, the E&E region has an extensive health system. Regrettably, it seems largely unable to respond effectively to a concentrated HIV/AIDS epidemic for reasons that are explored further in this report.

Third, there is a need to reject the widely held view that health systems are analogous to the governmental health sector. This can occur by defining health systems in a broad way to include all initiatives that contribute positively to HIV prevention and delivery of care, and support and treatment for people living with HIV and AIDS. Many of these services require innovative methods and are delivered by actors outside the governmental health sector, such as nongovernmental organizations (NGOs).

It is also essential that the Global Fund does not try to address all health systems issues alone. Rather, it should coordinate and engage in policy dialogue with other international partners working in the same field and focus its resources on definable interventions that will have demonstrable gains for national responses to one or more of the three diseases it targets. It is recommended that this be assured by following a twofold strategy, similar to that recently outlined by GAVI.

First, it is recommended that applications be focused within certain health system themes; namely, governance, financing, pharmaceutical and commodity management, human resources management and planning, service delivery, and public health and surveillance (Figure 1). This report contains suggestions for activities that might fall within each of these themes based on the experience of three countries— Kyrgyzstan, Tajikistan, and Ukraine.

Figure 1: Proposed Thematic Areas for Global Fund Support to Strengthen Health Systems in E&E Region to Improve HIV Prevention, Care, Support, and Treatment

Second, any proposal submitted to the Global Fund for HSS should have a robust monitoring and evaluation plan. This plan should allow measurements in at least two areas; namely, those elements of the health system that have been strengthened, and the effect this will have had on HIV/AIDS programs.

Finally, this executive summary presents a number of practical recommendations for those countries and partners developing an HSS proposal for the Global Fund that are further explained in Section 8 of the report.

Preparing a Bid

First, a technical needs assessment should be conducted to identify gaps in the health system that are adversely affecting disease responses. In a few cases, this may have already occurred. In most cases, it will be required. Because this must occur before applying to the Global Fund, financing for this must come from other sources. Financing assessments of this nature would enable a donor to exert considerable leverage with a modest amount of funds.

Second, a decision will be needed on whether to include the HSS elements in a disease-specific application or as a stand-alone component. The latter should be considered if the funding request is large, if the proposal contains more than one element, if the interventions would have tangible benefits for more than one disease, if the application supplements other disease-specific Global Fund grants, or if the application is not mutually dependant on elements within a disease-specific application being submitted in the same round.

Bid Content

Although bid content will be largely determined by country-specific considerations, some general principles can be identified. First, care should be taken to avoid financing inappropriate systems developments. For the region this should, for example, exclude expansion of health sector infrastructure and ad hoc expansion of existing, fragmented laboratory facilities.

As a second general principle, two broad scenarios can be identified. An ideal setting would be characterized by a well-advanced, well-designed, multidonor approach to HSS; a facilitating and motivating government leadership style; good donor implementation and financing mechanisms such as a sector-wide approach (SWAp); a well-developed and trusted primary care sector; and an established national public health body.

It is doubtful that many countries in the region have these components. On the contrary, they represent a more realistic scenario in which these components are largely absent. In such a scenario, it may be preferable to seek to integrate key HSS thematic areas into a disease-specific application. Suggestions for these thematic areas are contained in Figure 1 and explained further in the text.

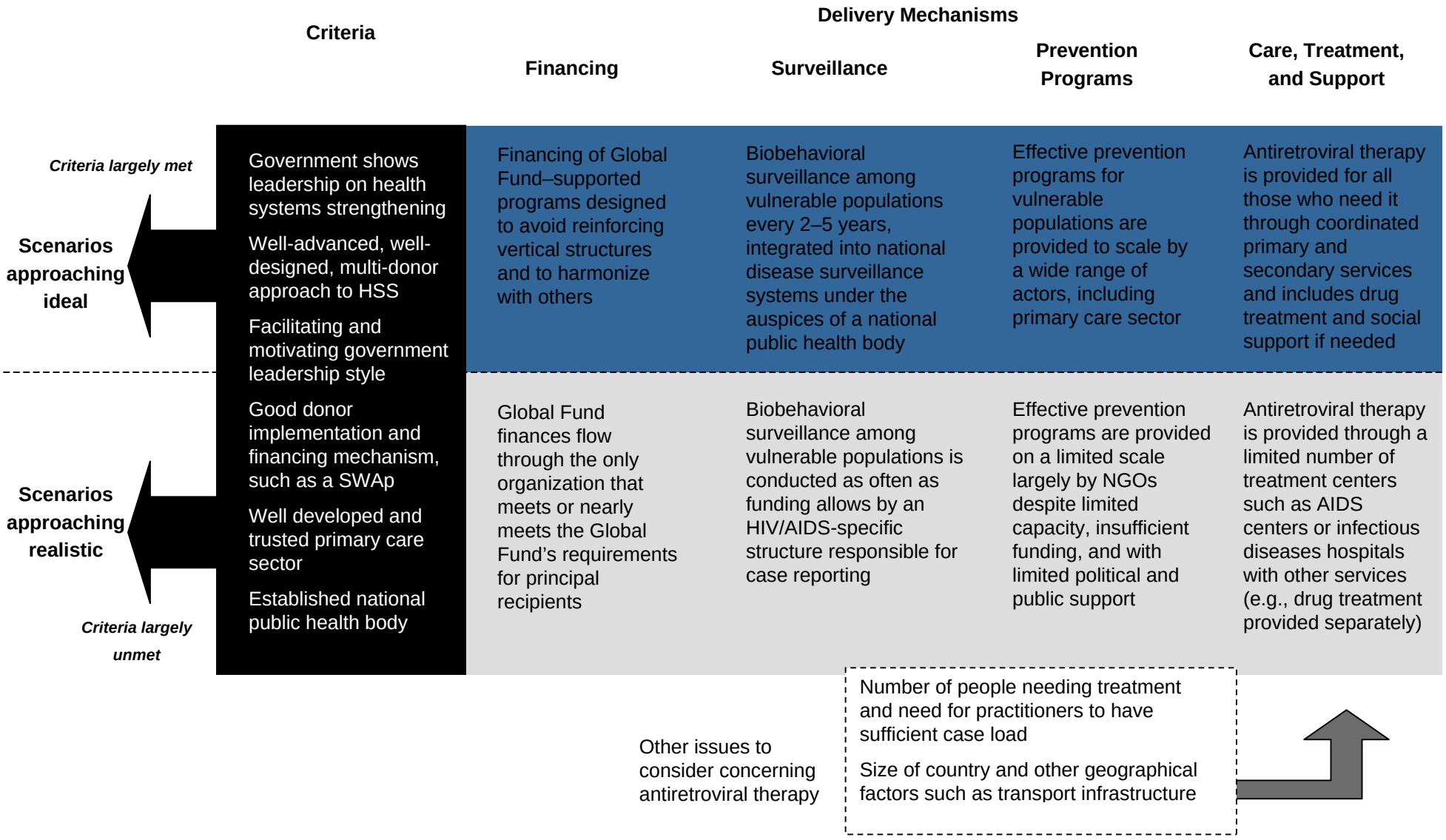
Delivering Key Services

Each country will need to decide how it will deliver key services and how it will manage Global Fund finances for these. Advantages and disadvantages of different structures

are considered in more detail in Annex F and illustrated in Figure 2. However, a few general comments follow:

- *Financing* in the realistic scenario outlined above is likely to flow through the organization that most nearly meets the Global Fund's requirements for principal recipients (Global Fund, 2003d). In practice, it is likely that not many organizations will meet these requirements. In situations that more closely resemble the ideal scenario outlined above, other factors might be considered, such as not reinforcing vertical structures. Although the Global Fund is financing through SWAps in other settings (e.g., Mozambique), not many countries in the region beyond Kyrgyzstan are contemplating introducing a health SWAp.
- *Biobehavioral surveillance* among the most vulnerable populations provides vital information for planning a response to a concentrated HIV/AIDS epidemic. In most countries of the former Soviet Union, the realistic scenario is to do this through AIDS centers. In a few countries that have approximately the ideal scenario and in other Eastern European countries, it may be possible to provide this through a newly developed national public health body, or one based on existing structures, such as the Sanitary and Epidemiological Service.
- *Prevention services for vulnerable populations* such as injecting drug users, sex workers, and men who have sex with men, require trust to be established between the service provider and the client. As a result, the most realistic scenario is probably to provide these through NGOs, but it may be difficult to reach the required scale through this method because of weak NGO capacity in many countries. In a more ideal scenario, services could be provided by family physicians; however, positive examples of this are scarce. HIV is spreading particularly rapidly in many prisons in the region, largely through injecting drug use. Services in prisons can be provided only with the cooperation of prison authorities, but given the nature of services needed, it may be most realistic to involve NGOs in this. Even in an ideal scenario, it is likely that the prison health service would be separate from general health services, although stronger linkages and coordination are needed. Where the prison health staff are willing, they should play a key role in providing prevention services for those in prison.
- *Care, support, and treatment* for persons living with HIV/AIDS in most countries will need to be delivered in a limited number of treatment centers in order for clinicians to have a sufficient case load and for trust to be established with potential clients. Realistically, this is likely to be in AIDS centers or infectious diseases hospitals. In small countries where few people are living with HIV/AIDS, one treatment center will suffice. In larger countries, particularly those with poor transport infrastructure and those with more individuals living with HIV/AIDS, a more decentralized system will be required. However, countries would need to be very close to the ideal scenario to be able to deliver the required care and treatment through primary care services, particularly because most people who require antiretroviral therapy are injecting drug users who need concomitant drug treatment if they are adhere to the therapy.

Figure 2: Proposed Delivery Mechanisms for Different Scenarios



1. INTRODUCTION AND BACKGROUND

In 2004, the Joint United Nations Programme on AIDS (UNAIDS) and the World Health Organization (WHO) estimated that 1.4 million people were living with HIV/AIDS in the Europe and Eurasia (E&E) region, and that over the same period, around 60,000 people died from the disease (UNAIDS/WHO, 2004). Despite significant progress, interventions remain too limited to have a real affect on the epidemic. For example, in 2004, UNAIDS/WHO estimated that effective prevention services were reaching only 10 percent of sex workers, 4 percent of men who have sex with men, and less than 8 percent of injecting drug users, and that antiretroviral therapy was being provided to only 11 percent of those in need (UNAIDS/WHO, 2004). Although addressing HIV/AIDS is a priority of the U.S. Government and the U.S. Agency for International Development (USAID), funds available for the region are limited and declining. Therefore, it is necessary to use funds strategically to leverage additional resources.

The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2002, is providing significant funding for the response to HIV/AIDS in the region. In the first five rounds of its operations, the Global Fund committed up to $717 million[2] for activities in the region, of which around 73 percent was for the HIV/AIDS response (Global Fund, 2005f). The Global Fund has recently announced decisions of its fifth round of proposals (Global Fund, 2005g, 2005h). For the first time, it was possible to apply specifically for funds under a component termed health systems strengthening (HSS) (Global Fund, 2005e)[3]. The focus of this component ties in well with priorities of the U.S. Government in general and the President's Emergency Plan for AIDS Relief in particular, which acknowledges the need to strengthen health systems (Synergy Project, 2005).

This report is the product of work funded by USAID's E&E Bureau through The Synergy Project. It focuses on how the resources of the Global Fund can be used to address underlying barriers in the health system to scaling up effective HIV/AIDS programs in the E&E region.

2. METHOD

Full details of the method followed in this assignment are provided in the scope of work document (Annex D; Synergy Project, 2005). The Synergy Project assembled a team of two international consultants with experience in the fields of health systems and HIV/AIDS, respectively. They visited Kyrgyzstan, Tajikistan, and Ukraine between October and December 2005. The aim was to visit three countries that were at different stages in strengthening their health care systems. In-country activities consisted largely of group and individual interviews with key informants. A limited number of field visits were made, allowing some direct observation of project activities. In addition, a visit was made to the Global Fund's offices in Geneva to discuss plans with staff there. A range of international experts in the fields of HSS and HIV/AIDS were interviewed in person or by telephone. A full list of all those interviewed is included as Annex A. A literature review was conducted including a search of

[2] This amount is referred to by the Global Fund as the 'lifetime' budget; that is, the maximum total amount available for the activities proposed. This can be for a period of up to five years. When the Global Fund agrees to fund a proposal, it makes an initial grant agreement for the first two years. Release of future amounts, up to the maximum approved, depends on grant and program performance and requires an application to be made for continued funding.

[3] The Global Fund agreed to finance three HSS proposals out of the thirty submitted in Round 5.

the Partners for Health Reform (PHR*plus*) resource center database. A list of all documents reviewed appears in Annex B. A short questionnaire was sent to USAID Missions in the region seeking to establish why countries did not apply for HSS funds in Round 5.

There are some inevitable limitations in a study of this nature. Time was limited, which meant that it was not possible to visit many activities or to conduct interviews outside of the capital cities. The people selected for interviews were largely recommended by USAID staff, particularly in Tajikistan. Interviews were conducted in English, which meant that some participants had to communicate through an interpreter. There were some logistical problems, particularly in Tajikistan, due to flight delays and cancellations. The visit to Ukraine coincided with celebrations of World AIDS Day, which meant it was not possible to conduct interviews with everyone the team wished to meet.

3. DEFINING HEALTH SYSTEMS

The World Health Organization defines a health system very broadly, as *all the activities whose primary purpose is to promote, restore or maintain health* (WHO, 2000). However, respondents tended to use the term much more narrowly, viewing the terms "health system," "health sector," and "health service(s)" as interchangeable. In particular, in the E&E region, when people talk about the health system, they limit themselves to those formal health services provided by government. Annex G illustrates differences between formal definitions of health systems and common usage in the region. For purposes of this study, we have utilized the broad definition that WHO uses when referring to health systems. As a result, this study includes all services, programs, and activities with a primary focus on health, provided by a range of organizations including nongovernmental organizations (NGOs) and non-health ministries.

4. HEALTH SYSTEMS STRENGTHENING

Although at its broadest HSS includes anything that strengthens activities within a health system, formal definitions that are available imply a narrower focus on more formal health services. For example, the Health Systems Action Network[4] identifies the objective of HSS as seeking to *measurably improve the performance of the people and shared systems that support all health services* (Health Systems Action Network, 2005).

In addition, some distinguish between HSS and health reform on the basis that the latter includes policy change but the former does not (Arias et al., 2004). However, in this document the term "health systems strengthening" is used throughout, even in settings where substantial policy change is involved or implied.

Various systems are in use for classifying components of HSS (e.g., Emrey, 2005). In this document we use a slight modification of a system that is being proposed by a USAID working group to the U.S. State Department for use by the Global Fund.[5] The six categories are governance, financing, pharmaceutical and commodity management, human resources management, service delivery, and public health and disease

[4] For more details of the Health Systems Action Network see Hhttp://www.hsanet.org/H

[5] F. Duncan, personal communication. The modification is that two categories have been grouped together, primarily to avoid separating surveillance and monitoring and evaluation, which are seen as inextricably linked in terms of responding effectively to a concentrated HIV/AIDS epidemic. The two categories merged are information systems, monitoring, evaluation, and public health functions: surveillance, prevention, and outreach.

surveillance.[6] These categories have been used as an analytical tool throughout this document.

5. HEALTH SYSTEMS STRENGTHENING IN THE E&E REGION

To understand what is needed to strengthen health systems in the region requires an understanding of the Soviet health system. A brief summary of this is provided in Annex H. Failing to understand this contextual background could lead to incorrect assumptions about what is needed, based on the situation in other regions (e.g., Africa and Asia), where in most cases there are no institutions and little or no health staff (Friedman 2005).

As a result of the legacy of the Soviet health system in the region, much of the focus on strengthening health systems has been on reforming the system. Over the last fifteen years, international developmental agencies have allocated significant funds for this purpose within the E&E region. These funds have supported programs a wide range of elements in health systems, including governance, public-private partnerships, policy, management, organization (including devolution and decentralization), finance (provider payment systems), procurement (including rational drug use), primary care and family medicine development, restructuring and rationalization, quality improvement, public health, information systems, human resources development (at all levels), privatization, and NGO development.

Some of the most successful of these have been the Zdrav Reform, ZdravPlus, and ZdravPlus II programs in Central Asia. In brief, ZdravReform leveraged change in the old system; ZdravPlus expanded primary health care reform geographically and programmatically; and the current program, ZdravPlus II, seeks to solidify and institutionalize individual health services and expand programs to public health and medical education. USAID and other development partners are implementing similar programs based on some or all of these principles in Albania, Armenia, Azerbaijan, Georgia, and Romania.

5.1 COUNTRY CASE STUDIES

A brief description of the key health systems and health reform issues in Kyrgyzstan, Tajikistan, and Ukraine is presented below.[7] A more detailed description of these issues is presented in Annex E.

5.1.1 KYRGYZSTAN

Health care reform in Kyrgyzstan is held are a widely accepted example in the E&E region[8] because the efforts took place in a difficult context of political and economic transition as well as severe economic pressures. In 1996, with the support of external donors, Kyrgyzstan embarked on a comprehensive ten-year health sector reform program that accomplished a number of major improvements. Primary health care has been restructured and strengthened and significant restructuring and rationalization of the excess capacity in

[6] Slight modifications were made to some of the names for the sake of brevity.

[7] This material is largely summarized from publications of the European Health Observatory (European Observatory on Health Care Systems, 2000a, 2000b; 2004; 2005).

[8] Although USAID's Central Asia Republic Bureau (USAID/CAR) regards it as a vulnerable success because of instability risks.

the hospital sector has occurred. These fundamental changes in the structure of health service delivery have been driven by changes in health financing, including the establishment of the Mandatory Health Insurance Fund as a single-payer system that pooled all state health funding, and the introduction of new provider payment systems. In service delivery, family medicine was introduced, new evidence-based clinical practice guidelines are being developed and implemented, a facility accreditation function has been established, various other quality assurance and improvement techniques are being introduced, and priority programs such as those for maternal and child health are developing. The population has become much more involved in health through health promotion and the establishment of village health committees. However, much remains to be done. The next phase of the health reforms will be governed by the recently approved Manas Taalimi Health Reform Plan 2005–2010, which donors are supporting through the first Commonwealth of Independent States sector-wide approach (SWAp). In addition to institutionalizing the existing reforms, the emerging or next-generation reform issues include strengthening the public health system (i.e., Sanitary and Epidemiological Service; SES), medical education reform, and integrating and strengthening vertical infectious diseases systems. Activities to stop the spread of communicable diseases, in particular tuberculosis (TB), malaria, and HIV, must be continued and strengthened, and the population should be encouraged to take greater responsibility with regard to its own health.

5.1.2 TAJIKISTAN

The health care system in Tajikistan in the post-Soviet period has been severely affected by the country's civil war, economic collapse, and a dramatic decline in health financing. In summary, while health care reform depends partly upon a sustained recovery of the country's economy, key reforms are being implemented, although to date these have been largely confined to policy work. Additional sources of health funding must be explored, although health insurance is likely to remain a long-term objective pending further economic recovery. The Ministry of Health (MOH) has now turned more attention to health sector reform. It has made an important start in reducing the excess number of hospital beds, and in shifting the emphasis from training specialists to training family physicians. New ways of paying for health facilities and health professionals are being explored in order to promote more efficient and effective practice. Tajikistan officials wish to maintain the positive features of the national health care system, such as an extensive health care network, combined with new funding and management practices intended to encourage a better use of resources. While coming late to the reform process, Tajikistan is making significant progress after many years of war, deterioration, and declining health status.

5.1.3 UKRAINE

In Ukraine, the basic principles of health care delivery have changed little since independence, with much of the system still working according to the Semashko model[9] with resource allocation based on capacity (number of beds, number of visits). During the past fifteen years, Ukraine has gone through a long debate on the best approaches to developing primary health care, involving the transition to a model based on the principles of family medicine/general practice. However, the lack of a clear national policy on primary health care development has impeded the progress of reform and preserved the status quo.

[9] Named after Nikolai A. Semashko, the USSR's People's Commissar for Health Care from 1918 to 1939.

Ukraine still lacks an integral long-term program for reforming the national health care system. Subsequent attempts at reform were largely unsystematic and inconsistent, and they failed to fundamentally restructure health care. At the same time, experts, politicians, and citizens have become increasingly aware that acute problems in the health care system are not only due to a shortage of funds, but also to inefficiency in financing, planning, and regulation. Consequently, despite many problems, some limited reform now does seem possible.

6. HEALTH SYSTEMS BARRIERS

A number of health system barriers can be identified in countries in the E&E region that hinder the development of effective national responses to HIV/AIDS, although the extent to which these barriers exist varies from country to country. Overall, however, these barriers mean that coverage of essential HIV/AIDS services remains low. For example, in 2004, UNAIDS/WHO estimated that effective prevention services were reaching only 10 percent of sex workers, 4 percent of men who have sex with men, and less than 8 percent of injecting drug users, and that antiretroviral drugs were being provided to only 11 percent of those in need (UNAIDS/WHO, 2004). Three conceptual barriers are first identified, followed by barriers in the thematic areas identified in this document (see Figure 3).

6.1 CONCEPTUAL

First, there is a general *failure to clearly distinguish different types of HIV/AIDS epidemics* (e.g., generalized and concentrated) and to program accordingly (see Annex C; Burrows and Sharma, 2005). In the region, the epidemic is concentrated among vulnerable populations, yet much programming is based on experiences and lessons learned from a generalized epidemic. As a result, resources are diverted away from where they are most needed. For example, focused prevention programs among the most vulnerable populations, such as injecting drug users, sex workers, and men who have sex with men are being retargeted toward diffuse and unfocused programs aimed at the general population. Although many countries in the region claim to be focusing on vulnerable populations, Box 1 presents some simple criteria to assess whether or not such claims are true. No country in the region is doing this yet.

Box 1: Evidence of an Appropriate Response to a Concentrated HIV/AIDS Epidemic

Biobehavioral surveillance is conducted at least once every two years among sex workers, injecting drug users, men who have sex with men, and in prisons, and is used to drive the national response.

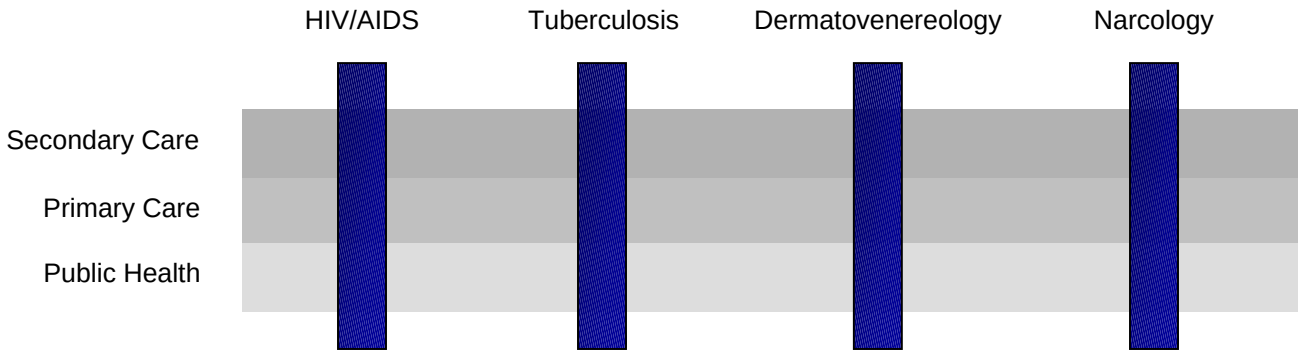
Resources for prevention activities are allocated proportionately to the degree to which particular populations are affected. For example, if 70 percent of HIV infections occur among injecting drug users, more than 70 percent of the financial resources for prevention should be focused on that population.

Coverage of proven, effective prevention programs among these groups exceeds 60 percent (USAID et al., 2004).

Figure 3: Health Systems Barriers to Effective HIV/AIDS Programming in the E&E Region

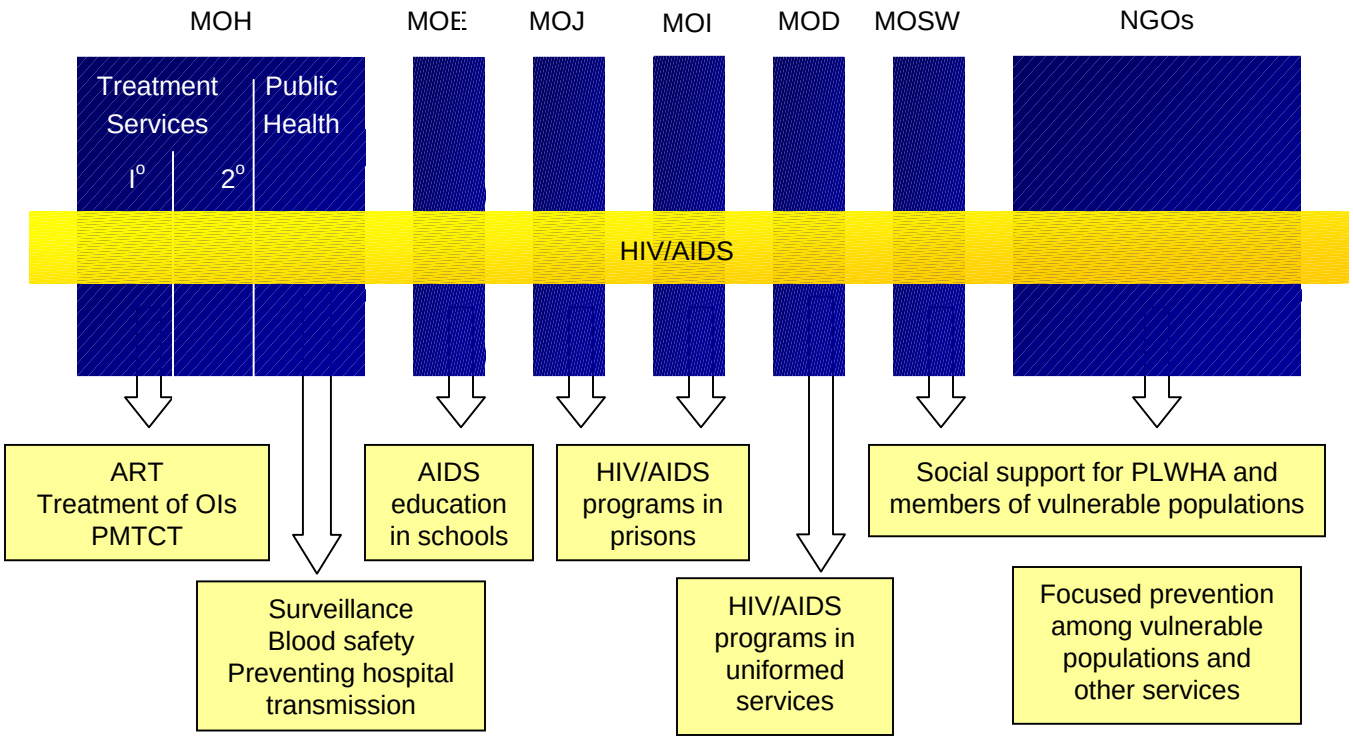
Third, there is a tendency to promote *overly simplistic notions of horizontal and vertical programs.* The Soviet health care system was recognized as being excessively fragmented and vertical. Rather than organizing services around key levels such as primary care, secondary general hospitals, public health, and so on, they were structured around disease-specific and other narrow specialties such as dermatovenereology, TB, HIV/AIDS, narcology, etc. These specialties had responsibility for all functions at all levels (Figure 4).

Figure 4: 'Verticalization' of Soviet Health System



Clearly, it makes sense to integrate these services in a horizontal manner. This is a key aim of health reform programs in the region. However, there are some problems with this. First, the integration is largely limited to the health sector in general, and to the government health services in particular, which are vertical structures that are unable to deliver all required HIV-related services (Figure 5). Whereas it is reasonable to integrate services that can be fully delivered by the health sector (e.g., laboratory services), it would be unrealistic to expect even an integrated public health sector alone to be able to deliver all services required to effectively tackle an HIV/AIDS epidemic.

Figure 5: HIV/AIDS as a Horizontal, Cross-Cutting, Multisectoral Issue*



*Abbreviations: ART, antiretroviral therapy; MOD, Ministry of Defense; MOE, Ministry of Education; MOH, Ministry of Health;, MOI, Ministry of Interior; MOJ, Ministry of Justice; MOSW, Ministry of Social Work; OIs, opportunistic infections; PMTCT, prevention of mother-to-child transmission; PLWHA, persons living with HIV/AIDS.

In addition, services that appear to be integrated may themselves be new vertical structures. For example, in Kyrgyzstan, health promotion activities are not delivered through general primary care staff members, who are overly burdened with other activities,

but through a network of health promotion centers, which have been established as a public health structure separate from the SES. Although it is undoubtedly laudable to be seeking to promote health, this system has many similarities to the disease/specialty-specific centers that are being so painstakingly dismantled.

6.2 GOVERNANCE

Several respondents highlighted problems of governance and leadership as key obstacles preventing national health systems from responding effectively to HIV/AIDS. First, *leadership may be absent or extremely transitory.* For example, when the writers of this report visited Ukraine, the government had been suspended and many ministers and deputy ministers had been removed, including the deputy minister responsible for HIV/AIDS. Although a post had been created for a deputy minister responsible for HIV/AIDS, TB, and narcology, this post had not yet been filled. Any appointment made may be short term given that parliamentary elections are scheduled for March 2006.

Second, *coordination between different agencies may be weak and fragmented.* For example, in 2005, a study in Ukraine (MOH, DFID, UNAIDS, 2005) documented a number of organizations with some coordination role related to HIV/AIDS. Following publication of this report, the National Coordination Council of Ukraine was established. However, this body has not met since the deputy minister responsible for its formation was removed from office. Although there is widespread support for the concept of a unified, national HIV/AIDS coordinating authority, opinions differ as to how it should relate to other issues such as TB, drug use, and so on.

Third, there are problems of *leadership style*. A key legacy of the Soviet period is a highly centralized and hierarchical approach to governance, particularly within government structures. For example, the Soviet system of government orders (‘prikaz’) still prevails in much of the region. Authorities responsible for a particular area often see their role more in terms of command and control than in facilitating and coordinating a more collegial type of leadership, a style aspired to by international organizations and NGOs. For example, government respondents in Tajikistan expressed their desire for more governmental control of coordinating processes, tendering, and procurement.

Fourth, the *policy, legal, and regulatory environment* relating to implementing HIV/AIDS programs is often inadequate. In some cases, appropriate policies are simply absent, while in others policies may be in place that prevent the establishment of appropriate interventions; for example, those that prohibit NGOs from providing certain services.

Finally, countries may have inadequate *analytical and planning capacity.* This has been seen, for example, in the degree of support some country coordinating mechanisms (CCMs) have required to prepare successful grant applications. It appears that such analytical and planning capacity may be even lower in relation to health systems than it is in relation to specific diseases such as HIV/AIDS and TB.

6.3 FINANCING

A number of financing issues are serving as barriers to an effective HIV/AIDS response. The first is the *level of overall financing* available to the health sector and the AIDS response. This is low throughout the region, and in some countries (e.g., Tajikistan) it is extremely low and has declined dramatically since Soviet times. From 1990 to 1998, the

per capita expenditure on health fell from $69 to $2.50 (European Observatory on Health Care Systems, 2000b).

Second, financing mechanisms may be *unduly complex and inappropriate;* for example, in Ukraine (Lekhan and Rudiy, 2005). In particular, the Soviet system:

- Channeled a disproportionate amount of funding to secondary and tertiary systems on the basis of an institution's size in general, and number of beds, in particular. As a result, there is excess bed capacity and unnecessary hospitalizations in the system.
- Directed resource allocation not by improving the population's health status, but by maintaining health care settings.
- Used multipayer systems with some services financed by the state budget and some from municipal budgets. This is an unduly complex process and results in patchy availability of services.
- Had multiple and parallel financing mechanisms that directed money to narrow specialties and away from general, primary services.

These had specific effects, including the growth of huge and underutilized secondary and tertiary hospitals, nondelivery of key services, and concentration of power in the hands of the heads of narrow specialties.

Also, in different countries, particularly in Central Asia, donors have provided *uncoordinated financial support to parts of the health system*. In many cases, this has created more parallel financing mechanisms. Problems with coordination exist between donor funds and nationally funded programs, and between donor-supported programs.

In many parts of the region there is a strong reliance on both *formal and informal out-of-pocket payments*. For example, a recent study in Ukraine concluded that people pay more often for drugs than the state pays, despite a provision in the constitution that health care should be provided free of charge. This discourages poor and marginalized people from utilizing services or delaying their use of services, or both.

In addition, it may be *difficult to obtain information on the amount of money being spent* on health on a national basis in general, and on the national HIV/AIDS response, in particular. No country in the region systematically compiles national HIV/AIDS accounts. Governments often report what has been budgeted for the national AIDS program but rarely report on what was actually spent. In addition, the national AIDS program does not cover the full extent of the national AIDS response.

Finally, *countries may be unable to absorb funds* provided to them by international agencies. For example, the World Bank granted a significant loan to Ukraine for HIV/TB services at least two years ago, yet those resources remain largely unused because the country is unable to procure goods and services in line with World Bank requirements.

6.4 PHARMACEUTICAL AND COMMODITY MANAGEMENT

Despite theoretical systems in place to ensure that drugs and commodities are available either free of charge or at low cost, these systems often fail, resulting in *shortages of commodities, or stock-outs, or both*. Reasons for this include absence of sufficient funding

and delays in procurement processes. As a result, many people have to buy the drugs and commodities they need if they want them on time or on a regular basis.

Public procurement of drugs, equipment, and related commodities is particularly problematic in many countries (Drew, 2005b). Prices paid are extremely high and the processes are excessively slow. Although measures in place are intended to ensure the quality standards of products purchased, the measures are excessively complex and are often dealt with by companies making informal payments (e.g., to register drugs or to have drugs entered onto a national drugs list). Because companies have to bear the cost of this, they may not be interested if the market is considered too small or the bureaucratic hurdles too high. Public officials responsible for making procurement decisions are often poorly paid and are subject to political interference. Civil society bodies tasked with holding government to account are relatively new and are relatively weak. However, there have been notable successes in this area, such as the All-Ukrainian Network of People Living with HIV highlighting the high price the Ministry of Health has been paying for antiretroviral drugs (All-Ukrainian Network of People Living with HIV, 2005).

In addition, there are problems related to *management of drugs and other commodities* after they have been procured. For example, it is very difficult to move drugs from one oblast to another. Supply management is based primarily on budget; that is, procurement officials assume that all purchased drugs will be used rather than making an accurate assessment of previous levels of consumption.

6.5 HUMAN RESOURCES MANAGEMENT

Salaries within the government health sector are usually very low. For example, in Tajikistan, the salary of a government physician is only $5–10 per month. This results in physicians having low motivation, they hold multiple posts, their attention is diverted to income-generating activities both within and beyond the health system, they receive informal under-the-table payments from service users, there is extensive rural-urban migration, and turnover is high.

In countries that have made progress in instituting health reform, staff salaries have risen through mechanisms such as taxation, savings through reform, and through formal copayments from service users. For example, in Kyrgyzstan, salaries rose by 70–80 percent from 2001 to 2003 (Anonymous, undated b), but levels remain low.

The Soviet health services were *very hierarchical, with the highest positions occupied by physicians*, and many countries in the region (e.g., Ukraine) retain this legacy. Nurses have limited training and hence have a low position in the hierarchy and little sense of professional identity. There is little understanding of the need for professional managers/administrators at a senior level, nor of the role of other staff, such as social workers. As a result, the sector is highly biomedical in orientation and focused toward curative services. This results in a highly hierarchical form of interaction between physicians and their patients. Although this has changed in some places where reforms have progressed well (e.g., Kyrgyzstan), physicians recall how it used to be: “You commanded that patients be tested, you demanded answers …” (Wolfe, 2005). In such a system, there is little place for patients as end-users of services to be actively involved in service choice and review. Although this hierarchy is still largely in place in much of the region, it is beginning to

change with the emergence of strong user groups within civil society, such as the All Ukrainian Network of Persons Living with HIV.

There are widespread reports of *stigma and discrimination* among health staff toward persons living with HIV/AIDS and other vulnerable populations. Part of this is related to lack of knowledge about infection routes and fears of contracting the infection. For example, one respondent reported, “In April of this year, one person living with HIV/AIDS was admitted to hospital. He asked her to wear gloves when carrying out invasive procedures on him. She did not want to. He advised her that he was HIV positive. She panicked and called the Ministry of Health as she did not know what to do.” Other underlying factors are causing this stigma and discrimination by health staff, such as the hierarchy described above, and judgmental attitudes toward activities associated with HIV transmission, such as injecting drugs and selling sex. For example, one respondent said, “One pregnant woman went for an abortion to a maternity hospital. The doctor did not want to do this but called all the students and nurses to see the person so they could see the ‘shame’ of what was happening to their nation.” As a result, vulnerable people do not trust government health services and avoid contact with them. Of particular concern are the views of one respondent that much of the training health care providers receive simply reinforces stigma.[10]

6.6 SERVICE DELIVERY

Many of the problems of service delivery relate to the *legacy of the Soviet health system* (see Annex H). Elements of this legacy include:

- Fragmented, specialized services that seek to provide public health, as well as primary and secondary services in particular fields (see Figure 4). However, not all these elements exist in all countries (e.g., AIDS centers were not established outside the Soviet Union). Nevertheless, in most settings, these structures are largely intact, although some have collapsed, such as dermatovenereology in some countries. Others have been integrated into a reformed health system; this is true, for example, in Kyrgyzstan.
- Competition between different medical services. For example, there may be disputes over who should treat specific opportunistic infections in persons living with HIV/AIDS, such as pneumocystis pneumonia or nonpulmonary TB. There may be markedly different approaches between different services. For example, in Ukraine, respondents reported that the TB service was particularly traditional.[11]
- An excess of narrowly specialized health workers and a lack of generalists (e.g., family physicians).
- A proliferation of infrastructure, particularly hospital buildings, including inpatient facilities and laboratories. Many of these are either underutilized or inappropriately occupied by people who could be treated on an outpatient basis.

[10] This was a general comment and did not relate to one training in particular. Factors contributing to this include fear-based messages, negative ways of referring to members of vulnerable populations and insufficient focus on addressing negative attitudes, and modeling/promoting supportive ways of interacting with vulnerable populations.

[11] Aspects of this include an overall biomedical emphasis, particularly a strong focus on the role of physicians, in-patient therapy, and extensive use of laboratory and radiological investigations. In addition, in Ukraine, this includes resistance to adopting the tenets of Directly Observed Treatment Short Course (WHO, 2005) as a national TB strategy.

- A lack of trust in health services in general and some services in particular (e.g., narcology), which is seen as having close links with police. This absence of trust particularly affects populations most vulnerable to HIV, such as injecting drug users.
- An inadequate public health system that is effectively excluded from the major public health issues of the country. The main public health organ in post-Soviet states is the SES.[12] Although there are plans to reform this to become a modern public health system in Central Asia, many respondents were skeptical about this, particularly in Ukraine. For example, one observer commented, "It is completely impossible to re-orientate SES to public health. They mostly fulfill police functions."
- Services are geographically scattered, meaning that people may need to travel considerable distances to access different services. AIDS centers for example, are in some cases, sited far away from centers of population.

In summary, the health sector in the region is highly developed and systematized. However, it is rigid, inflexible, and not client-focused. There is a need to promote more client-centered approaches.[13]

Despite the consensus that the health system in the region needs reform, carrying out reform has proved to be *a complex and time-consuming process*. For example, the current health care system in Ukraine is little changed from the Soviet system (European Observatory on Health Systems and Policies, 2004). Even where significant progress has been made (e.g., in Kyrgyzstan) (European Observatory on Health Systems and Policies, 2005) the reform of public health services has been particularly slow.

6.7 PUBLIC HEALTH AND DISEASE SURVEILLANCE

Although the region's health system generates large amounts of data, there are significant problems with the health information system as a whole and as it relates to HIV/AIDS in particular. First, the disease reporting system has been largely based on *a rigid and incomplete system of HIV/AIDS case reporting*. This is used as the main source of official data on HIV/AIDS, yet it is incomplete and says more about HIV testing policy than HIV prevalence or incidence. Efforts to establish essential systems of biobehavioral surveillance in the region among the most vulnerable populations are being made but these are in their infancy. It is unclear how these will be systematized and sustained.

Second, *surveillance data are rarely used to drive the response to HIV/AIDS in the region*. Despite strong data regarding the concentrated nature of the HIV/AIDS epidemic, particularly among injecting drug users, programming in most countries has not been developed on that basis. Rather, activities have been designed and implemented on the basis of assumptions that a generalized sexual epidemic is either happening or imminent. Consequently, finances available for focused prevention programs among the most

[12] Most Eastern European countries have an equivalent agency. For example, in Bulgaria it was termed the Hygiene Epidemiological Inspectorate.

[13] A client-centered approach puts the needs and wishes of the client at the forefront when designing and delivering systems. For example, if such an approach sought to provide services for injecting drug users, this might influence where and when services would be provided and what services would be provided in a single location. In the region, many health services could now be described as staff-centered, because they are structured around the needs and wishes of staff.

vulnerable populations are inadequate and coverage of these programs remains too low to make a difference.

The major public health institutions in the region, such as the SES, are largely excluded from collecting and analyzing data on the major public health issues affecting the region. In particular, TB and HIV/AIDS monitoring and surveillance may be absorbed by vertical TB and HIV/AIDS structures rather than by the SES or its equivalent.[14]

Finally, it is *difficult to obtain information on the amount of money being spent* on health on a national basis and on the national HIV/AIDS response.

7. HEALTH SYSTEMS STRENGTHENING AND THE GLOBAL FUND

This section of the report explores the involvement of the Global Fund in issues of health systems strengthening. It first explores the effects of the Global Fund on the system before examining more specific effects of HIV/AIDS grants to Kyrgyzstan, Tajikistan, and Ukraine. It then reviews arguments for and against the Global Fund having a stronger focus on HSS, and debates whether HSS should be a specific component in subsequent Global Fund rounds.[15] The section concludes by reviewing the experience of nations applying for funds to strengthen health systems in the Global Fund's fifth round of applications.

7.1 ASSESSING THE SYSTEM EFFECTS OF GLOBAL FUND FINANCING

Whether or not the Global Fund intentionally seeks to strengthen health systems, there will be inevitable system effects as a result of its funding simply because of its scale. Currently, a number of initiatives are seeking to broadly assess the system-wide effects of Global Fund financing. USAID, the European Commission, and other donors support the System Wide Effects of the Fund (SWEF) Research Network through PHR*plus* (PHR*plus*, 2005; SWEF Research Network, 2005). This is being done through a number of country case studies[16] focused on the four thematic areas of policy environment, public/private mix, human resources, and pharmaceuticals and commodities (Bennett and Fairbank, 2003). Part of SWEF is the Global Fund Tracking Study supported by the United Kingdom's Department for International Development and other donors (Brugha et al., 2005a, 2005b; London School of Hygiene and Tropical Medicine, 2004; Starling et al., 2005), which has been supporting four case studies in Africa.[17] Findings from the SWEF activities were presented at a conference held in Washington, DC, in November 2004 (American Public Health Association, 2004; Brugha and Stillman, 2004; Schneider, 2004a, 2004b).

The Global Fund has developed a number of indicators for tracking the system effects of its work. These cover the three areas of sustainability, additionality, and partnerships (Global Fund, 2005i).

Other relevant information has been gathered on the collective, system effects of global health partnerships (McKinsey and Company, 2005) and on other specific partnerships,

[14] This may be less true in Eastern Europe than in the former Soviet Union because AIDS centers were not established there.

[15] It is important to clearly distinguish these two issues. The first relates to the principle of whether or not Global Fund finances should be used to strengthen health systems, whereas the second relates to the mechanism(s) whereby this could be done.

[16] In Benin, Cambodia, Ethiopia, Georgia, Mozambique, Nicaragua, Tanzania, Uganda. and Zambia.

[17] Mozambique, Tanzania, Uganda, and Zambia.

such as the GAVI. In addition, other organizations have collected anecdotal evidence of system effects in particular countries (Friedman, 2005; Physicians for Human Rights, 2005).

7.2 TO WHAT EXTENT HAS HEALTH SYSTEMS STRENGTHENING BEEN PART OF PROGRAMS FUNDED BY THE GLOBAL FUND UNDER DISEASE-SPECIFIC COMPONENTS?

For the purpose of this study, lessons are largely drawn from HIV/AIDS programs of Kyrgyzstan, Tajikistan, and Ukraine.[18] Rather than analyzing these issues country by country, an attempt has been made to analyze issues thematically according to a number of key themes. These are illustrated diagrammatically in Figure 6.

Figure 6: System Aspects of Global Fund Grants in Countries in the E&E Region

	Areas of Contribution	Areas of Concern
Governance	• Greater involvement of civil society organizations • Modeling participatory leadership styles • Promoting a multisectoral approach	• Limited progress in overcoming autocratic leadership styles
Financing	• Significant additional finance	• Concerns regarding sustainability • Creation of parallel financing mechanisms • Overlooking other significant health needs
Pharmaceutical and Commodity Management	• Increased availability of key commodities, such as antiretroviral drugs • Innovations, such as decentralized procurement	• Weak national procurement systems, especially on timeliness
Human Resources Management	• Provision of training • Involvement of nontraditional providers and user groups	• Lack of overall national strategies for human resources • Limited focus on pre-service training • Little emphasis on motivation and retention of staff • Very strong stigma and discrimination among health providers • Diversion of staff from other priorities
Service Delivery	• Strong leadership on need to provide effective prevention services to those most affected by concentrated epidemics, such as injecting drug users • Involvement of NGOs	• Little progress on integrating TB and HIV/AIDS services; in some cases, separation has been reinforced • Little progress on rationalizing physical infrastructure, such as laboratories
Public Health and Disease Surveillance	• Formal commitment to developing national HIV/AIDS monitoring & evaluation systems • Leadership in financing second-generation HIV/AIDS surveillance	• Limited progress in institutionalizing second-generation surveillance activities and concerns over sustainability • Concerns that data are not being used to drive response

[18] Kyrgyzstan, Tajikistan, and Ukraine each have an HIV/AIDS grant from the Global Fund. Tajikistan has two. Kyrgyzstan and Tajikistan also have TB grants, and both were granted monies for malaria work in Round 5.

A key innovation for the region, spearheaded by the Global Fund, has been the introduction of civil society organizations of persons living with HIV/AIDS into the governance structures for national HIV/AIDS responses through the CCMs or equivalent structures.

This inclusion has inevitably involved advocating for a more collegial and participatory leadership style rather than government-led command and control. Although some progress may have been made in this area (e.g., in Kyrgyzstan and Ukraine), progress has been limited because attitudes and practices are deeply entrenched.

The Global Fund has also championed a multisectoral approach to governance of the national response to HIV/AIDS and integration of this into responses to TB and malaria. This has not always complemented the narrower and conventional approaches to governance and management of the formal health sector.

7.2.2 FINANCING

By the end of Round 5, Global Fund financing for the region stood at up to $717 million for activities, of which around 73 percent was for the HIV/AIDS response (Global Fund, 2005f). This is a significant boost to health financing in the region and to the response to the three diseases. However, there are concerns about the nature of this financing in three main areas. First, it is unclear how activities will be sustained after the completion of Global Fund grants. This is particularly important for the recurrent cost implications of capital purchases such as laboratory equipment, and for the continuation of antiretroviral therapy. Second, there are concerns about the establishment of alternative/parallel financing mechanisms, such as:

a. The use of the United Nations system (for HIV/AIDS) and an international NGO (for TB) in Tajikistan due to inadequate national capacity to manage the funds;

b. The use of an international NGO in Ukraine following the suspension of grants to three principal recipients;

c. The use of vertical HIV/AIDS and TB institutions in Kyrgyzstan. There are concerns that this system is bypassing the single-payer system that has been introduced in the country and which is intended to lead to the establishment of a SWAp. However, it does not appear that the Global Fund has ever been formally asked to either pool its funds within a SWAp or to parallel finance the overall health reform strategy.[19]

Third, there are concerns that financing that targets specific diseases may be overlooking other significant national health priorities.

7.2.3 PHARMACEUTICAL AND COMMODITY MANAGEMENT

A key requirement of an effective health system is that essential pharmaceuticals and commodities should be available and appropriately used. Global Fund grants have contributed significantly to this, particularly, for example, to purchase antiretroviral drugs in Ukraine. However, significant issues must be addressed, not the least of which is ensuring that national procurement systems can securely manage funds and in a way that ensures good-quality products are purchased at the best possible price within the required time

[19] The Global Fund is financing activities in at least one country, Mozambique, through a SWAp (Global Fund, 2005n), so there is no reason, in principle, why this should not be possible in other settings.

frame. Traditional procurement mechanisms have proved particularly weak on the issue of timeliness (SWEF Research Network, 2005). The Global Fund has supported innovations in these areas, including decentralized procurement of some commodities by NGOs in Ukraine (Drew, 2005b).

7.2.4 HUMAN RESOURCES MANAGEMENT

Many of the programs supported by the Global Fund have had a strong focus on the people providing services, especially training providers. Training innovations introduced with Global Fund support have included training multidisciplinary teams together to provide antiretroviral therapy. In addition, the Global Fund has allowed countries to pioneer the involvement of nontraditional health workers to provide key services, including NGO-based social workers and members of user groups.

However, proposals to the Global Fund seem to have the following concerns in common:

a. Proposals are developed without an overall strategy for human resource management within the health system and the health sector;

b. Proposals place less emphasis on pre-service training than on in-service training; and

c. Proposals do not fully consider issues associated with staff motivation and retention.

Concern has also been expressed that Global Fund monies for malaria, HIV/AIDS, and TB risk diverting staff away from other issues and that price differentials are introduced within the health system (Bennett and Fairbank, 2003).

A key issue is that health workers in the region discriminate against persons living with HIV/AIDS and other vulnerable populations. Some progress has been made in addressing this through Global Fund grants, but only on a relatively small, local scale.

7.2.5 SERVICE DELIVERY

Although some progress has been made at the local level in promoting cooperative work between specialties (e.g., TB and HIV/AIDS; narcology and HIV/AIDS), progress has been relatively limited. Indeed, in Kyrgyzstan, the availability of Global Fund money has further entrenched the separation between TB and HIV/AIDS services.

A key contribution of the Global Fund has been to sharpen the focus on developing effective models for HIV prevention programs in the region, given the concentrated nature of the epidemic. For example:

a. Focusing on the most vulnerable populations, particularly injecting drug users, sex workers, men who have sex with men, and prisoners;

b. Moving away from traditional expert-led, didactic, knowledge-based approaches to innovative, peer-led, participatory methods; and

c. Integrating communication methods as part of evidence-based comprehensive approaches.

These elements are challenging for more conventional health promotion approaches delivered through the health sector.

In addition, the Global Fund has supported a shift in the public-private mix of service provision, particularly through the involvement of NGOs as key implementers. This has not been easy because of the complete dominance of government structures in health service provision until recently. As a result, NGO capacity is low, and mechanisms for cooperation between governments and NGOs (including financing mechanisms) are poorly developed. Despite some progress, there is still little conceptual understanding of this broadened approach to health systems. The majority of stakeholders who were consulted continue to see health systems in a traditional, narrow sense of the governmental health sector.[20]

Also, a key distinct feature of the region's health services is an excess of physical infrastructure, particularly hospital buildings. This may be a key difference from other regions such as Africa, where expanded physical infrastructure may be one of the key requirements of HSS. In Kyrgyzstan, a successful health reform program managed to reduce the square footage of the hospital sector by almost 40 percent and the number of hospital buildings by more than 46 percent, resulting in considerable financial savings (Purvis et al., 2005). There is a need to ensure that Global Fund financing does not undermine or delay such gains. This may be particularly important in laboratory capacity development. While such a development is needed to support delivery of key services such as antiretroviral therapy, it is essential that equipment purchases and renovation of laboratory infrastructure is part of an overall national plan and is well coordinated with the efforts of other financing mechanisms.

7.2.6 PUBLIC HEALTH AND DISEASE SURVEILLANCE

The Global Fund has been at the forefront of financing the significant progress that has been made in improving HIV/AIDS surveillance and monitoring in the region, particularly through the introduction of biobehavioral surveillance studies among the most vulnerable populations. However, less progress has been made on using the data derived from these studies to drive the development of appropriate disease responses in the countries. There is also need to institutionalize and sustain these biobehavioral studies in the future.[21]

In addition, the Global Fund has strongly supported the development of national HIV/AIDS monitoring and evaluation systems as envisaged by the Three Ones strategy. However, there has been less thought regarding how they can be integrated into or coordinated with overall health information systems.[22]

7.3 SHOULD THE GLOBAL FUND HAVE AN EXPLICIT FOCUS ON STRENGTHENING HEALTH SYSTEMS?

Global Fund grants are having an impact on national health systems, yet since the time the Global Fund was originally conceived there have been debates about the extent to which this should be an explicit focus for the Global Fund (e.g., Chalmers, 2001). Those arguing for such a focus point out:

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[20] For example, most stakeholders believed that donor-funded, NGO-delivered HIV prevention services are not part of the health system, although such services are activities whose primary focus is to maintain health. In Ukraine, for example, the law may be partly responsible for these attitudes because it specifies that the government should provide health services.

[21] The work in Central Asia by USAID and the Centers for Disease Control and Prevention offer a good example of how this can occur.

[22] This issue highlights many of the conceptual issues raised earlier in this report. In general, conventional health information systems focus on data collected from the health sector. By contrast, much of the data in an HIV/AIDS M&E system comes from special surveys or other sectors. However, there is some overlap (e.g., on antiretroviral treatment, prevention of mother-to-child transmission, etc.).

- The need for basic health services to respond effectively to HIV/AIDS;
- The presence of other significant health problems in countries affected by HIV/AIDS, TB, and malaria;
- Concern over establishing parallel vertical programs with separate financing and monitoring systems, and diverting scarce human resources;
- Concern over sustainability of externally funded vertical programs; and
- The absence of even basic health systems in many places such as Africa (Oxfam, 2002).

This debate is not specific to the Global Fund but it is also pertinent for other global health partnerships[23] (High Level Forum on the Health Millennium Development Goals, 2005) such as GAVI (GAVI, 2005). These partnerships have had some beneficial effects on health systems such as strengthened planning, strengthened monitoring and evaluation, improved accountability, and greater involvement of nongovernmental stakeholders. However, there have been significant weaknesses as well, including poor coordination, high transaction costs, varying degrees of country ownership, poor alignment with country systems, an undermining of the sustainability of national development plans, a distorting of national priorities, a diversion of scarce human resources, the establishment of uncoordinated service delivery mechanisms, and poor coordination (High Level Forum on the Health Millennium Development Goals, 2005).

Clearly, global health partnerships will not achieve their potential unless they build health system capacity. The GAVI group has decided it will do this by focusing on a limited number of themes; namely, staff issues, drugs, equipment, infrastructure, and organization and management, particularly at the district level.

On the other hand, some have argued that the scale of HIV/AIDS in some parts of the world and the extremely high price of new and effective drugs to treat the disease required a new and urgent, focused response (Global Fund, 2003b). Concerns about an HSS approach by the Global Fund and other donors include the following:

- The need for a multisectoral approach for an effective response to HIV/AIDS;
- A perception that conventional health systems had been slow to respond to the HIV/AIDS pandemic;
- The massive resources and long time frames that would be needed to build capacity in some national health systems; and
- The difficulties of demonstrating tangible benefits to HIV/AIDS, TB, and malaria programs through interventions to strengthen health systems (Synergy Project, 2005).

In the end, the Global Fund was established on the basis of principles that require it “to address the three diseases in ways that will contribute to strengthening health systems” (Global Fund, 2003c). Nevertheless, debates on this issue continue.

[23] For more information on global health partnerships see Carlson, 2004.

7.4 HEALTH SYSTEMS STRENGTHENING AS A STAND-ALONE COMPONENT

In Round 5 proposals to the Global Fund countries will be able to apply for funds for HSS purposes. This change coincided with the abandonment of the joint TB/HIV category for applications from Round 5.

The guidelines for Round 5 applications were clear that the Global Fund was approaching health systems from a broad perspective. They specifically mention that the Global Fund does not view the health system and health sector as synonymous, and specifies that the former may include activities in other sectors (Global Fund, 2005e).

A question currently being debated is whether or not the Global Fund should continue in future rounds to accept applications for HSS activities separate from disease-specific proposals. This debate is summarized in Table 1.

Table 1: Should Health Systems Strengthening Be a Separate Component for Proposals from Countries in the E&E Region to the Global Fund?

Arguments for a separate component	Arguments for inclusion in disease-specific components?
Emphasizes importance of health systems. Less likely to reinforce vertical, disease-specific 'empires'. Allows common problems to be addressed in one proposal.	In the region the main problems are HIV/AIDS and, to some extent, TB. Malaria is an issue in only a few countries. The E&E region has a concentrated HIV/AIDS epidemic, largely among injecting drug users. This requires a vastly different response than that of a generalized epidemic. Traditional health services have responded poorly to such an epidemic. There is less risk of focusing only on the public health sector if HSS activities are included in disease-specific proposals. Global Fund and in-country systems are poorly developed for generating and assessing separate HSS proposals. For example, countries have mechanisms to generate HIV/AIDS and TB proposals but it is unclear how they would generate a proposal simply for HSS. The in-country workload to generate a disease-specific proposal that includes HSS elements is much less than that to generate separate disease-specific and HSS components. The experience of applications for the HIV/TB component in the region was poor. There are risks of gaps and duplication, particularly when applications are made to the same round. For example, if activities were included in an HIV/AIDS proposal and strengthening human resources was included in an HSS proposal, problems might arise if one but not the other was funded. A strong and clear link to impact on diseases is more likely if HSS elements are included in disease-specific applications. Everything a country needs can fit within existing disease-specific application structures.

7.5 THE HEALTH SYSTEMS STRENGTHENING COMPONENT IN ROUND 5

Applications to the HSS component accounted for around 15 percent (30 of 202) of all components reviewed by the technical review panel (TRP)[24] in Round 5. The success rate was low. Only 10 percent (3 of 30 applications) were approved compared with more than 35 percent for other components. As a result, the TRP discussed the causes of this and has made some observations to the Global Fund board (Global Fund, 2005k). In summary, the successful HSS proposals focused on a small range of activities that were considered realistic and could be implemented with clear budgets and work plans. Unsuccessful proposals were largely broad and ambitious, with vague objectives and poor work plans and budgets.[25] In particular, the TRP identified the following problems associated with the HSS component:

- The definition of HSS in the proposals and guidelines was too broad (i.e., it was unclear what could be included).
- The proposal form was not specifically designed for HSS applications (i.e., it was more appropriate for disease-specific applications).
- There was little guidance for applicants on what linkages to the three diseases might have been.
- It was unclear how to link applications for HSS and the three diseases when applying for multiple components.
- Global Fund systems (from CCMs to the TRP) have not been established to address HSS applications (Global Fund, 2005k).

The TRP asked the board to review these issues and to specifically decide whether the Global Fund should retain a separate HSS component or more fully specify what HSS elements can be included in disease-specific proposals. More guidance on what specific elements of HSS the Global Fund wishes to finance was also requested. Outcomes of these decisions have potential implications for a wide range of structures and functions, including the composition of CCMs and the TRP, to the content of proposal forms and guidelines. At its eleventh meeting, the Global Fund's board tasked the Portfolio Committee with examining the issues raised by the TRP and to present recommendations at the board's thirteenth meeting, scheduled for April 2006 (Global Fund, 2005h).

7.6 LESSONS FROM SUCCESSFUL HEALTH SYSTEMS STRENGTHENING PROPOSALS IN ROUND 5

7.6.1 RWANDA

Rwanda submitted a proposal for just under $34 million over five years focused on scaling up the country's system of community-based health insurance. It also included elements of strengthening health management systems and monitoring/evaluation, and electrification of seventy-four health centers (CCM Rwanda, 2005). It was one of five

[24] A proposal may have more than one component (e.g., for HIV/AIDS, TB, malaria and HSS). The TRP reviews only proposals that are considered eligible after a screening process conducted by the Secretariat.

[25] The Global Fund Secretariat has produced a table outlining the strengths and weaknesses identified by the TRP of all thirty proposals submitted under the health systems strengthening component (Global Fund, 2005m).

proposals to be classified by the TRP in Category 1.[26] The TRP considered this to be a "strong, well-written and highly innovative" proposal with no identified weaknesses. The proposal's strengths included:

- A strong evidence base and track record of community-based health insurance in Rwanda;
- A strong focus on overcoming main barriers to care for people with AIDS, TB, and malaria;
- Full integration with strategies for national health sector development and health care financing; and
- An innovative and creative approach to the neglected issue of social protection (TRP, 2005a).

7.6.2 MALAWI

Malawi submitted a proposal for just over $65 million over five years, focused on significantly expanding the number of health surveillance assistants, nurses, clinical officers, and physicians in the country, and significantly improving the quality of training for nurses by refurbishing training schools, hiring additional tutors, and supporting training courses in four institutions (CCM Malawi, 2005). The TRP considered this to be a "strong and exciting proposal." The only weakness identified was inadequate detail in the first-year work plan and budget. The proposal's strengths included the following:

- It was an exciting proposal that could serve as a model for the region;
- It had a health sector plan with wide-ranging inputs and outputs;
- It had well-articulated links to the three diseases;
- It addressed the need for short-term delivery of services and longer-term building of capacity; and
- It made strong linkages to existing Global Fund grants for work on HIV and malaria (TRP, 2005b).

7.6.3 CAMBODIA

Cambodia submitted a proposal for just over $5 million over five years focused on strengthening health sector planning, and procurement and distribution of medical supplies in the public health sector (CCM Cambodia, 2005). Although the TRP recommended the proposal be accepted, a number of weaknesses were identified. One was the extent to which NGOs and a range of key government personnel were to be involved in the proposed planning processes. A second concerned whether or not the health management information systems were strong enough for the proposed processes. Significant strengths were also identified. They included:

- The planning subcomponent, which was well described and focused on system strengthening.

[26] Category 1 proposals are those requiring no or only minor clarifications.

- Gaps and priorities related to drug system functioning wee clearly identified.
- The proposal described a good track record of principal recipients and subrecipients.
- The proposal articulated a good functioning CCM.
- The proposal described plans to phase out ad hoc salary supplements and to replace them with performance-based salary incentives.
- Support was being requested for all levels of the system (TRP, 2005c).

7.7 APPLICATIONS FOR HEALTH SYSTEMS STRENGTHENING FROM THE E&E REGION

The Republic of Georgia submitted the only HSS application to the Global Fund from the E&E region. Questionnaires were sent to a number of USAID Missions to try to identify reasons why other countries did not apply for HSS funds in Round 5. Reasons included:

- No awareness that it was possible to apply for funds in this category;
- Countries had already identified the type of work for which they were submitting applications in Round 5 and lacked capacity to submit additional applications; and
- A lack of clearly identified structures in country to develop an application of this nature.[27]

Georgia submitted a proposal for just over $800,000 over five years focused on strengthening HIV/AIDS surveillance and monitoring and evaluation (CCM Georgia, 2005). This was submitted alongside an HIV/AIDS proposal for just under $5 million over five years. The TRP considered both of these proposals together because the HSS component was considered too small to justify a stand-alone Global Fund grant.[28] Both components were considered to have several weaknesses and were not recommended for funding. The weaknesses of the proposal included the following:

- An unconvincing strategic plan with inadequate focus on primary prevention among drug users and other vulnerable groups;
- Failure to address measures to ensure confidentiality and avoidance of coercion in voluntary counseling and testing services in the penitentiary system and uniformed services;
- Inadequate focus on why key measures planned under the Round 2 grant were not yet in place;

[27] Countries have now largely established and identified ways of generating disease-specific proposals. Although these occur under the umbrella of the country coordinating mechanism (CCM), this body often lacks the capacity to write the proposal and often relies on capacity within disease-specific structures (e.g., AIDS centers/program, TB program). It is unclear who would be responsible for writing an HSS proposal for the CCM and whether or not such capacity exists in E&E countries. For example, one respondent from Central Asia said, " We could look at health reform issues in conjunction with ZdravPlus II but would be hard pressed to find a national body or bodies in Kyrgyzstan, Kazakhstan that would be prepared to write a systems strengthening proposal on behalf of essentially moribund CCMs. Therefore, what the Fund would get is a ZdravPlus proposal to be implemented and monitored by ZdravPlus."

[28] There are many examples of proposals the Global Fund accepted in previous rounds under the HIV/AIDS component that included very similar elements to those identified separately in this proposal as health systems strengthening.

- Failure to use domestic resources to finance the modest HSS component; and
- Inconsistencies in numbers.

8. DONOR SUPPORT TO COUNTRIES TO INCLUDE HEALTH SYSTEMS STRENGTHENING EFFORTS IN PROPOSALS TO THE GLOBAL FUND

The terms of reference for this assignment specified that the assessment team should analyze how donors and USAID can best support countries to include HSS efforts in their proposals to the Global Fund and to then successfully implement these grants, including monitoring and evaluation. This issue is explored here, with a particular focus on the provision of technical support to applications.

8.1 PREPARING TO BID

A bid to the Global Fund under the HSS component requires that a technical needs assessment[29] be conducted. Given that a needs assessment would need to be conducted before the application is submitted, it is clear that financing for this would need to come from another source. Using funds in this way would allow a donor to exert considerable leverage with only modest amounts of financing.

The focus of such a needs assessment should be on identifying gaps and weaknesses in the health system having an adverse effect on HIV/AIDS programming. It should also identify ways in which money from the Global Fund could contribute to filling those gaps and produce demonstrable gains for HIV/AIDS programming. This will be easier in a country such as Kyrgyzstan, which has a clear idea of the kind of health system it is trying to develop (Ministry of Health, 2005) than in Ukraine, where this picture is only beginning to emerge (Lekhan and Rudiy, 2005). Based on feedback from Round 5 applications, the Global Fund's TRP is likely to consider a proposal to be stronger if it is clearly and explicitly linked to well-defined national policies (e.g., on health reform or on human resource development in the health system).

Also, in preparing a bid, a decision must be made whether to prepare a separate HSS component or to integrate the HSS aspects into a disease-specific application. It is likely that the Global Fund may have clearer instructions for this for Round 6,[30] and these will need to be followed. It is also possible that the Global Fund may decide not to continue with a stand-alone HSS component. Assuming it does, the following factors should be considered when a country decides whether to apply for a separate HSS grant:

- *Size*—Although there are no definite rules regarding size, the TRP was clear that it considered the application from Georgia[31] too small to justify a separate grant. Countries should consider whether their proposal is large enough to justify a separate grant.

[29] Although developing a methodology for such an assessment is beyond the scope of this study, the six thematic areas described in this report could be used as lenses to identify country-specific barriers that exist and that need to be addressed in order for HIV/AIDS programs to be more effective.

[30] Dates for Round 6 have not yet been announced.

[31] $800,000 over five years for second-generation surveillance.

- *Number of elements within the component*—This issue is linked to that of size. It is easier to justify a separate HSS component if it consists of several elements rather than just one.[32] However, these elements need to be clearly defined. A common reason given by the TRP for rejecting HSS proposals was that it considered the proposal to be too broad or vague.

- *Benefits for more than one disease*—If the planned measures would benefit not only HIV/AIDS programming but also programs for TB and malaria, this would be a strong justification for having a separate HHS component. Improving coordination of TB and HIV programming and improving treatment of TB/HIV coinfection is a high priority for the Global Fund. However, it is already possible to include these elements in disease-specific applications. Indeed, there is now a requirement to address this issue in proposals for HIV/AIDS funding in countries where TB is a significant issue and in proposals for TB funding in countries where HIV/AIDS is a significant driver of the TB epidemic. Consequently, this factor alone might not be a sufficient reason for a separate proposal.

- *Positive interactions with existing Global Fund grants*—Where a country has an existing Global Fund grant or grants, it is clear that the TRP expects the proposal to explain how a new grant would link to existing ones. This was considered to be a strong issue in Malawi's HSS application in Round 5 (CCM Malawi, 2005) and a weakness in Georgia's (CCM Georgia, 2005). It is quite acceptable for the proposal to address constraints that have been hindering implementation of other Global Fund grants. Indeed, this is likely to be considered a strength assuming that the explanations are rational and valid, and not simply an attempt at justifying poor grant management. On balance, the strongest justification for a separate HSS application would be on the basis of whether a country believes it would complement existing disease-specific grants.

- *Interactions with concurrent disease-specific applications (i.e., other applications to the same round)*—The TRP identified this as a problem in Round 5. Because each component is assessed on its own merits, it is possible for each to be either accepted or rejected independently of other components. This would create problems if any activity were contingent on an element in a different component. Some countries addressed this by including the same element in two different components. However, the TRP has highlighted this issue and it is unlikely that this will be an acceptable strategy in future rounds. If something is absolutely essential to the implementation of elements within a disease-specific proposal, this should be included within that proposal and not in a separate HSS application.

[32] However, this is not necessarily the case. The successful proposals from both Malawi and Rwanda had one primary element.

These factors are summarized in Table 2.

Table 2: Is a Separate HSS Application Justified? Checklist of Factors to Consider[33]

Yes	No
The proposed budget is sufficient to justify a separate grant The proposed HSS component would have several elements The proposed HSS component could not be funded from other sources The proposed grant would have demonstrable benefit for more than one of the Global Fund's target diseases The proposed grant would have clear added value for existing disease-specific programs using Global Fund grants Elements within the proposed grant are not essential to concurrent disease-specific applications	The proposed budget is insufficient to justify a separate grant The proposed HSS component would have only one element that fits clearly within a disease-specific application to the same round The proposed grant would primarily or exclusively have benefits related to a particular disease The proposed HSS elements are essential for the successful implementation of disease-specific elements being proposed at the same time (i.e., in an application being submitted to the same round)

8.2 THEMATIC FOCI FOR APPLICATIONS

Six specific thematic areas have been identified that countries in the region could use to focus their HSS applications to the Global Fund. USAID could use these thematic areas to provide technical assistance to countries and could be used by the Global Fund to provide guidance for countries in the region. These areas may also be relevant to countries in other regions, although that was not the focus of this work. These thematic areas are illustrated diagrammatically in Figure 1.

The first of these are collective elements related to *governance.* First is the need to link HIV/AIDS policy and strategy to health policy and strategy. Where a country has clearly linked its policies and strategies on health and HIV/AIDS, it needs to point out the linkages between them. However, in some countries, these policies and strategies are not linked. Indeed, in some, the policies and strategies contradict each other. In such situations, mechanisms need to be established to identify and maintain linkages between HIV/AIDS and health policies and strategies. The country CCM should play a key role in this.[34] Funding for such processes could be included in an HSS proposal to the Global Fund. However, in many countries it is not just that there are no linkages between HIV/AIDS policy and strategy and those for health, many countries simply lack a clear health policy or strategy. It seems unlikely that the Global Fund would be willing to fund the complete development of such a policy or strategy but it might be willing to contribute to this, particularly if its contribution was clearly focused on HIV/AIDS, TB, and where appropriate, malaria.

Many CCMs lack the capacity to carry out key governance tasks such as developing plans and analyzing and formulating policy. They usually lack secretariats and are often

[33] Assuming that subsequent Global Fund rounds continue to allow separate applications for HSS.

[34] However, many country coordinating mechanisms lack the capacity to do this. One respondent from Central Asia comments, "One of the major themes of the Global Fund's recent Moscow workshop for grant recipient countries was CCM strengthening, and not without reason. In CAR in particular, CCMs have a distinctly formalistic quality to them, serving as the source for application signatures but otherwise abdicating programmatic leadership—including strategic planning, implementation, and M&E to the principal recipients and program intervention units. In this light, this section reads like a proposal application guide to donor agencies who ghost-write applications for moribund CCMs. … In an ideal world, cognizant national authorities, embodied in a functioning CCM, will identify systemic issues, formulate their response, and secure and/or purchase necessary technical assistance for these efforts."

dependent on the principal recipient to act in this capacity. Measures to strengthen the planning and policy analysis capacity of CCMs could form an important part of an HSS proposal.

Linked to this issue is the question of leadership style. The Global Fund has made progress in promoting more collegial and consultative forms of leadership rather than the more familiar command-and-control approach. However, considerably more could be done in this area because autocratic leadership styles are still widespread and deeply entrenched.

The second thematic area identified by this review is that of *financing*. There are many reasons why a country needs to know how much it is spending on the response to HIV/AIDS:

- Knowledge of spending levels is an indicator of political commitment, recommended by UNAIDS.
- Some donors (e.g., the Global Fund) require countries to decide eligibility for funding.
- Knowledge of spending levels is required for effective planning and for calculating resource gaps.
- Knowledge of spending levels is required to monitor additionality of donor funds and to assess the likelihood of being able to sustain activities.

National HIV/AIDS accounts are now available to determine financing levels, either as a stand-alone process or as a subaccount of national health accounts. Some countries such as Ukraine have begun to introduce these. However, no country in the region is yet producing these on a systematic and regular basis. Providing financial support for the development and maintenance of such accounts would be an important Global Fund contribution. In addition, preparation and maintenance of national HIV/AIDS accounts should be a mandatory requirement for lower–middle income countries receiving Global Fund monies for HIV/AIDS because these countries are eligible to receive such funding only if they meet certain cofinancing requirements.

In addition, many of the anomalies in the health systems in the region arise because of the way they are financed. Although extensive reform of the financing of the health system in general, and the public health sector in particular, is beyond the mandate of the Global Fund's scope, the Global Fund could take steps to ensure that its considerable financial resources are deployed in ways that promote positive changes and that do not hinder reform. Such measures might include:

- Promoting simplified and unified financing mechanisms where appropriate;
- Coordinating and integrating different funding sources, particularly state and local budgets;
- Identifying measures to promote greater cooperation between different donors and national funding mechanisms; and
- Promoting decentralization of financial management and control.

Some of these points raise fundamental questions about the utility of the Global Fund's current financing mechanism through a principal recipient because in many cases this has resulted in establishing additional, parallel financing systems, thereby adding further layers of complexity to an already complex situation. However, this reflects the capacity problems at the country level more than intrinsic problems within the Global Fund's systems because there is no reason why Global Fund finances cannot be integrated into national financial systems. In particular, Global Fund grants can be managed by multiple principal recipients and a considerable degree of decentralization can be achieved by giving subgrants to subrecipients.

A third thematic area is that a key part of many Global Fund grants has been the provision of equipment, drugs, and other commodities that might collectively be termed *pharmaceutical and commodity management*. Public procurement processes in many countries of the region are excessively bureaucratic and nontransparent, meaning that prices paid are often too high, products may be of variable quality, and the entire process is inordinately slow. Solutions to this include bypassing public procurement processes through United Nations agencies, NGOs, or procurement agents. Although the approaches of these agencies could be seen as models for reforming public procurement, this does not occur in practice. Strengthening public procurement of equipment, drugs, and other commodities could be included in an HSS proposal. Elements to consider include the following:

- Explicitly learning lessons from procurement carried out by NGOs and United Nations agencies. For example, the experience[35] of the International HIV/AIDS Alliance in Ukraine shows the value of decentralized procurement for certain items,[36] the useful scrutiny role that can be played by a stakeholder-based tender committee, and the fact that in many settings direct negotiations produce better results in terms of price, quality, and timeliness than conventional tender competition (Drew, 2005b).
- Initiatives that move away from a focus on process to those focused on the key results of price, quality, and timeliness.
- Reform of procurement law and simplification of bureaucratic practices.
- Initiatives to strengthen the independence and professionalism of public service, including addressing the issue of public sector pay.
- Initiatives that reduce or remove political interference in procurement processes.
- Initiatives that strengthen the capacity of civil society groups to analyze procurement processes and hold governments accountable. An excellent example of this is the role played by the All-Ukrainian Network of People Living with HIV in highlighting

[35] Following the suspension of three Global Fund grants to Ukraine, the Alliance was appointed as steward of the Global Fund's grant to Ukraine. This role began in early 2004 and has continued into the second phase of grant implementation.

[36] Particularly those that are readily available and do not require highly technical specifications, such as condoms. Despite the strong opposition to decentralized procurement from many circles, it produces better results in some settings, it fits better with decentralization promoted under health reform, and contributes to building decentralized capacity. Claims that decentralized procurement runs contrary to the Three Ones principles are unfounded. The principles do not require one national procurement agency any more than they require one organization to implement all activities.

price discrepancies in different processes to procure antiretroviral drugs (All-Ukrainian Network of People Living with HIV, 2005).

The fourth thematic area identified is that of *human resources management*. Many countries lack overall human resource plans for either the health sector or for HIV/AIDS programming. Proposals for human resource initiatives that are based on such plans (e.g., Malawi's HSS application [CCM Malawi, 2005]) are more likely to be accepted. The Global Fund may be willing to finance the development of such plans, particularly if they are focused on target diseases.

A key barrier to effective HIV/AIDS programming is the low salaries paid to health workers in the public sector. There are many ad hoc and individual responses to addressing this, some of which have been supported by the Global Fund. However, some countries (e.g., Kyrgyzstan) have been trying to address this more systematically. It is worth noting that part of the successful HSS proposal submitted by Cambodia in Round 5 included performance-based salary incentives.[37] Consequently, similar schemes could be proposed to the Global Fund, particularly parts of overall packages that provide funding for staff who work specifically on HIV/AIDS and TB issues.

Training will be an important part of any initiative to strengthen health systems, and the Global Fund has had a strong focus on supporting training of a wide range of staff to date. However, elements that have not been such a strong focus include developing an overall HIV/AIDS training plan, pre-service training for health professionals, and retaining and motivating trained staff. All these elements could form part of an HSS proposal to the Global Fund.

Reports are widespread that health workers in E&E countries discriminate against persons living with HIV/AIDS and other vulnerable populations, and they are a cause of considerable concern. Of particular concern are reports that some HIV/AIDS training has reinforced stigma and discrimination. Training and other activities focused on tackling stigmatizing attitudes and discriminatory practices among health workers will be required if national HIV/AIDS programs are to be effectively implemented. Such activities could form part of an HSS program. Programs should have safeguards in place to ensure that training provided is not reinforcing stigma and discrimination.

Other areas that have already been supported by Global Fund monies include promoting the use of multidisciplinary teams, creating more meaningful roles for nurses and social workers, and employing members of vulnerable populations in program implementation, (for example, as field workers). Although to date such initiatives have been financed as part of particular HIV/AIDS program elements, they could also be part of an HSS proposal.

The fifth thematic area is *service delivery*. A key practical focus for Global Fund financing should be to promote the joint working of key medical specialties (see Figure 4). A wide range of initiatives could be conceived, including:

- Improving national, regional, and local coordination;
- Joint training for relevant professionals;

[37] The United Kingdom's Department for International Development played a key role in designing and funding this initiative.

- Developing clear and workable protocols for managing TB/HIV coinfection;
- Designing improved and more rational services for injecting drug users, including HIV prevention and antiretroviral therapy; and
- Designing improved treatment services for sexually transmitted infections for the most vulnerable populations, including sex workers and men who have sex with men.

The Global Fund already has given considerable support to promoting the involvement of nontraditional health players in program implementation. Such players include other government ministries, NGOs, and private companies. Given the concentrated nature of the HIV/AIDS epidemic in the region, any initiatives to strengthen health systems should be conceptualized broadly enough to permit and expand this involvement. A large range of imaginative and innovative ideas could be developed and incorporated into proposals within this thematic area.[38] Initiatives based on a concept of HSS limited just to the public health service should be avoided.

Finally, a significant problem facing the region is excessive and inappropriate infrastructure, established on the basis of vertical medical specialties (see Figure 4) and maintained by the heads of these specialties, and a financing mechanism based on the number of beds. Maintaining this infrastructure consumes a huge proportion of the health budget. To date, very little progress has been made in addressing this, although Kyrgyzstan has begun to dismantle this system. The Global Fund should not support large-scale infrastructure reform but should ensure that it does not make the situation any worse by expanding the physical infrastructure in the public health sector. One area in which the Global Fund can make a significant contribution is laboratory rationalization. This could occur by requiring countries in the region to submit a plan for rationalizing and strengthening their laboratory services before providing funds for equipment and commodities.

The final thematic area is that of *public health and disease surveillance*. Public health is poorly understood in the region and is highly fragmented across medical specialties. In addition, the major public health body[39] is often poorly financed, has extremely limited capacity, is excluded from major public health issues, and is excessively focused on public health "policing." Initiatives to strengthen and promote modern public health in E&E countries could be part of an HSS proposal, either by strengthening existing bodies, such as the Sanitary and Epidemiological Service, or establishing new bodies, such as institutes of public health.

National HIV/AIDS surveillance systems in countries of the region are largely based on reporting registered HIV/AIDS cases, leading to considerable under-reporting in some instances. Recently, biobehavioral surveillance among the most vulnerable populations has been introduced in many countries using monies provided by the Global Fund. There is now a need to systematize and sustain this surveillance alongside case reporting. The work being supported in Central Asia by USAID and the Centers for Disease Control and Prevention provides one model for this system (Drew and Choudhri, 2005). In addition,

[38] Possible examples might include providing targeted voluntary counseling and testing for vulnerable populations and providing antiretroviral therapy through outreach services.

[39] The Sanitary and Epidemiological Service or its equivalent.

there is a need to build the capacity to analyze and use data from this surveillance, particularly to drive appropriate responses to national HIV/AIDS epidemics. Such elements could be usefully incorporated into an HSS proposal.[40]

9. SPECIFIC QUESTIONS ABOUT DISCRETE AREAS OF HEALTH SYSTEMS

The scope of work for this assignment specified that the evaluation was to investigate some discrete areas of health systems that might be suitable for Global Fund–supported interventions (see Annex D; Synergy Project, 2005). Some of these have been partially addressed in earlier parts of this report. However, they are explored in detail here for the sake of completeness and ease of reference.

9.1 DELIVERY SYSTEMS

The essential question regarding delivery systems is how to identify the best and most appropriate systems for delivering key services in a concentrated HIV/AIDS epidemic, particularly one affecting injecting drug users. These systems need to ensure that the most marginalized populations are being reached and that services are being scaled up. Although this will depend on local and national factors, some general observations can be made for the region as a whole. Annex F and Figure 2 capture these observations for the three key services of biobehavioral surveillance among vulnerable populations; focused prevention services among the most vulnerable populations; and care, support, and treatment services for persons living with HIV/AIDS. In addition, the overarching issue of financing mechanisms for these services is also considered.

Annex F is structured to show the various roles that different sectors might play in delivering these services. The sectors considered are NGOs, unreformed health structures,[41] and reformed health structures.[42]

9.2 SCALE-UP IN CONCENTRATED EPIDEMICS

Although the scope of work (Annex D) focuses on technical issues such as how to scale up HIV prevention services to the most vulnerable populations, these are not the primary barriers to scale-up. A recent paper (Sharma et al., 2005) concludes that insufficient resources are being allocated to prevent and reduce the HIV epidemic among the most vulnerable populations. Available resources are not being used to support strategies known to be effective; and services are not being focused on where the vulnerable populations are located. This is why coverage remains inadequate. The paper concludes,

> *The overall sense is that a neglect of concentrated epidemics will drive the overall prevalence over the one percent mark, encouraging governments to reduce their interest in vulnerable populations and shift to the more comfortable general population strategies of mass media HIV*

[40] Note, however, the TRP did not believe that a proposal for $800,000 over five years for second-generation surveillance was sufficiently large to merit a separate consideration.

[41] These consist of the vertical health structures (see Figure 2) such as AIDS centers, TB dispensaries, dermatovenereological dispensaries, and narcological dispensaries.

[42] These consist particularly of primary care systems such as family physicians, family group practices, and family medical centers. Ideally, these systems should include a modern public health service focused on the main public health problems facing the country.

awareness-raising, further neglecting work among vulnerable groups. Eventually, if the neglect continues for a long enough period, a true generalized epidemic occurs.

9.3 TRAINING

Global Fund grants contain a strong focus on training, and the number of people trained is a key[43] coverage indicator. However, training is usually planned element-by-element during proposal design with relatively little consideration of what this might look like for the program as a whole or for individuals working within the program. At times, this results in more training being planned than can be absorbed by the program as a whole or by particular individuals.[44]

In addition, most training has consisted of short, ad hoc, in-service training workshops. More consideration needs to be given to the following:

- Pre-service training for health professionals;
- Ongoing courses of training such as those provided in Ukraine on antiretroviral therapy by the WHO Knowledge Hub; and
- Consideration of other training methods, such as mentoring, study visits etc.

Not only is it important to train people, but it is also vital to ensure that they use their training, that they are retained within the program, and that they remain motivated. Important elements in this regard are support visits, evaluation of training implementation, and refresher trainings.

Training should not be seen as a stand-alone product but as a means of promoting program implementation. Training should be delivered at an appropriate time and should be tailored toward how a program is to be implemented. This is particularly important in relation to antiretroviral therapy. In Ukraine, training was focused on a few treatment centers, meaning that key professionals in those centers received essential, quality training. However, training was based on a multidisciplinary care team model that was not fully operational at the time. Consequently, it meant that untrained staff people were involved in the care and treatment of persons living with HIV/AIDS who were on antiretroviral therapy,[45] particularly in some in-patient settings. In Tajikistan, many physicians were trained without a clear understanding of how treatment was to be delivered. In addition, delays in procurement meant that training was completed at a time when antiretroviral drugs were not available in country.

Training should be provided to all staff who will be involved in an activity. For example, in Ukraine, physicians, nurses, and social workers simultaneously received antiretroviral therapy training. Although this was a new practice and it was met with some opposition,

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[43] A Level 1 indicator.

[44] In such situations, the wrong people may attend training, particularly in situations where salaries are low and trainees are paid to attend trainings. Indeed, attending a training workshop can be a major cause of role diversion in such settings (see Section 6.5, Human Resources Management).

[45] The problem is a gap between the model on which training was based and actual practice. The model assumed that treatment is provided to a person by a multidisciplinary team consisting of a nurse, a physician, and a social worker who would provide services both to inpatients and outpatients. In practice, these teams often provide services only to outpatients. Other staff work with inpatients and many staff have not yet been trained.

particularly from physicians, it was important because it emphasized the need for staff from different disciplines to contribute to teamwork and to respect each other. This joint training aided the introduction of NGO social workers into government treatment centers, resulting in improved antiretroviral therapy adherence.

9.4 FINANCIAL BARRIERS TO PREVENTION AND CARE

Financial barriers are not the main barriers limiting access of vulnerable populations to HIV prevention and care services (Drew, 2005e[46]). The primary barriers include the limited availability of these services and the lack of trust that members of vulnerable populations have in government services. Nevertheless, some financial barriers are preventing persons living with HIV/AIDS from accessing care, support, and treatment services. The most significant of these are widespread informal user fees in the health sector. Although these will be partially overcome by providing free drugs such as antiretroviral drugs, a more lasting solution will require attention to the issue of salaries for health workers and the introduction of a more formal system of payments for services.[47] In some countries, there are also some anomalous financial barriers, such as in Albania, where persons living with HIV/AIDS can receive free treatment as inpatients but not as outpatients. As a result, persons living with HIV/AIDS may be inappropriately admitted to the hospital simply for financial reasons.

9.5 INCENTIVES

The issue of incentives has been covered to some extent in the sections on financing mechanisms and human resources. Low salaries in the public sector are a major barrier to implementation of effective HIV/AIDS programs. Some progress has been made in Kyrgyzstan in passing on savings from health reform to staff, but no country in the region is making performance-based payments, as Cambodia is doing.

A major systems barrier to effective HIV care, support, and treatment is financing the health service on the basis of the number of beds. Where this remains the practice (e.g., Ukraine), inpatient services will be prioritized, infrastructure will remain excessive, and there will continue to be unnecessary and prolonged hospitalizations.

9.6 ACCESS TO MEDICINES

Funds provided by the Global Fund have done a great deal to make medicines more available, particularly antiretroviral drugs. For example, the number of people on antiretroviral therapy now exceeds 2,500 in Ukraine alone. Nevertheless, there are other barriers to making medicines accessible apart from the availability of drugs (Drew and Malkin, 2005). Many persons living with HIV/AIDS are active injecting drug users and they will be able to adhere to antiretroviral therapy only if they receive concomitant treatment for their drug use. In addition, persons living with HIV/AIDS require not only antiretroviral therapy, but also treatment for opportunistic infections. It is a regrettable paradox that some persons living with HIV/AIDS are able to get expensive antiretroviral drugs but they are unable to access inexpensive treatment for opportunistic infections.

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[46] This report examined the barriers that resulted in slower than expected take-up of free antiretroviral therapy in Ukraine. These are summarized in Figure 1. These reports are accessible from the Alliance Ukraine Web site: Hhttp://www.aidsalliance.kiev.ua/cgi-bin/index.cgi?url=/en/gfund/extrew/synergyta.htmH

[47] This might include a system of social insurance, or a more formal system of user fees, including a mechanism for effective exemptions for those unable to pay.

Massive problems remain with the public procurement of pharmaceuticals and commodities, characterized by excessive price, political interference, nontransparent procedures, and inordinate delays. As a result, there are widespread concerns about the risk of stock-outs and fears of sustainability of treatment once Global Fund financing ends. In addition, drug supply management is often weak and rigid, meaning that it may be difficult to transfer surplus stocks from one geographical area to another.

In some settings, medicines are provided free of charge, but there are informal or formal charges for related services such as medical consultation, laboratory tests, or both.

9.7 PUBLIC-PRIVATE MIX

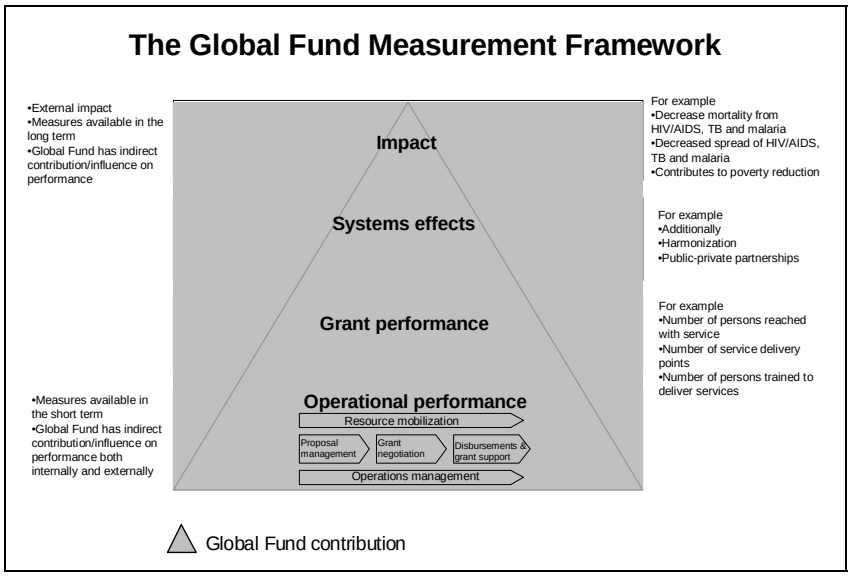
This issue has been covered extensively in other sections, particularly in relation to NGOs. The Global Fund has provided essential support to the greater involvement of this sector on both governance and implementation of HIV programs. More limited progress has been made with the for-profit sector.

9.8 MONITORING

A key question that arises if Global Fund finances are to be used to strengthen health systems is how such interventions are to be monitored, particularly for any effect they might have on the three diseases of malaria, TB, and HIV/AIDS. This section explores those issues; it is divided into two parts. The first part explores work that has already occurred on this issue, primarily by the Global Fund. The second part analyzes this work through the lenses of the six thematic foci identified earlier in this report and suggests additional indicators to track the effects of health systems strengthening initiatives.

The Global Fund has developed a four-level measurement framework to monitor its performance (see Figure 7).

Figure 7: Monitoring Global Fund Performance[48]



[48] A graphic appears in Global Fund, 2005i.

Two of these levels are particularly relevant to monitoring HSS. The first is *operational performance*. Since the Global Fund was established, work has been ongoing to define monitoring and evaluation needs and systems, culminating in the publication of a multiagency monitoring and evaluation toolkit (Global Fund, 2005[49]). This toolkit encapsulates shared, international understanding of indicators used to monitor disease-specific programs. It focuses on services delivered in key areas and on measuring their coverage at three levels: the number of people trained, the number of service delivery points, and the number of people reached. These three coverage levels have provided a sound basis for monitoring disease-specific programs. These same indicators can be used to monitor the disease-specific effects of HSS programs supported by the Global Fund. Indeed, being able to demonstrate a change in indicators of this nature should be considered the essential evidence that HSS initiatives are having demonstrable effect on HIV/AIDS or another target disease.

However, it should be possible to directly measure the operational performance of grants to strengthen health systems. The draft second edition of the toolkit contains suggested indicators to measure operational performance of HSS grants (see Annex I). Once the second edition of the toolkit is released, any proposal for HSS would be expected to include both these indicators to measure the strengthening of health systems and indicators of disease-specific benefits. The HSS indicators are arranged according to six areas: service delivery, human resources, community systems strengthening, information systems and operational research, infrastructure, and procurement and supply management. For each area, three levels of indicators are proposed—outputs, outcomes, and impact (see Annex I). For impact indicators in all six areas, reference is made to disease-specific outcome indicators. This makes sense in many ways because the desired effect (i.e., the impact) of these HSS initiatives is to be observed at the disease-specific level.

The second level is *systems effects* (Global Fund, 2005i) and is focused on three issues: additionality of Global Fund monies, partnership development, and sustainability. The Global Fund has proposed indicators in each of these three areas (see Annex J).

This section concludes with an analysis of the adequacy and appropriateness of the indicators developed by the Global Fund for monitoring HSS initiatives. This occurs first in general terms and then by using the lenses of the six thematic areas identified in this report (see Figure 1). Annex K contains some additional indicators that the authors of this report propose to use in tracking progress against these themes, particularly in the E&E region.

First, as the toolkit notes, the indicators of operational performance are strongly focused on the government health sector.[50] Although the toolkit includes a comment that similar indicators would be welcomed for the NGO sector, there is the risk that this emphasis may inadvertently strengthen the widespread view that the national health system and government health sector are analogous. Second, the indicators are most relevant to countries experiencing generalized, sexual epidemics, and for this and other reasons[51] the indicators may be more relevant to countries in other regions than in E&E. Third, the split

[49] Draft second edition dated September 2005.

[50] Except those to strengthen community systems.

[51] For example, the nature of the human resources indicators.

of indicators between two levels—systems effects and operational performance—may be confusing. It may be preferable to include all these indicators at the systems level but to split them into those that are measured internationally, by the Global Fund, and those that are measured nationally by grant recipients.

Now to examine these indicators through the "lenses" of the thematic areas identified in this report. On the issue of *governance*, some of the partnership and harmonization indicators at the level of system effects seek to measure the degree of involvement of NGOs in program governance structures, however, these are largely focused on mechanics and structures. There are situations in which NGO representatives believe their participation is minimal or nonexistent even where the conditions implied by the indicators have been fulfilled. Conversely, NGO representatives may believe they have real and valuable involvement in governance in situations where some of these mechanisms are not in place. For this reason, an indicator is included in Annex K that focuses on assessing the satisfaction of NGOs with their degree of participation in program governance and implementation. Additional suggested indicators include those focused on assessing links between the grant and health and HIV/AIDS policy.

Regarding *financing*, many of the additionality and sustainability indicators of the system effects of the Global Fund require information about national-level spending on HIV/AIDS. However, in the E&E region, this information is largely absent because no country is regularly producing national HIV/AIDS accounts. The number of countries with national HIV/AIDS accounts is included as an indicator in Annex K. None of the currently proposed indicators track the degree of integration of Global Fund monies with other health financing mechanisms. A suitable indicator is proposed in Annex K, along with an indicator that measures the extent to which Global Fund finances are decentralized in country.

There are some indicators related to *pharmaceutical and commodity management* in the monitoring and evaluation toolkit as HSS-specific indicators of operational performance. However, the output indicators are specific to TB. Although these are of critical importance, they may need to be broadened to include HIV/AIDS pharmaceuticals and commodities. The outcome indicator regarding stock-outs is important and will be particularly useful if they are divided by drug category and individual product. Key issues of cost and timeliness of procurements are not directly addressed by the proposed indicators.[52] Possible indicators of these are included in Annex K.

A number of indicators related to *human resources management* are included in the monitoring and evaluation toolkit as HSS-specific indicators of operational performance. However, these indicators appear to imply a shortage of health staff and understaffed institutions. As a result, they may be of limited relevance to the E&E region where there are more problems associated with poorly paid, poorly trained, and unmotivated staff with stigmatizing and discriminatory attitudes toward persons living with HIV/AIDS and members of vulnerable populations. Although the proposed indicators focus on training,[53] they do not really address these other issues. For this reason, Annex K proposes a number of other indicators.

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[52] Although it is recognized that untimely procurement can result in stock-outs.

[53] As do the disease-specific coverage indicators.

The toolkit is perhaps strongest in the area of *service delivery*, particularly in the disease-specific sections. The HSS-specific section contains some indicators. Annex K suggests some additional indicators that focus on coordination of services, including TB/HIV coinfection and integration of laboratory services.

Finally, indicators related to *public health and disease surveillance* appear under the heading "information system and operational research" in the monitoring and evaluation toolkit. However, these would simply track whether or not the studies have occurred. They would not track whether the studies are integrated into other surveillance/information systems or whether the studies are being used to drive the national HIV/AIDS response. Annex K proposes indicators for these along with a measure of how many countries have an integrated public health structure responsible for the country's major public health issues.

10. CONCLUSION

This study has sought to identify health systems barriers to effective HIV/AIDS programming in the E&E region. These barriers are considerable, and clearly, they cannot be overcome by the Global Fund alone. However, by coordinating with other international partners and focusing interventions where they can have maximum impact on the three target diseases of malaria, TB, and HIV/AIDS, it is clear that the Global Fund can play a very significant part in overcoming these barriers. It is the view of the assessment team that this would occur most effectively in the region by encouraging countries to include HSS elements in disease-specific proposals rather than having a separate category for applications of this nature.

USAID can leverage considerable finances for countries in the E&E region by providing them with technical assistance to develop HSS-related proposals for the Global Fund. Key principles of such technical assistance should include the following:

- Promoting appropriately focused responses for low-level and concentrated HIV/AIDS epidemics;
- Promoting relevant policy changes in the health sector; and
- Broadening the view of the health system beyond the government health sector.

HSS elements for a proposal can be clustered into six themes: governance; financing; pharmaceutical and commodity management; human resources management and planning; service delivery; and public health and surveillance (see Figure 1). Any HSS-related proposal will need clear monitoring criteria both for the HSS-related activities and for the proposed disease-specific effects.

11. ACKNOWLEDGMENTS

The assessment team thanks all persons who made this work possible. We thank in particular the E&E Bureau staff at USAID for commissioning the work; Susan Duberstein and Ellen Smead at the Synergy Project for managing overall logistics; the Academy for Educational Development and Irina Reshevskaya for managing logistics in Central Asia and Ukraine, respectively; Forest Duncan, Delna Ghandhi, Andreas Tamberg, and Michael Borowitz for commenting on the initial draft; and all respondents who spoke with the team in person or by telephone.

ANNEXES

ANNEX A: SCHEDULE OF MEETINGS

Dushanbe, Tajikistan[54]

October 4, 2005

Faridun Kamoliddinov, START project, Academy for Educational Development

Peter Argo, Country Representative, USAID and Aziza Khamidova, Health Specialist, USAID

William Paton, UN Resident Coordinator; Igor Bosc, UN Deputy Resident Coordinator; Zebo Jalilova, Deputy Manager Implementation Unit for Grants of the Global Fund to Fight AIDS, TB and Malaria; Saleban Umar, National Program Officer, UNAIDS

Deputy Minister Avgonov, Ministry of Health

Zuhra Halimova, Executive Director, Open Society Institute

October 5, 2005

Meeting with USAID Contractors: Umed Ibragimov, CAPACITY; Mikhail Chitalkin, AIDS Foundation East West; Marian Sheridan, Zdrav Plus; Vladimir Magkoev, Open Society Institute; Thomas Mohr, Project HOPE

Nazira Artikova, Liaison Officer, World Health Organization

October 6, 2005

Niloufar Pourzand, Program Coordinator and Nisso Kasymova, HIV/AIDS Project Officer, UNICEF

Saleban Omar, HIV/AIDS Advisor/Focal Point, UNAIDS; Maria Boltaeva, Monitoring and Evaluation Officer, UNAIDS; Zebo Jalilova, Deputy Head, Global Fund HIV/AIDS and UNDP

Arsen Khadziev, Human Development Consultant, World Bank

October 7, 2005

Kelsey Harris-Smith, Chief, Office of Defence Cooperation

Aziza Khamidova, Health Specialist, USAID

Amir Ansari, Health Specialist, UNICEF

Saleban Omar, HIV/AIDS Advisor/Focal Point, UNAIDS; Maria Boltaeva, Monitoring and Evaluation Officer, UNAIDS

Debriefing session with Peter Argo, Country Representative, USAID; Aziza Khamidova, Health Specialist, USAID; William Paton, UN Resident Coordinator; Igor Bosc, UN Deputy Resident Coordinator; Zebo Jalilova, Deputy Manager Implementation Unit for Grants of

[54] George Purvis experienced problems with flights; therefore, Roger Drew conducted all interviews alone in Dushanbe.

the Global Fund to Fight AIDS, TB and Malaria; Saleban Umar, National Program Officer, UNAIDS; Umed Ibragimov, CAPACITY; Nazira Artikova, Liaison Officer, World Health Organization; Maria Boltaeva, Monitoring and Evaluation Officer, UNAIDS; Arsen Khadziev, Human Development Consultant, World Bank; Yukie Mokuo, UNICEF

Bishkek, Kyrgyzstan

October 7, 2005[55]

Damira Bibosunova, Project Management Specialist Health, USAID

Ainura Ibraimova, Mandatory Health Insurance Fund

Ainagul Isakova, Coordination and Monitoring HIV/AIDS

Chris Lovelace, World Bank

Elvira Mureatlieva, CAPACITY

October 9, 2005

Sheila O'Dougherty, Chief of Party and Mark McEuen, Country Manager, ZdravPlusII

October 10, 2005

Damira Bibosunova, Project Management Specialist Health, USAID

Shayloobek Niayzov, Minister of Health; Kasymbek Mambetov, State Secretary

Ainura Ibraimova, Deputy Minister and Director of the Mandatory Health Insurance Fund

Sabyrjan Abdikarimov, General Director, State Sanitary Epidemiological Department

Ainagul Isakova, Head of the Unit for Coordination and Monitoring in HIV/AIDS Area

October 11, 2005

Elvira Muratlieva, Country Director, CAPACITY

Ainagul Osmonova, Country Manager, World Bank Program Intervention Unit

Gulmira Aitmurzaeva, Republican Center for Health Promotion

Boris Shapiro, Director General of the National AIDS Center and Talgat Subanbaev, Program Manager, Project Implementation Unit, Global Fund to Fight AIDS, TB and Malaria, AIDS Component

Aisuluu Bolotbaeva, Public Health Programs' Coordinator, Soros Foundation Kyrgyzstan

[55] Preparatory meetings conducted by George Purvis.

October 12, 2005

Avtandil Alisherov, General Director, National TB Center

Aleksander Kahn, Project Manager, Global Fund Project, TB component

Janicka Roos, Regional Director, Central Asia Regional HIV/AIDS Program

Melitta Jakab, Resident Adviser, World Health Organization/U.K. Department for International Development Health Policy Analysis Project

Chris Lovelace, Senior Manager, World Bank

October 13, 2005

Mirlan Mamyrov, Chief Specialist on Monitoring and Evaluation, Unit for Coordination and Monitoring in HIV/AIDS Area

Boris Shapiro, Director General of the National AIDS Center

Ekaterina Paniklova, Program Officer, UNDP

Geneva, Switzerland, Global Fund

October 14, 2005

Beth Ann Plowman and Prerna Banati, Strategic Information and Evaluation

Valeriy Chernyavskiy and Karmen Bennett, Fund Portfolio Managers

Ruwan de Mel, General Manager Portfolio Services and Projects; K. Carl Manlan, Program Officer

Daniel Low-Beer, Senior Manager, Strategic Information and Evaluation

Interviews in Washington, DC[56]

October 27, 2005

Meeting with Robert C. Emery, Supervisory Health Development Officer, Office of Health, Infectious Diseases, and Nutrition; James R. Heiby, Medical Officer with Central Asian Republics and Russian Federation Quality Improvement Experience; Forest Duncan, E&E Bureau; Delna Ghandhi, Global Health Bureau, USAID

November 14, 2005

Anthony Boni, Pharmaceutical Management Specialist, USAID

D'Arcy Richardson, Senior TB and Infectious Disease Advisor, USAID

[56] Conducted by George Purvis alone.

Meeting with Neen Alrutz, Global Fund Liaison; Margaret Wynne, Special Assistant to the Director, Office of Global Health Affairs; Peter Mamacos, Office of Global AIDS Coordinator; Forest Duncan, E&E Bureau, Health Development Officer

Telephone Interviews

November 1, 2005

Michael Favorov and Baurzhan Zhussupov, Centers for Disease Control and Prevention, Almaty*[57]

Kerry Pelzman and Andreas Tamberg, USAID, Almaty, Central Asia Regional Mission*

Joe Kutzin, World Health Organization Europe, Copenhagen*

November 2, 2005

Michael Borowitz, Open Society Institute*

November 22, 2005

Neen Alrutz, Global Fund Liaison, USAID*

December 6, 2005

Paul Ehmer, USAID

December 8, 2005

Claudia Allers, Jeff Sanderson, Dragana Veskov, and Tony Hudgins, John Snow Incorporated/Deliver**

December 9, 2005

Sara Bennett, Abt Associates**

Ukraine

November 29, 2005

Visit to Kiev City AIDS Center**[58]

Visit to Programs of Ukrainian Harm Reduction Association**

November 30, 2005

Andrey Klepikov, Director, International HIV/AIDS Alliance in Ukraine

[57] * Roger Drew only.

[58] ** George Purvis only.

Meeting to discuss procurement and drug supply attended by Betsy Wilskie, Program for Appropriate Technology in Health; Zahedul Islam Mohamed, Médecins sans Frontièrs; Olga Kosyak, UNICEF; Tetyana Tarasova, UNICEF

Andrey Huk and Oleg Semerik, POLICY Project

December 1, 2005

Victor Rybchuk, former Deputy Minister of Health

Meeting to discuss monitoring and evaluation attended by Veena Lakhumalani, British Council; Oleksiy Yaramenko, POLICY Project; Lyudmyla Husak, Alliance; Olga Varetska, Alliance; Anna Dovbakh, Alliance; Larisa Bochkova, National AIDS Center; Vinay Saldanha, UNAIDS

Nancy Godfrey and Oleksander Cherkas, USAID

Volodymyr Romaniv and Valeriy Khmarskyy, World Bank Program Intervention Unit

Eliot Pearlman and Natalya Pidlisina, NGO Coalition

December 2, 2005

Svitlana Kupryashkina-McGill, International Renaissance Foundation

Aleksandrina Tetyana, Ministry of Health

Svetlana Antonyak, Lavra Clinic

Vladimir Zhovtyak and Arthur Ovsepyan, All-Ukrainian Network of Persons Living with HIV

December 7, 2005

Eliot Pearlman and William Wickham, General Director, Delta Medical*

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ANNEX C: TYPES OF HIV/AIDS EPIDEMICS IN THE E&E REGION[59]

HIV/AIDS in the region: Epidemics are concentrated yet significant

In 2004, 39.4 million people in the world were living with HIV/AIDS, 4.9 millions had acquired HIV infection that year, and 3.1 million people died as a result of AIDS. Although sub-Saharan Africa remains the most severely affected region, the most rapid spread of HIV is occurring in East and Central Asia, and in Eastern Europe. There are several types of epidemics in Europe, although they are all of a *concentrated* type.

Types of Global HIV/AIDS Epidemics[60]

Risk Factors	Type of Epidemic	Location Examples
Limited injecting drug use, limited sexual risk factors	Low-prevalence epidemic	Philippines, Western countries
Injecting drug use, limited links to limited sexual risk factors	Injecting drug use epidemic	Iran, Estonia
Injecting drug use, links to some sexual risk factors	Concentrated injecting drug use–sexual transmission crossover epidemic	Vietnam, Ukraine, Russia, Indonesia
Sexual risk factors conducive to vulnerable group transmission (e.g., many sex workers with large numbers of clients)	Concentrated sexual epidemic	Thailand, Cambodia, parts of West Africa
Sexual risk factors conducive to widespread transmission (e.g., low rates of male circumcision, high concurrent partner rates, interaction prevalence countries)	Generalized epidemic	Southern and parts of eastern Africa

According to UNAIDS, an HIV/AIDS epidemic is generalized when HIV prevalence is more than 1 percent in the general population. If that stage has not been reached, a country may be considered to have a concentrated epidemic if HIV prevalence is more than 5 percent in any identifiable subpopulation. An epidemic is considered low-level if HIV prevalence is less than 1 percent in the general population and less than 5 percent in any subpopulation. However, where subpopulations are large and HIV prevalence among them is high, it is possible that an HIV epidemic may be very large even though HIV has not spread significantly beyond the vulnerable subpopulation. Alternate definitions:

- Concentrated—if transmission occurs largely among vulnerable groups and vulnerable group interventions would reduce overall infection.
- Generalized—if transmission occurs primarily outside vulnerable groups and would continue despite effective vulnerable group interventions.

[59] This annex is based on a presentation originally made at a workshop for USAID regional health managers' held in Kiev, in September 2005 (Drew, 2005a).

[60] The table and the logic model are based on the work of David Wilson of the World Bank, presented at an M&E training workshop held at Andrija Stampar School of Public Health in Zagreb, July 2005.

- In Western and Central Europe, an epidemic is occurring in some countries among men who have sex with men and injecting drug users. Heterosexual spread is also significant, particularly among those in countries with serious epidemics.
- Belarus, Moldova, Russia, and Ukraine are the worst-affected countries in the region with serious epidemics, particularly among injecting drug users.
- Although the Baltic States are economically well developed, they have significant HIV/AIDS epidemics, particularly among injecting drug users.
- In Central Asia, overall rates of HIV infection are low but there have been well-documented local outbreaks among injecting drug users in some places.
- In Southeast Europe and the Caucasus, HIV prevalence is believed to be low, although vulnerability is considered high.

Given the state of the epidemic in Europe, an opportunity exists to halt and reverse the epidemic if action is taken on the basis of accurate information and targeted toward those most vulnerable to the disease. Barriers to effective action include:

- Lack of accurate, strategic information;
- Low program coverage;
- Limited financial and human resources.

A concentrated epidemic requires a distinctive approach to programming and monitoring and evaluation … that is not focused on the general population, but on the most vulnerable subpopulations, such as injecting drug users, sex workers, and men who have sex with men. This can be done by using the following eight step logic model toward monitoring and evaluation/surveillance in concentrated epidemics:

Understand the problem…	**Step 1:** Through biological surveillance,[61] estimate the HIV prevalence among the most vulnerable population subgroups. **Step 2:** Estimate the size of the most vulnerable subpopulations. **Step 3:** Through behavioral surveillance understand the risk interactions between members of vulnerable subpopulations. **Step 4:** Estimate the proportion of HIV infections occurring due to different risk behaviors.
Monitor the effectiveness and appropriateness of the response…	**Step 5:** Design a national program that seeks to provide proven, effective HIV prevention services to at least 60% of all members of the most vulnerable populations. **Step 6:** Track program coverage and confirm through national surveillance surveys. **Step 7:** Repeat behavioral surveillance among vulnerable populations to track program outcomes. **Step 8:** Repeat biological surveillance among vulnerable populations to track program impact.

[61] The state of HIV/AIDS surveillance in the region was reviewed in 2004 (Drew and Choudhri, 2005).

ANNEX D: TERMS OF REFERENCE

The Synergy Project

Statement of Work

Recommendations for Advising Donor Support to Resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to Address Health Systems Barriers to Effective HIV/AIDS Programs in the USAID/Europe and Eurasia (E&E) Region

Final *(October 17, 2005)*

I. IDENTIFICATION OF THE TECHNICAL ASSISTANCE

The USAID Mission for Europe and Eurasia (USAID/E&E) has requested The Synergy Project to provide technical assistance to conduct a study of how best to harness the resources of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to address the underlying health system barriers to scaling up effective HIV/AIDS programs in the E&E region. This work will be undertaken with advice from USAID's Europe and Eurasia Bureau, USAID's Bureau for Global Health, USAID's Missions for Ukraine and for the Central Asian Republics.

II. GENERAL BACKGROUND

The health status for most people of the E&E region is worse than it was before independence. Life expectancy has declined. There is a rapidly increasing HIV epidemic, fuelled by injecting drug use. According to UNAIDS in 2004 there was an estimated 1.4m people living with HIV/AIDS in the region with an estimated 60,000 deaths. Approximate adult prevalence is 0.8 percent, with most of those affected under 30 years of age. If no action is taken the consequences will be very high; with declining economic growth, increased health expenditure, increased dependency and the undermining of national security.

USAID has supported HIV/AIDS program efforts both through its bilateral and regional programs. However, as USAID regional funds are limited and declining, we are committed to focusing them on catalytic actions. Addressing HIV/AIDS is a U.S. Government priority. The legislation for the President's Emergency Plan for AIDS Relief, acknowledges the need to strengthen health systems, stating that successful strategies to stem the spread of the HIV/AIDS pandemic will require clinical medical interventions, the strengthening of health care delivery systems and infrastructure, and determined national leadership and increased budgetary allocations for the health sector in countries affected by the epidemic as well as measures to address the social and behavioral causes of the problem and its impact on families, communities, and societal sectors. To date there has been very low coverage of effective programs. Many of the barriers to scaling up effective control of HIV/AIDS and HIV-TB coinfection are constraints to the wider health system.

The GFATM was set up in 2002 and has approved grants to over 100 countries to date. The total value of proposals agreed in the E&E region is approximately $668m of which 74 percent is for HIV/AIDS. The GFATM can support addressing health system constraints and Round 5 of the GFATM explicitly encourages countries to submit proposals for this purpose and we anticipate that the GFATM will continue to encourage this though the guidance may

evolve in subsequent rounds. The guidance for Round 5 of the GFATM identifies the following systems components:

***** National monitoring and evaluation systems;

***** Human resources;

***** Health infrastructure development;

***** Procurement and supply management systems; and

***** Operational research.

USAID's Health Systems Strengthening Division in the Bureau for Global Health identifies similar health systems components that may be helpful in identifying health systems barriers.[62] The study needs to advise USAID on how we can help countries interpret and use the GFATM guidance on health system strengthening in future rounds.

USAID funding for E&E countries is declining, so modest USAID technical assistance for Global Fund activities could leverage substantial additional resources for health system strengthening. Investing in this infrastructure to address HIV/AIDS will also enable countries to support other priorities, including TB and new and emerging diseases such as avian flu. This study will also increase awareness of health system constraints to scaling up priority programs and could facilitate greater national commitment to health system strengthening.

There is often a fear of supporting health systems in that there is a feeling that health system strengthening will require massive resources and it will be difficult to demonstrate impact on HIV/AIDS. The study will need to help countries identify their most critical health system barriers to scaling up HIV/AIDS efforts and then identify how to help them decide which discrete elements to include in their GFATM proposal. It will be critical to ensure that that the elements selected are clearly linked to HIV/AIDS impact. Identifying the critical health system barriers at country level needs to be done systematically drawing on already available information. In addition it needs to draw on the on-going assessment of the impact of the GFATM on health systems.

Possible discrete areas of health systems could include:

—Identifying and expanding the most effective delivery systems for reaching the marginalized.

—Identifying the most appropriate delivery systems (including exploring whether reconfiguration would be needed so as) to achieve scale up of interventions through the GFATM and other resources.

—Identifying how to scale-up HIV/AIDS prevention in concentrated epidemics, where the public structures have difficulty in reaching marginalized populations. For example, can the narcological service reach IDUs? Can dermato-venerology reach sex workers? Should the public service be contracting with NGOs? How do you scale-up prevention when NGO capacity is limited.

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[62] See Attachment 1: "Health Systems and Enabling Environment Presentation

-Ensuring training is appropriately planned, organized and managed. Possible examples include (i) Ensuring the appropriate people are trained in appropriate skills (ii) ensuring the models for training used are appropriate for the setting including the stage of the epidemic, population density etc.

—Addressing the financial barriers to users accessing HIV prevention and care.

—Aligning the incentives both at the institution and individual level with best practice. Possible examples include (i) ensuring the payments do not encourage hospital admissions where outpatient treatment would be preferable (ii) linking reimbursement with following WHO/national guidelines (iii) where additional payments are provided to health workers working on HIV/AIDS linking these to performance.

—Improving access to medicines, including the outpatient level.

—Public/private mix including involving the emerging private for profit sector where appropriate.

—The consultant team will review monitoring arrangements for assessing the effects of health system interventions on HIV/AIDS including making recommendations on specific indicators where appropriate

III. OBJECTIVES OF THE ASSIGNMENT

The specific objectives for this assignment are to:

—Summarize from available reports which aspects of the health system in the E&E region are the greatest barriers to scaling up effective control of HIV/AIDS and HIV-TB coinfection.[63] Based on this, identify and prioritize discrete sections of health systems that could be included in GFATM applications.

—Analyze the extent to which countries have included health system strengthening efforts in their Global Fund HIV/AIDS proposals including the factors that encouraged/discouraged countries from doing so and the outcome of these proposals. Examine the role of the country coordinating mechanism in this process.

—Analyze how donors and USAID in particular can best support countries to include health system strengthening efforts in their GFATM proposals and then to successfully implement these grants including monitoring and evaluation.

IV. METHODOLOGY

To meet the assignment objectives, a two-person team of E&E region experts, including a GFATM and HIV Specialist and Health Systems Specialist, will review relevant literature, including Round 5 GFATM successful proposals from the E&E region, conduct interviews with key experts in Dushanbe, Tajikistan; Bishkek, Kyrgyzstan; Kyiv, Ukraine; and Geneva, Switzerland, prepare a final report, and conduct a presentation of findings in Washington, D.C.

[63] Though there is substantial analysis on health systems and on HIV/AIDS there is less work on looking at HIV/AIDS through a health systems lens. It is this literature that we are most interested in.

The criteria for country selection included a) having a significant or growing HIV/AIDS burden, b) support for efforts in health sector reform and c) endorsement from the USAID missions.

The assignment will be conducted through the following activities, presented in chronological order:

Activity 1: Interviews in Tajikistan, Kyrgyzstan, and Geneva

The consultant team will travel first to Bishkek, Kyrgyzstan; Dushanbe, Tajikistan; and Geneva, Switzerland. They will meet with members of the USAID Missions and implementing partners as advised by the Mission, OSI and implementing partners as advised by OSI, host country government, members of the CCM, other donors including the World Bank and other relevant in country stake holders including principal recipients and subgrantees as well as organizations that work on health systems.

In Geneva, the consultant team will meet with GFATM headquarter staff to discuss Round 5 proposal outcomes and the inclusion of health system strengthening efforts submitted in proposals from E&E region countries. The consultant team may also wish to discuss health systems strengthening proposals submitted from other regions.

Activity 2: Document Review, Interviews by Phone, and Analysis of Round 5 Applications

The consultant team will review research on health systems in the E&E region and current documentation on the effects of GFATM. A suggested list of references is included in Attachment 1. This document review will be supplemented by phone interviews with key experts, including but not limited to OSI staff, USAID/Central Asia (USAID/CAR), USAID/Ukraine and donors such as DFID and World Bank. USAID and others as requested will generate a suggested list of key interviews.

The consultant team will carry out data analysis and also conduct a detailed review of E&E region successful Round 5 applications and where possible, a review of relevant unsuccessful applications also.[64]

Activity 3: Interviews in Ukraine

The consultant team will travel to Kyiv, Ukraine to conduct interviews with members of the USAID Missions and implementing partners as advised by the Missions, OSI and implementing partners as advised by OSI, host country government, members of the country coordinating mechanism (CCM), other donors including the World Bank and other relevant in country stake holders including principal recipients and subgrantees as well as organizations that work on health systems.

Activity 4: Preparation of the Final Report and Presentation

All data collected will be analyzed to prepare a draft report and draft presentation, to be submitted to USAID and other parties as requested by USAID/E&E for review. In the final versions of the report and presentation the team will incorporate comments provided.

The final report will read well, be of high technical quality and respond to the requirement of the statement of work. The report will address all 3 specific objectives but will focus on

[64] The results of Round 5 will be released to the public on/about October 1.

understanding the barriers to countries including health system strengthening aspects in their proposals to the GFATM and how USAID and other development partners can best support countries to include this in future applications to the GFATM.

The primary audience for this report and presentation is USAID staff in the E&E Bureau and Missions. It is anticipated these findings will be very useful to a wider audience in the E&E region and to the GFATM and the report will be widely distributed among stakeholders in the E&E region.

Activity 5: Presentation of Findings in Washington, D.C.

In this final phase, the consultants will travel to Washington, D.C. to conduct a team presentation of findings to USAID/E&E and the Global Health Bureau and others invited by USAID/E&E.

Activity 6: Report Dissemination

Upon approval from USAID/E&E, the Synergy Project will disseminate the final report to stakeholders in the E&E region.

V. DELIVERABLES

1. Assessment Report, Draft #1: The consultant team will prepare a draft report to be submitted via email no later than December 12 to USAID/E&E, USAID/CAR, USAID/Ukraine, and other parties requested by USAID/E&E for comments and review.

2. Assessment Report, Draft #2: The consultant team will prepare a second draft of the assessment report to incorporate comments received. This will be submitted to USAID/E&E and other parties as requested by USAID/E&E no later than January 9.

3. Assessment Report Draft #3: The consultant team will prepare a third draft of the assessment report to incorporate comments from USAID/E&E and other parties as requested by USAID/E&E and any points raised during the final presentation. This will be submitted to USAID/E&E on January 27.

4. Final Assessment Report: The Synergy Project will submit to USAID/E&E and other parties as requested the final assessment report, edited and formatted according to USAID branding guidelines no later than February 10.

5. Presentation, Draft #1: The consultant team will prepare a draft presentation to be submitted via email no later than January 9 to USAID/E&E.

6. Presentation, Draft #2: The consultant team will prepare a second draft of the presentation to incorporate comments received. This will be submitted to USAID/E&E for final approval on content no later than January 11.

7. Final Presentation: The Synergy Project will submit to USAID/E&E and other parties as requested by USAID/E&E the final presentation, edited and formatted according to USAID branding guidelines no later than January 16.

8. Presentation: The consultant team will travel to Washington, D.C. to present findings of the assessment. This presentation will take place during the week of January 16.

VI. TEAM COMPOSITION AND DESIRED QUALIFICATIONS

The team will consist of 2 consultants, with a combination of skills that include:

1) Strong background in health systems in the EE region, including human resources, health financing health systems infrastructure development; monitoring and evaluation, and procurement/commodities management.

2) Strong knowledge of HIV/AIDS in the EE region.

3) Strong knowledge GFATM regulations and processes as well as experience in supporting EE countries in their GFATM applications.

This team will be a combination of international and national consultants and guided by significant input from the E&E health team.

VII. REPORTING REQUIREMENTS

Final Assessment Report: The final Assessment Report will be no longer than 50 pages, excluding annexes. All versions of the report will be prepared and submitted in MS Word format. The report is expected to include an executive summary and annexes such as a list of documents reviewed, agencies and persons interviewed, list of resources, bibliography, etc.

A draft report will be submitted by the consultant team to USAID/E&E, USAID/CAR, USAID/Ukraine and other parties as requested by USAID/E&E for review. Written comments will be provided to the consultant team, who will then revise the report to incorporate comments and suggestions. Following USAID/E&E approval of this second draft of the report, The Synergy Project will edit and format the report according to USAID logo and branding guidelines. This report will be processed through Synergy's technical review processes prior to submission to USAID/E&E. One electronic copy of the final report will be submitted to USAID/E&E and other parties as requested by USAID/E&E. 60 hard copies will be submitted to USAID/E&E and disseminated as requested.

The English version of the Assessment Report will be posted by Synergy on USAID's Development Experience Clearinghouse (DEC).

Final Presentation: The final presentation, directed toward an audience of USAID staff in the E&E region, will present findings of the assessment. All versions of the presentation will be prepared in MS PowerPoint. The duration of the presentation will be finalized at a later date, but it is expected to last no more than 2 hours and allow time for a question and answer session.

A draft presentation will be submitted by the consultant team to USAID/E&E, USAID/CAR, USAID/Ukraine and other parties as requested by USAID/E&E for review. Written comments will be provided to the consultant team, who will then revise the presentation to incorporate comments and suggestions. Following USAID/E&E approval of this second draft of the presentation, The Synergy Project will edit and format the presentation according to USAID logo and branding guidelines. This presentation will be processed through Synergy's technical review processes prior to submission to USAID/E&E. One electronic copy of the final PowerPoint presentation will be submitted to USAID/E&E and other parties as requested by USAID/E&E.

VIII. RELATIONSHIPS AND RESPONSIBILITIES

USAID/E&E will:

Approve the Synergy budget and SOW.

Provide overall technical guidance.

Assist with collection of documents and recommendations for the background document review.

Provide a list of contacts to Synergy for coordination of interviews.

Provide comments on the draft versions of the report and presentation.

Submit approval to Synergy on all deliverables.

Provide a list of recipients and contact information for the final report.

USAID/Central Asian Republics (CAR) will:

Provide technical guidance to the consultant team.

Provide a list of contacts for interviews to Synergy for coordination of interviews in conjunction with AED/CAR and supplement the preliminary interview list.

Provide comments on draft versions of the report and presentation.

Approve concurrence cables for team travel.

USAID/Ukraine will:

Provide technical guidance to the consultant team.

Provide a list of contacts for interviews to Synergy for coordination of interviews in conjunction with the local translator and supplement the preliminary interview list.

Provide comments on draft versions of the report and presentation.

Approve concurrence cables for team travel.

Other parties, as requested by USAID/E&E, will:

Provide comments on the SOW.

Provide a list of contacts for interviews to Synergy for coordination of interviews in Kyrgyzstan, Tajikistan and Ukraine, and supplement the preliminary interview list.

Provide comments on the draft versions of the report and presentation.

The Synergy Project will:

Provide the GFATM and HIV Specialist and E&E Health Systems Specialist to USAID/E&E.

Coordinate as listed in Section X of this Statement of Work the necessary logistical support.

Provide assignment management, including a Senior M&E/HMIS Specialist to provide technical guidance to the consultant and team, as needed and review the report and presentation, a Program Manger to manage and support this activity throughout the assignment and a Project Assistant will provide additional administrative support.

Editing and formatting of the report and presentation according to USAID branding guidelines to finalize these deliverables prior to submission to USAID/E&E.

Process the Final Report and Presentation through Synergy's technical review process.

Disseminate the final report.

Consultant Team: The GFATM and HIV Specialist and Health Systems Specialist will be responsible for the overall organization of the work, including arrangements for preliminary interviews via phone and interviews with GFATM personnel in Geneva, maintaining records and notes of all interviews and meetings. Each team member will facilitate the preparation of the assessment report and presentation, assuring the drafts and final versions are prepared in accordance with the Statement of Work. Work will be divided equally among team members.

The team members will also consult regularly with USAID/E&E, Synergy, and others as requested by USAID/E&E throughout the assignment to ensure progress is sound. The GFATM and HIV Specialist will serve as Team Leader and be responsible for managing local expenditures including translation and transport in Ukraine and submission of all deliverables.

X. LOGISTICS

Synergy will assist with the pre-fieldwork collection of documents for review, recruit, provide, manage, and support the consultant team, provide administrative support for arranging international consultant travel, provide an advance to consultants prior to departure to all travel, manage expenses, and assist with arrangements for teleconferences between USAID/Ukraine, USAID/CAR, USAID/E&E, and the consultant team.

To support fieldwork Synergy will coordinate with AED/CAR in Tajikistan and Kyrgyzstan, and a local translator in Ukraine to coordinate assistance with in-country: logistics, including arrangements for meetings, translation, local transport, and visa processing.

USAID/E&E will coordinate the final presentation time and venue.

Points of Contact	Position Title	Telephone	Email
USAID/E&E			
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XI. FUNDING

USAID/E&E will provide funds from field support.

XII. Assignment Schedule

Please consult this tentative table of assignment activities.

Activities	Duration/Due Date
Activity 1. Interview is Tajikistan, Kyrgyzstan, and Geneva	**September 29 – October 14**
Preliminary Document Review (1 day)	Due Date: Prior to Travel
Conduct Interviews in Tajikistan, Kyrgyzstan, and Geneva	September 30 – October 14
Activity 2. Document Review, Phone Interviews, and Analysis of Round 5 Applications	**October 15 – November 26**
Document Review and Analysis of Round 5 Applications	October 2/3
Activity 3. Interviews in Ukraine	**November 28 – December 3**
Activity 4. Preparation of the Final Report and Final Presentation	**December 4 to Mid-February**
Team submits Draft #1 of the Report for comments	December 12
Review	December 12 – 23
Comments Returned to Team	December 23
Team Incorporates Comments	December 23 – January 9
Team Submits Draft #2 of the Report and Draft #1 of the Presentation to Synergy	January 9
USAID/E&E sends approval on Draft #2 of the Presentation	January 12
Synergy copy-edits and formats, according to USAID guidelines, Draft #2 of the final Presentation	January 13 - 16
Review of Draft #2 of the report	January 9 – January 20
Team incorporates additional comments for Draft #3	January 20 – January 27
Team submits Draft #3 of the Report	January 27
USAID/E&E sends approval on Draft #3	January 30
Synergy copy-edits and formats Draft #3 of the report	January 31 – February 10
Synergy submits final version of the report to USAID/E&E	February 10
USAID/E&E send approval on deliverables	February 15
Activity 5. Presentation in D.C.	**Week of January 16**
Final Presentation in D.C.	TBD
Activity 6. Report Dissemination	**February 10 - 14**

Attachment 1: SUGGESTED REFERENCE MATERIALS

A suggested list of reference materials includes the following documents. This list is not exhaustive.

GFATM Regulations

Work that PHR*plus* and other organizations engage in to identify the health system effects of the GFATM—the Systemwide Effects of the Fund (SWEF) work.

Literature on Health Systems strengthening in the EE region including reports from WHO, European Observatory, World Bank studies, OSI and Human Rights Watch.

Other USAID projects including CAPACITY Project in CAR and Project HOPE looking at TB/HIV under our CAR regional TB control program.

Relevant guidance from the Aidspan and Physicians for Human Rights e.g. Guidance to the Global Fund to Fight AIDS, Tuberculosis and Malaria and Support for Human Resources for Health

Reports from Synergy GFATM Technical Assistance Assignments

USAID Bureau for Global Health, Health Systems Presentation, Bob Emrey, August 17, 2005

USAID Bureau for Global Health, Health Systems website, http://www.usaid.gov/our_work/global_health/hs/index.html

Health Systems Action Network website http://www.phrplus.org/hsan.html

ANNEX E: HEATH REFORM: COUNTRY CASE STUDIES

Kyrgyzstan[65]

Kyrgyzstan is a Central Asian state bordered by China, Kazakhstan, Tajikistan, and Uzbekistan. The capital is Bishkek, located close to the northern border. Kyrgyzstan is very mountainous, with almost 90 percent of the territory 1,500 m above sea level. At the end of 2003, the population was estimated to be approximately 5 million. Since independence in 1991, Kyrgyzstan has implemented major health reforms, and is generally known as the biggest success in health reform of countries of the former Soviet Union.

As with most countries of the former Soviet Union, health care is provided by an extensive network of urban and rural facilities that provide services at the republic, oblast, rayon, and city/municipal levels. Local state administrations are owners of health facilities providing primary and secondary care, including polyclinics and regional and district hospitals, and are in charge of health care on their territories. Rationalization of the network of health facilities was a high priority of national health reforms. The private health sector has developed since the 1990s, starting with pharmacies and later expanded to include the provision of health services. However, the private sector is still comparatively small and comprises primarily ambulatory care and pharmacies. The private health providers that emerged during the years of transition are located primarily in large cities (Bishkek and oblast capitals). Nongovernmental organizations (NGOs) have emerged in the health sector primarily in the form of professional associations. They include associations of physicians and pharmacists, nurses, cardiologists, patients with diabetes, and blood donors. In recent years, some of the functions of the Ministry of Health (MOH) have been transferred to NGOs. In particular, accreditation of health facilities has been delegated to the Medical Accreditation Commission. The Association of Family Group Practices and the Hospitals Association contribute to monitoring the quality of health services and participate in the development of clinical protocols.

The MOH implements the health policy and develops and implements a State Benefits Program and other targeted health programs. It is responsible for the quality of health services and the safety and effectiveness of pharmaceuticals, medical products, and equipment. It has direct managerial responsibility only for the small number of specialized republic health facilities and the tertiary level facilities in Bishkek. The MOH is also responsible for financial planning and budgetary management. The primary regulatory functions of the MOH include the development of methodical guidelines that are compulsory for all health care providers; the licensing and attestation of health providers; and quality assurance procedures. At the facility level, the authority for health planning, regulation, and management is vested in the administration, which has financial and managerial autonomy.

Prior to recent reforms, the health care system was fragmented into four levels of government administration: republic, oblast, city and rayon, serving overlapping populations. Furthermore, many national programs, such as immunization schemes, were

[65] This brief description is taken from European Observatory on Health Systems and Policies, Health Care Systems in Transition (European Observatory on Health Care Systems, 2005).

operated through separate vertical systems. The fragmentation of health care budgets was one of the major challenges to the reform of health care financing and of the health care delivery system. One of the key elements in the reform of health financing was the centralization of financing at the oblast level to enable better risk-pooling and to break the integration of finance and provision that contributed to excess physical capacity. A complementary reform was the granting of more autonomy to health facilities to manage their budgets. With the introduction of new provider payment methods, especially copayments by patients, health facilities have been given greater flexibility in the internal allocation of resources. A Mandatory Health Insurance Fund is the "single payer" in the health sector. It has been given responsibility for pooling funds and purchasing health care services, as well as for budgetary health funding. It also has additional roles in quality assurance and the development of health information systems. The Mandatory Health Insurance Fund is accountable to the Ministry of Finance and local state administrations on the use of budgetary resources and health care financing. Private, out-of-pocket payments constitute the main source of health financing, contributing to almost half of total health financing. General budget revenues (of the republic and local governments) constitute 44 percent. Government health spending decreased from 4.0 percent of gross domestic product in 1995 to 1.8 percent in 2003.

Since independence in 1991, Kyrgyzstan has undergone dramatic economic and political change, transforming itself from a Soviet republic with a command economy into an independent state with a more democratic and market-oriented system. The drastic contraction of funding for health had a negative impact on the quality of health services, which is likely to have contributed to the deterioration of the health status of the population. The change in funding has driven the master plan of the Manas Health Care Reform Program which has included:

- Major restructuring of health delivery (strengthening of primary care and rationalization of hospitals at both the secondary and tertiary levels);
- The development of a state benefits package with clear description of covered services;
- Introduction of a new mechanism for the equitable allocation of resources among regions;
- Improving the management of facilities by replacing line item budgeting/financing by a system of provider payments (global budgets in hospitals and capitation in primary care);
- Development of human resources by establishing an Institute of Public Health for the training of managers and for the retraining of physicians as Family Medicine Doctors;
- Quality assurance improvements, improving the physical infrastructure and modernizing the health information system;
- Modernizing health planning, management, and delivery systems; and
- Introduction of contracts between purchaser and providers and between health providers of primary, secondary, and tertiary care.

In summary, health care reform in Kyrgyzstan has taken place in the difficult context of political and economic transition and severe economic pressures. In 1996, with the support of external donors, Kyrgyzstan embarked on a comprehensive, ten-year health sector reform program, which has now entered its final phase. The country has managed to accomplish a number of major improvements and has become a regional leader in health reform. A mandatory health insurance system has been introduced, followed by new provider payment methods and contract arrangements. The single-payer system, which unites all previous achievements of health reform and serves as a catalyst for reform, has also been introduced. Primary care has been restructured and strengthened. Nevertheless, more remains to be done. The restructuring of health care delivery needs to be continued, with an emphasis on the hospital sector and the State Sanitary and Epidemiological Service. It is also necessary to further develop the concept of quality assurance. Activities to stop the spread of communicable diseases, in particular tuberculosis, malaria, and HIV/AIDS, must be continued and strengthened, and the population should be encouraged to take greater responsibility for its own health.

Tajikistan[66]

Tajikistan is primarily a mountainous country, with most of the population living in valleys in the north and southwest. It is surrounded by Afghanistan, China, Kyrgyzstan, and Uzbekistan. The capital city is Dushanbe. Post-independence development has been badly affected by civil war, by interruptions to inter-country trade, and by being in a politically volatile region. The 1999 census estimated the population at approximately 6 million. Nearly three-quarters of the population lives in rural areas. Tajikistan is among the world's twenty poorest nations with perhaps 80 percent of the population living in poverty. In 1998, the gross domestic product per capita was about $215. The Tajikistan economy suffered badly after the collapse of the USSR, with the loss of subsidies from Moscow (perhaps 40 percent of government revenue), as well as most of its export market, followed by the disastrous effects of the civil war. The Tajikistan population has suffered from a continuous drop in living standards during the 1990s. The gross domestic product dropped most sharply, by minus 29 percent, in 1992 during the war. The country has huge foreign debts to Russia and Uzbekistan. In 1998, the external debt was $880 million. Subsequently, due to these difficulties, Tajikistan has been a late arrival to health care reform.

Tajikistan has the youngest population of all countries of the former Soviet Union, with 70 percent younger than 30 years of age. It also has one of the world's highest birth rates. Communicable disease is a major threat, with a breakdown in the clean water supply and sewage infrastructure, as well as a breakdown in public health measures such as mosquito control and immunization. As a result, there have been increases in cases of tuberculosis, malaria, typhoid, and diphtheria. The rates for illegal drug use, HIV infection, and sexually transmitted infections have also risen.

The structure of the present health system has evolved from the Soviet Semashko model of health care with few structural changes. The state remains the main payer and provider of health care services. Private payments, however, are believed to now be larger than public sources of revenue. As with most countries of the former Soviet Union, health delivery system is provided by an extensive network of urban and rural facilities that provide services at the republic, oblast, rayon, and municipal levels. At the republic level, the Ministry of Health (MOH) runs national-level health care services, whereas local authorities (oblast and rayon) administer most regional and local health care services. The MOH is responsible for health policy for the country, but has no control over the overall health budget, and directly manages only national-level health facilities. Its primary responsibilities include development of health care policy; implementation of national disease programs; direct management of republic-level institutions, scientific research institutes, and educational institutions for health professionals; formulating policies on pharmaceutical registration and control; setting standards for quality of care in public and private health care policies; providing sanitary and epidemiological services for the population; developing human resources and training policies for health professionals; licensing and certifying individuals and institutions engaged in health services; ensuring international collaboration; and making international agreements in the field of health.

[66] This brief description is taken from European Observatory on Health Systems and Policies, Health Care Systems in Transition (European Observatory on Health Care Systems, 2000b).

Local authorities are responsible for most social services, including health and education services. Tajikistan has a hospital-centered service management structure because the central management of most health services is located in hospitals. The allocation of resources within the framework of state ownership followed rigid central planning guidelines, passed on down the administrative hierarchy, using quantitative indicators based on indicators such as number of hospital beds and number of staff. There was little coordination across vertical and horizontal divisions of the health services. Structural and funding distortions have produced an overemphasis on hospital services at the expense of primary health care. Facility managers have little discretion, being tied to detailed budget lines. Rural health services are administered from the central rayon hospital. The heads of rural health services (nurse posts, physician clinics, and village hospitals) all report to the chief physician of the central rayon hospital.

Private health services are regulated, but regulations allow public physicians to engage in private medical practice that can be reimbursed from user fees, employer contributions, and from health insurers. Pharmacists and dentists now run private businesses, but there are only a few private physicians. Professional associations of doctors and nurses did not exist in Soviet times. These are now being established, but they have no formal role in accreditation or regulation and have had little influence so far over health policy. A National Association of Nurses was established. A Physicians' Association exists but it is not very active.

The delivery of health care services is divided between four administrative levels: national (republic), regional (oblast), district (rayon), and village. The MOH runs national-level institutions, and local administrations run other health care services. In rural areas, primary care is delivered through nurse posts, rural physician clinics, and small rural hospitals. In urban areas, primary and secondary care is delivered by polyclinics, basic secondary care by district (rayon) hospitals, specialized secondary care in regional (oblast or city) hospitals, and more complex care in republic hospitals. There are severe shortages of drugs and medical supplies. Health personnel are paid very low salaries that do not encourage high-quality professional care, their training is outdated, and clinical treatment protocols need revision. The population increasingly pays for health services, either officially or unofficially, which is causing serious inequities in access to health care.

Reform plans include the following:

- Reducing hospital beds, closing small rural hospitals, strengthening primary health care, training family physicians, and upgrading the polyclinics;
- Upgrading central rayon (district) hospitals to provide a wider range of services;
- Developing day treatment and opening nursing homes for dependent, long-stay patients;
- Setting standards to improve the quality of services and updating health care technology;
- Adopting national programs on immunization, tuberculosis, iodine deficiency, and infectious diseases;
- Introducing new health financing methods based on needs-based and output-based funding;

- Updating and upgrading medical education;
- Developing a national policy on pharmaceutical production and distribution;
- Privatizing limited services such as pharmacies and medical equipment.

In summary, while health care reform depends partly on a sustained recovery of the country's economy, the reforms outlined above are being implemented. Additional sources of health funding must be explored, although health insurance is likely to remain a long-term objective pending further economic recovery. The MOH has now turned more attention to health sector reform. It has made an important start in reducing the excess number of hospital beds, and in shifting the emphasis from training specialists to training family physicians. New ways of paying health facilities and health professionals are being explored in order to promote more efficient and effective practice. Tajikistan wishes to maintain the positive features of its health care system, such as an extensive network of health care, combined with new funding and management practices intended to encourage a better use of resources. While coming late to the reform process, Tajikistan is making significant progress after many years of war, deterioration, and declining health status.

Ukraine[67]

Ukraine is the second largest country in Europe, bordered by Belarus, Hungary, Poland, the Republic of Moldova, the Russian Federation, and the Slovak Republic. The 2001 census recorded a population of 48.4 million, with 67 percent living in urban areas. There are nine cities of with a population greater than 1 million, including the capital, Kiev, at about 2.6 million. Ukraine's population has fallen by 3.6 million or 7.5 percent. The birth rate fell by almost 40 percent between 1990 and 2001, but it has been increasing since, albeit slightly. The total fertility rate is now ranked lowest in Europe. The age structure of the population is changing because of an increase in the number of elderly people and a decrease in young people. Like many other countries in the region, Ukraine experienced a resurgence of communicable diseases, such as diphtheria, tuberculosis, and cholera. Ukraine is facing a number of new problems, such as the emergence of HIV, which is now estimated to have reached a prevalence of 1 percent in the adult population. Ukraine is still in the process of developing plans for health reform, and is substantially behind most other countries of the former Soviet Union in this regard. There are constitutional barriers to health reform in Ukraine. For example, the constitution forbids the closure of health institutions and promises free health services to all. However, the state can not effectively fund these institutions.

The formal health care system is supervised by the state, and as in other former Soviet republics, lines of accountability are fragmented. In theory, the Ministry of Health has responsibility for health policy. In practice, its influence is limited because it directly manages only a few specialized facilities. As with most former Soviet countries, health delivery system is provided by an extensive network of public urban and rural facilities that provide services at the republic, oblast, rayon, and municipal levels. Most health care is delivered in facilities owned and managed at regional and district levels, and funded by the respective tiers of government from allocations provided by the Ministry of Finance or raised locally. By the end of 2000, Ukraine had 24,166 such institutions. In contrast, the network of private health facilities is poorly developed. At the end of 2000, only 5,860 private individuals and 1,050 legal entities were registered to practice medicine independently. The role of voluntary health insurance is relatively small, largely because of the high costs of commercial insurance premiums, which are unaffordable for the majority of the population. Although there are legal provisions for public participation in the health sector and a number of professional medical associations and various patient groups had been created recently, they have not played any noticeable role in decision making, with the possible exception of the physicians' association, PULSE, which was disbanded after only one year of existence. This brief overview indicates that the organizational structure of the health care system in the Ukraine has essentially remained unaltered from the Soviet period. However, intensive work is under way to establish a legislative base for health care reform.

Unlike many other areas of the economy, health care financing in Ukraine has essentially retained the Soviet tax-based approach, providing universal and theoretically free coverage, but out-of-pocket payments constitute a major source of revenue for the health care system. In the early 1990s, about 80 percent of governmental (state and local)

[67] This brief description is taken from European Observatory on Health Systems and Policies, Health Care Systems in Transition (European Observatory on Health Care Systems, 2004).

expenditure on health care was for inpatient care. This share gradually declined over time, dropping to just over 60 percent of public in 2002. This decline can be explained in part by the more than 30 percent reduction of hospital beds during the 1990s.

In summary, the basic principles of health care delivery have changed little since independence, with much of the system still working according to the Semashko model, with resource allocation based on capacity (number of beds, number of visits). During the past 15 years, Ukraine has gone through a long debate on the best approaches to developing primary health care, involving the transition to a model based on the principles of family medicine/general practice. However, a lack of a clear national policy on primary health care development has impeded progress of reform and preserved the status quo. Ukraine still lacks an integral long-term program for reforming the national health care system. Subsequent attempts to reform were largely unsystematic and inconsistent, and failed to fundamentally restructure health care. At the same time, experts, politicians, and citizens have become increasingly aware that acute problems in the health care system are due not only to shortage of funds, but also to its inefficiency in financing, planning, and regulation. Consequently, despite these many problems, some limited reform now seems possible.

ANNEX F: POSSIBLE DELIVERY MECHANISMS FOR ESSENTIAL HIV/AIDS SERVICES IN A CONCENTRATED EPIDEMIC

	NGOs	Unreformed Health Structures	Reformed Health Structures
Financing	There are concerns about funding for NGOs passing through governments[68]; however, this may be needed for long-term sustainability. In some countries, (e.g., Latvia), municipalities are beginning to finance HIV prevention activities through NGOs.	In some countries, these structures act as principal recipients for Global Fund grants. There are concerns that large amounts of donor funding flowing through these structures may undermine accountability to governmental structures, such as the Ministry of Health, and may reinforce vertical empires.	Although funding through central systems, (e.g. MOH, SWAp, Health Insurance Fund) might be seen as ideal, it is not happening in any of the three countries visited. For this to happen would require mechanisms to ensure clear benefits for the relevant target disease(s). Mechanisms to fund NGOs and non–health sector organizations would need to be established.
Biobehavioral surveillance among vulnerable populations	NGOs have a clear and established role in providing access to vulnerable populations and in providing social support and counseling when following 'surveillance plus' methodologies.[69] However, there is little place for small-scale, project-specific studies (e.g., knowledge, attitude, practices) that are often poorly designed and have intrinsic biases.	In the former Soviet Union, AIDS centers often have strong, existing systems of passive case reporting. In many countries, these are being supplemented by biobehavioral surveillance among the most vulnerable populations, such as injecting drug users, sex workers, men who have sex with men, and prisoners. However, it is not yet clear whether these can be systematized and maintained. Linkages between this system and other public health functions are relatively weak.	In the former Soviet Union, the major public health body is the Sanitary Epidemiological Service (SES). Although ideally, SES might take on this role it currently is poorly equipped to do so. It has very limited professional capacity, is poorly financed, and is focused primarily on policing food hygiene establishments.[70] In Eastern Europe, the SES equivalent[71] may be better-placed to take on this role as there were no AIDS centers in these countries.

[68] In countries where this mechanism has not been used before, governments may be concerned about NGOs' ability to implement programs and account for finances. NGOs may be concerned that monies risk being diverted away to government use or that they will be treated not as partners but simply subcontractors. In many countries, where a governmental agency acts as the principal recipient, this mechanism is being pioneered with Global Fund grants. However, it remains to be seen whether governments (both national and local) will be willing to use such mechanisms for their own funds once Global Fund grants end.

[69] When HIV testing occurs for surveillance purposes only, the results are not usually given back to the people tested. However, in settings where access to voluntary counseling and testing is poor, this may be considered unethical. 'Surveillance plus' methodologies provide additional services to those participating in the studies including provision of HIV test results, counseling, treatment of sexually transmitted infections, etc.

[70] As a result, it usually has little experience in work related to HIV/AIDS.

[71] For example, the Hygiene Epidemiological Inspectorate in Bulgaria and the Republican Institute for Health Protection in Macedonia.

ANNEX F: POSSIBLE DELIVERY MECHANISMS FOR ESSENTIAL HIV/AIDS SERVICES IN A CONCENTRATED EPIDEMIC (continued)

<table>
<tr><th></th><th>NGOs</th><th>Unreformed Health Structures</th><th>Reformed Health Structures</th></tr>
<tr><td colspan="4">Focused prevention among:</td></tr>
<tr><td>IDUs</td><td rowspan="2">Generally, NGOs are well placed to provide services to these populations. They are flexible and usually have motivated, well-paid staff. They are often able to establish trust with the populations, which is a key barrier when dealing with government structures. However, providing services through NGOs is relatively expensive and it may be difficult to reach sufficient scale through this mechanism only. In addition, there are issues over sustainability, although there is really no reason why central and local government should not contract NGOs to provide these services, as is beginning to happen in some countries (e.g., Latvia). However, NGOs are not available in all parts of the region. In some places they lack capacity and may be closely linked to government structures.[72]</td><td>In some cases, HIV prevention services for IDUs have been provided at ‘trust’ points in governmental hospitals and through outreach workers based at these points. These may work well if the main barrier can be overcome, which is the profound sense of mistrust that IDUs have toward government agencies. In addition, narcology dispensaries may provide HIV prevention services for IDUs and drug treatment services. However, IDUs may be particularly reluctant to access such services because of perceived links between the narcology dispensaries and the police/internal security services.</td><td rowspan="2">Currently, reformed health structures are playing a very limited role in this area because they are largely poorly developed. However, even in countries with advanced reforms, reformed structures such as health promotion centers are more focused on HIV prevention among the general population rather than among the most affected and most vulnerable populations among whom the epidemic is concentrated. Although it might seem ideal to involve family doctors in such activities, there is a huge raft of issues that would need to be addressed to make this possible. These include low pay, lack of motivation, stigma and discrimination, low utilization of services, skills level, and work overload. Nevertheless, there are a few examples of emerging good practice. For example, Kyrgyzstan has introduced a friendly doctor voucher system. These vouchers are distributed to members of vulnerable populations by NGOs. They allow a person to receive services from a physician who has been trained to work positively with vulnerable populations. The physician is paid for each voucher received. This system is seen as very positive by NGOs because it builds trust in the government health services among vulnerable populations and gives incentives to physicians to work with these populations.</td></tr>
<tr><td>Sex workers</td><td>Although treatment for sexually transmitted infections was traditionally provided by dermatovenereological dispensaries, this provision has declined in many countries because of intrusive contact tracing methods and the growth of private sector treatment. Consequently, this sector has not widely been involved in providing easy access sexually transmitted infection treatment for sex workers. On the contrary, so-called ‘friendly clinics’ have been largely established under the auspices of NGOs and AIDS centers.</td></tr>
</table>

[72] For example, staff working in a government facility (e.g., an AIDS center) may establish an NGO to conduct activities that are difficult or impossible to conduct through the government agency. There are many examples of such NGOs working well, which makes the derogatory terms ‘pocket NGOs’ or ‘quasi-NGOs’ inappropriate in most settings. However, there are also examples of such NGOs being set up simply to get funds from sources that do not provide money to government agencies, and there is also a risk of diverting government staff away from their duties.

ANNEX F: POSSIBLE DELIVERY MECHANISMS FOR ESSENTIAL HIV/AIDS SERVICES IN A CONCENTRATED EPIDEMIC (continued)

	NGOs	Unreformed Health Structures	Reformed Health Structures
Focused prevention among:			
MSM		There does not appear to be a particular department of the traditional, Soviet-style health sector that would be particularly well-placed to provide HIV prevention services to men who have sex with men. Where these services have been explicitly developed, it has almost always been done by NGOs.	
Prisoners	In some countries, NGOs are providing HIV prevention services in prisons. However, often there are limits on the range of services they can offer. A key issue is the need to develop trust-based relationships between the prison authorities and NGOs. These take time to develop and can be quickly and easily undermined. It is essential for NGOs seeking to work in prisons to try to understand the views and perspectives on HIV/AIDS and related issues of prison authorities.	It is likely that even in a reformed health system the prison health services will retain some degree of separation from the health services provided to the general population. However, there is need to develop good coordination mechanisms between prison and population health services, not least to ensure continuity of services for a person who moves from one sector to another (i.e., when they are either imprisoned or released). There are likely to be key roles for prison service staff and prison health service staff in providing essential HIV prevention services, particularly for injecting drug users.	

ANNEX F: POSSIBLE DELIVERY MECHANISMS FOR ESSENTIAL HIV/AIDS SERVICES IN A CONCENTRATED EPIDEMIC (continued)

	NGOs	Unreformed Health Structures	Reformed Health Structures
Care, support and treatment	Experience in some countries, (e.g., Ukraine) has shown the important role that NGOs can have in providing social support and adherence counseling. This is particularly effective when delivered alongside government services. There is also a need to nurture and develop networks of persons living with HIV/AIDS, because these can play a wide variety of roles including advocating for and monitoring the quality of care, support, and treatment services.	In most countries of the region, antiretroviral therapy has been introduced through a small number of treatment centers. In the former Soviet Union, this has been particularly through AIDS centers. However, these are relatively poorly developed and have little clinical experience. In countries with large numbers of people requiring treatment (e.g., Ukraine), it is doubtful that sufficient scale will be possible through this mechanism only. In addition, there is a criticism that working through this system is reinforcing the old vertical empires. In Eastern Europe,[73] treatment is usually provided through infectious diseases hospitals.	In some countries, particularly those of Central Asia, there is a desire to deliver antiretroviral therapy through existing medical treatment services, including primary care practices and general hospitals. Issues to be considered include: • In small countries with a low-level epidemic, caseload will be low. If treatment is scattered, clinicians are unlikely to develop experience of managing side-effects, etc. • Do all participating centers need to offer treatment and monitoring? It may be possible to retain a small number of diagnostic and treatment centers while decentralizing monitoring.[74] • Geographical factors, such as size of country and ease of travel. Centralized services may be appropriate in small countries with good travel infrastructure. • Stigma and discrimination may mean that persons living with HIV/AIDS would rather visit a centralized, focused service rather than their own family doctor. One experienced HIV clinician concludes, “The idea that persons living with HIV/AIDS should be treated everywhere means they are not treated anywhere.”

[73] Including some former Soviet countries, such as Latvia.

[74] The intention is something that is common with other chronic conditions, such as treatment of hypertension, diabetes mellitus, etc. Diagnosis, problem-solving, and adjustments to treatment may take place at the secondary level, while provision of regular medications and routine health monitoring can occur at the primary level. A similar system could be established in some settings (such as large countries with poor transport infrastructure with significant numbers of people needing treatment). In such a system, there might be a limited number of treatment centers where people start on antiretroviral drugs and are seen if they have problems such as treatment failure, major side-effects, etc. There could be more monitoring centers where people attend monthly for routine health checks and for their monthly medication.

ANNEX G: WHAT IS THE HEALTH SYSTEM? FORMAL DEFINITIONS COMPARED TO COMMON USAGE IN E&E REGION

Characteristic	Formal Definition(s)	Common Usage
Source of financing	Includes all sources of financing, including international donor projects and NGOs.	Limited to government financing only. Includes national and regional budgets. Also would include donor money if provided as loan or budget support.
Implementing agency	Includes all implementing agencies such as NGOs and non-health ministries, provided that improved health is the primary purpose of activities.	Limited to activities implemented by government in general, and the Ministry of Health in particular.
Type of activities	Includes all types of activities that have as their primary purpose the improvement of health. This includes curative and preventive services.	This is focused on and largely limited to curative services. Other services such as those that promote health and prevent disease may be either excluded or marginalized within this concept of health system.
Degree of systematization	Includes both informal and one-time activities.	Largely excludes informal and one-time activities, such as projects.

ANNEX H: BRIEF INTRODUCTION TO THE SOVIET HEALTH SYSTEM[75]

The Soviet model of health care was known as Semashko after the name of the USSR's People's Commissar for Health Care from 1918 to 1930,[76] who was the leading architect of the Soviet health care system. It was used throughout the Soviet Union and was influential, to various degrees, in countries of Eastern Europe.[77]

Although countries have modified the original model over the last fifteen years, most still retain much of the original structure and service delivery components of the model. In general, this system is state-funded based on general taxation with state-owned delivery systems.[78] The formal health care system is supervised by the state, and lines of accountability are fragmented over four levels of government administration: republic,[79] oblast,[80] city,[81] and rayon,[82] serving overlapping populations. There is a national Ministry of Health (MOH) with affiliates in each oblast (region). The MOH implements health policy and implements a state benefits program and other targeted health programs. The health delivery system is provided by an extensive network of urban and rural facilities that provide services at the republic, oblast, rayon, and city/municipal levels. Furthermore, most national programs, such as immunization, and HIV/AIDS and TB services are operated through separate vertical systems. The public health function is provided through a vertical structure known as the Sanitary Epidemiological Service (SES). Medical education is provided through medical institutes, which report to both the Ministries of Health and Education. The national level has a large number of national research institutes that carry out research and provide clinical care through their own hospitals, which serve as national referral facilities.

Urban hospital care is provided through numerous specialized hospitals. The core of the hospital system is made up of three general types; adult, pediatric, and maternity. In addition, there are separate administrative structures for specific diseases known as dispensaries, which are part of a national vertical delivery system, similar to the SES. Areas with dispensaries include tuberculosis, sexually transmitted infections (dermato-venerology), psychiatry and drug use (narcology), and oncology. The dispensaries have a hospital and outpatient department. Urban primary care is delivered by separate adult and

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[75] This section is largely based on Borowitz et al., 1999, with clarifications provided in the way of personal communications by both Michael Borowitz and Andreas Tamberg.

[76] Nikolai A. Semashko (1874–1949).

[77] Only the countries of the Soviet Union had a complete Semashko model. The Balkans used the Stamper model. Central Europe (e.g., Hungary, Czech Republic) still had a tradition of Bismarkian insurance and reverted back to it once the Berlin Wall fell (Borowitz, personal communication).

[78] One argument is that the system functioned reasonably well, particularly in terms of tackling infectious diseases, while it was adequately funded. However, finances for the system largely collapsed when the Soviet Union broke up.

[79] This document follows standard practice in using the terms republic and nation synonymously. The term local is used to apply to all levels below this.

[80] This document follows standard practice in using the terms oblast and region synonymously.

[81] This document follows standard practice in using the terms city and municipality synonymously.

[82] This document follows standard practice in using the terms rayon and district synonymously. In some countries (e.g., Tajikistan), the term village is used. This is a subrayon level.

children polyclinics. Polyclinics provide care for a specific geographic area known as a catchment area, and include a group of primary care physicians and narrow specialists. Rural health care is organized around central rayon hospitals. These hospitals generally consist of departments serving pediatrics, adults, maternity services, infectious diseases, and so on, and have an affiliated polyclinic. There are a variety of rural facilities, with small rural hospitals that usually have an affiliated polyclinic that serves the geographic area where it is situated. The primary care system is provided by rural ambulatories, that generally covers a population between 1,500–6,000 people. They are supposed to contain an adult physician, a pediatrician, a midwife, and often a dentist. Because of the current low level of financing, these facilities are now almost always understaffed and often have only one physician. The lowest rural level is the feldsher points or stations. A feldsher is a physician's assistant, who lives in the community, has minimal training and equipment, and is responsible for health promotion and very simple medical treatment.

In summary, by international standards, the Soviet health system was highly specialty-oriented; was labor and energy cost-intensive; had an overdeveloped secondary and tertiary care hospital sector, and a seriously underdeveloped primary care sector,[83] with fragmented funding, service delivery, quality control, and administration. This is slowly being modified in many countries.

[83] Although this appears to be the case now, there are diverse views about whether this was the case during the Soviet period. For example, "The system emphasized specialized care, a social hygiene-oriented sanitary and epidemiological service (SES) and, by Western standards, massive primary health care (including nursing) staffing in numerous primary health care facilities, many of which were located in rural settings. … The point here is that the leading organizer of the vertical Soviet health care system worked in a command administrative economy that prioritized health care at both primary and tertiary levels. Semashko's emphasis on specialized curative services was a direct reaction to the dearth of those services in the pre-Soviet era. We should not conclude from this that primary health care was 'under-developed'. To the contrary, the emergence of SES and the profligate staffing of primary health care point to the contrary." (Tamberg, personal communication.)

ANNEX I: GLOBAL FUND INDICATORS TO MONITOR HEALTH SYSTEMS STRENGTHENING GRANTS[84] (GLOBAL FUND, 2005L)[85]

Area	Outputs	Outcomes
Service delivery	Health facilities in a district or region that provide specialized services (testing & counseling, PMTCT, ARV, STI treatment, malaria treatment, TB treatment, TB/HIV collaborative activities, other) according to national protocols and guidelines (number and percentage)	• Population covered by key services (testing & counseling, PMTCT, ARV, malaria treatment, TB treatment) (number and percentage) • Number of outpatient visits for HIV/TB/malaria per inhabitant • Percentage increase in patient satisfaction
	Health facilities supervised regularly according to national guidelines (number and percentage)	
	Districts with laboratories that have complete capacity and supplies to diagnose TB, malaria, and HIV (number and percentage)	
	Number of HIV tests carried out expressed as a percentage of sexually active population (specify age groups)	
Human resources	Number of health workers (by category and discriminated urban/rural and gender) per 100,000 population (by category)	• Health care personnel trained and deployed per category according to human resource development plan (number and percentage) • Percentage increase in patient satisfaction
	Annual output of trained health workers per 100,000 population (by category level)	
	Health workers (by category and region) who attended in-service training sessions (by type and length) according to national curriculum during the last year (divided by diseases if appropriate) (number and percentage)	
	Health facilities fully staffed per level of health care and per region according to national standards (divided by disease program if appropriate) (number and percentage)	
Community systems strengthening	• Number of sites with community coordination focal points in place • Number of community workers trained for implementing community-based activities • Number of existing NGO workers trained in basic package of skills • Number of community-based organizations with plans and regular monitoring systems • Number of communities providing basic defined package of community services (home-based care, outreach prevention, orphan care, training)	None specified

[84] These have been developed by the Global Fund and its partners and are contained in a draft version of the second edition of the M&E toolkit dated September 2005.

[85] Abbreviations: ARV, antiretroviral, PMTCT, prevention of mother-to-child transmission; STI, sexually transmitted infection.

ANNEX I: GLOBAL FUND INDICATORS TO MONITOR HEALTH SYSTEMS STRENGTHENING GRANTS (GLOBAL FUND, 2005L) (continued)

Areas	Outputs	Outcomes
Information system and operational research	Health facilities or districts reporting all indicators according to national guidelines (including using the national list of indicators) (number and percentage)	• Comprehensive health management information systems • Complete disease specific report available on annual basis • Behavioral surveys indicators available every 4–5 years • Estimated HIV prevalence rate available on a biannual basis
	Health facilities or districts submitting timely reports according to national guidelines (number and percentage)	
	Number of surveys that include core indicators for three diseases implemented according to national monitoring and evaluation plan (specify type)	
	Sentinel sites performing according to national standards (number and percentage)	
Infrastructure	Health facilities with arrangements for specialized services (counseling & testing, PMTCT, ARV, STI, HIV/TB services—*specify which and how many*) (number and percentage)	• Geographical access: Percentage of population living within reach of basic health services
	Health facilities applying national regulations regarding procurement and supply management (number and percentage)	
Procurement and supply management	• Technicians (by region) who have been trained in procurement and supply management (number and percentage) • Batches of anti-TB essential drugs (specify) that have a batch certificate showing acceptable quality testing results, among all batches of drugs procured during a specified time period (number and percentage) • Total number of stock-out days for any anti-TB essential drugs stocked (specify), among all storage facilities during a specified time period	• Number and percentage of health facilities or central warehouse with no drug stock-out during that last month (or defined period)

ANNEX J: GLOBAL FUND INDICATORS TO MEASURE SYSTEMS EFFECTS (GLOBAL FUND, 2005I)

Area	Indicators	Comments
Additionality	Levels and trends in donor assistance, public and private allocations on the three diseases; progress in reducing unmet need for HIV/AIDS, TB, and malaria spending	Two indicators—resource gap and change in external resources over time
	Percentage of households allocating to health services (catastrophic health expenditure) >0.40 of household income	
	Numbers and change in trained health care personnel	Two indicators—change in health care personnel over time and gap in health care personnel
Sustainability	Prices for key commodities procured with Global Fund funds, trend across time, comparison across countries	
	Total government health expenditure as a proportion of gross domestic product over time	
	Spending on HIV/AIDS, TB, and malaria as a share of total health spending	
	Inter-year change in HIV/AIDS, TB, and malaria spending is greater than Global Fund grant spending[86]	Two indicators—Global Fund additionality to country health spending and Global Fund additionality to country spending for HIV/AIDS, TB, and malaria
	Ratio of donor to total spending allocated to HIV/AIDS, TB, and malaria	
	Pledges and projections of long-term Global Fund funding against estimated requirements	
Partnerships and harmonization	Joint activities with other agencies that produce outputs to support alignment and harmonization in support of Global Fund activities—including Global Fund participation in OECD/MDG[87]/United Nations/bilateral agencies harmonization initiatives	
	Countries with relevant strategies (poverty reduction strategy papers, health sector, etc.) that specifically refer to Global Fund financing	
	Number of countries with CCMs that show functional membership of people living with or affected by HIV/AIDS, TB, and malaria	
	Number of CCMs for which all NGO members are selected by their own constituency based on a documented, transparent process	
	Number of CCMs for which all constituencies are represented in the CCM	
	Number of CCMs that have a documented, transparent process to solicit and review submissions, nominate principal recipients and oversee program implementation	
	Number of CCMs that have a chair and vice-chair from different constituencies	
	Number of CCMs that have a written plan to mitigate against conflict of interests	

[86] This indicator measures additionality as well. It is calculated by dividing a country's expenditure on the three diseases in the current year (including Global Fund resources) by the same country's expenditure on those diseases in the previous year plus the Global Fund resources for the current year. If the Global Fund's resources are 'additional', this ratio should be greater than 1.

[87] OECD, Organization for Economic Cooperation and Development/Millennium Development Goals

ANNEX K: PROPOSED ADDITIONAL INDICATORS TO BE CONSIDERED FOR MONITORING HIV/AIDS-FOCUSED HEALTH SYSTEMS STRENGTHENING IN E&E REGION[88]

Thematic Area	Global/International	National
Governance	Number of countries with Global Fund grants with clear and explicit links between the grant, national AIDS strategy and national health strategy	Percent of NGO respondents expressing satisfaction with the degree of NGO involvement in governance and implementation of national AIDS programs Percent of stakeholders expressing satisfaction with progress toward more collegiate and consultative leadership style
Financing	Number/percent of countries with Global Fund grants producing regular national HIV/AIDS accounts Number/percent of countries with Global Fund grants in which financing from a) Global Fund, b) other donors is integrated within a health financing plan described in a national health policy/strategy	Percent of financial resources from the Global Fund a) expended by subrecipients, b) disbursed onward by subrecipients to other organizations
Pharmaceutical and commodity management		Price paid per unit of each drug/commodity (comparisons to historic data; other agencies in-country; regional and global norms and minima) Mean length of time from decision to purchase to availability to client/patient
Human resources management	Number of countries with Global Fund grants with human resource development plans for each of HIV/AIDS and health sector Number of countries with Global Fund grants that have agreed standards for HIV/AIDS pre-service training for health workers	Average monthly salary for categories of health workers in the public sector (absolute value and as a percentage of valid comparison) Number/percent of health worker training schools providing adequate pre-service HIV/AIDS training Number/percent of staff in health facilities providing HIV-related services leaving service in a 12-month period Percentage of staff in health facilities providing HIV-related services expressing job satisfaction Number/percent of facilities providing ART through trained multidisciplinary teams including a minimum of physician, nurse, and social worker Number/percent of health facilities providing HIV-related services employing members of vulnerable populations (disaggregated for PLWHA, sex workers, IDUs, and MSM) Total number of members of vulnerable populations employed in national HIV/AIDS response (disaggregated for PLWHA, sex workers, IDUs, and MSM) Percentage of PLWHAs and members of vulnerable populations (IDUs, MSM, and sex workers) expressing the opinion that they face significant stigma and discrimination when attending specified health facilities (including AIDS centers, infectious diseases hospitals, dermatovenereological clinics, TB dispensaries, narcological dispensaries, family doctors, other)

[88] Abbreviations: ART, antiretroviral therapy; IDUs, injecting drug users, MSM, men who have sex with men, PLWHA, persons living with HIV/AIDS.

ANNEX K: PROPOSED ADDITIONAL INDICATORS TO BE CONSIDERED FOR MONITORING HIV/AIDS-FOCUSED HEALTH SYSTEMS STRENGTHENING IN E&E REGION (continued)

Thematic Area	Global/International	National
Service delivery	Number of countries with functioning national coordination system between TB and HIV/AIDS services	Number/percent of regions with an integrated public health laboratory service[89] Number/percent of regions with functioning coordination systems between HIV/AIDS services and each of TB, narcology, and dermatovenereology Number[90] of PLWHAs receiving integrated[91] ART and anti-TB therapy Number of PLWHAs who inject drugs receiving integrated ART and drug-substitution therapy
Public health and disease surveillance	Number of countries with Global Fund HIV/AIDS grants with low-level/concentrated epidemics in which bio-behavioral surveillance among the most vulnerable populations is integrated into a) disease surveillance systems, b) health management information systems Number of countries with Global Fund HIV/AIDS grants with low-level/concentrated epidemics in which bio-behavioral surveillance data are used to drive a more appropriate response to the epidemic focused on those most vulnerable to infection Number of countries with Global Fund HIV/AIDS grants with an integrated public health structure responsible for the major public health issues affecting the country, including HIV/AIDS, TB, and malaria (where appropriate)	

[89] While such an integrated service would include TB and HIV/AIDS services, it would need to be broader than this incorporating all major public health issues, such as STIs.

[90] This could be expressed as a percentage if the total number of persons living with HIV/AIDS receiving TB treatment is known, or the total number of persons living with HIV/AIDS needing TB treatment is known, or both.

[91] It is likely that countries may need to define what they mean by integrated treatment. However, this should make sense primarily from the point of view of people receiving the service.