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Original article

How have Global Health Initiatives impacted on health equity?

Johanna Hanefeld[1]

Abstract: This review examines the impact of Global Health Initiatives (GHIs) on health equity, focusing on low- and middle-income countries. It is a summary of a literature review commissioned by the WHO Commission on the Social Determinants of Health. GHIs have emerged during the past decade as a mechanism in development assistance for health. The review focuses on three GHIs, the US President's Emergency Plan For AIDS Relief (PEPFAR), the World Bank's Multi-country AIDS Programme (MAP) and the Global Fund to Fight AIDS, TB and Malaria. All three have leveraged significant amounts of funding for their focal diseases – together these three GHIs provide an estimated two-thirds of external resources going to HIV/AIDS. This paper examines their impact on gender equity. An analysis of these Initiatives finds that they have a significant impact on health equity, including gender equity, through their processes of programme formulation and implementation, and through the activities they fund and implement, including through their impact on health systems and human resources. However, GHIs have so far paid insufficient attention to health inequities. While increasingly acknowledging equity, including gender equity, as a concern, Initiatives have so far failed to adequately translate this into programmes that address drivers of health inequity, including gender inequities. The review highlights the comparative advantage of individual GHIs, which point to an increased need for, and continued difficulties in, harmonisation of activities at country level. On the basis of this comparative analysis, key recommendations are made. They include a call for equity-sensitive targets, the collection of gender-disaggregated data, the use of policy-making processes for empowerment, programmes that explicitly address causes of health inequity and impact assessments of interventions' effect on social inequities. (Promot Educ, 2008; 15 (1): pp. 19-23)

Key words: HIV/AIDS, equity, Global Health Initiatives (GHIs), gender

Key Points

- **Global Health Initiatives represent a significant new model for addressing global health issues and providing development assistance for health.**
- **The processes and policies through which GHIs operate have a significant impact on equity of access to health services, including on gender equity.**
- **GHIs need to consider the impact of their policies, processes and operational mechanisms on health equity and health systems.**

Introduction

Global Health Initiatives (GHIs) have emerged as new models of development assistance in the fight against diseases in low- and middle- income countries over the past decade. These structures are rapidly evolving and have succeeded in leveraging significant new amounts of funding – an estimated US$8.9 billion was spent on responses to HIV/AIDS alone in 2006.[i] These expanded levels of funding have the potential for making a major impact on health systems at country level, by improving access to health services, prevention, treatment, care and support for specific diseases.

This review explores the impact of GHIs on health equity, looking specifically at HIV/AIDS and focusing on gender equity. It focuses on gender as HIV/AIDS disproportionately affects women and the poor.[ii]

Three GHIs are examined in detail: the US President's Emergency Plan For AIDS Relief (PEPFAR); the World Bank's Multi-country AIDS Programme (MAP); and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). All three GHIs focus primarily on alleviating the impact of HIV/AIDS, but operate in very different ways. Together these GHIs provide almost two-thirds of external funding going to HIV/AIDS (1).[iii]

Equity and health

Equity[iv] has emerged as a policy priority in global health assistance with the growing realisation that aid and health sector reforms only benefit the poor and marginalised sections of the population where issues of equity in access and outcomes of health care are explicitly addressed (4).[v]

Equity and HIV/AIDS

HIV/AIDS has particularly emphasised linkages between health and wider socio-economic factors of inequity and inequality (5). Socio-economic inequalities increase people's risk of HIV infection, and once infected they act as barriers to treatment, care and support for people living with and affected by HIV/AIDS.

Health systems play a key role in determining access to treatment and the care people receive, including for HIV/AIDS (6).

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Gender, geographic location, income and social status among others are factors determining access to treatment, and all are mediated through the health system. The linkages between treatment, morbidity and socio-economic status became more starkly visible in the mid-1990s, when life-prolonging anti-retroviral drugs (ARVs) were developed. Initially deemed too expensive and complex for public health care systems in low- and middle-income countries, by 2002 international political opinion had shifted and treatment was increasingly viewed an ethical imperative in the South.

However, the availability of new and expensive treatments can exacerbate inequities, at least temporarily, where access to treatment remains limited. By December 2006, WHO estimated only 28% of those requiring ARVs were receiving them worldwide (7), and while systematic evidence is scarce, many are concerned about inequities in treatment access (6). An inherent feature of anti-retroviral treatment (ART) scale-up in the poorest countries is that ART centres are initially established in urban settings and ART is only rolled out later to rural areas.

Equity, HIV/AIDS and gender

Women represent half of all people in the world living with HIV/AIDS, and in sub-Saharan Africa they constitute nearly 60% of all infections (2). Gender also determines socio and economic status and the gender inequities in these reflect women's vulnerability to HIV/AIDS. Women often have less access to economic resources and are financially dependent on a husband or partner; enforcing condom-use in a relationship may be difficult if the woman depends on her partner for survival or income. Where women find it difficult to gain formal or informal employment, they may be more likely to resort to transactional or commercial sex, to ensure their survival and that of their children (8). They are also affected by gender-based violence, which has deleterious effects on women's health and well-being worldwide (9).

Women carry the main reproductive burden, and are more likely to be affected by inadequate health services and treatment.

Cultural norms may also make it harder for women to protect themselves from HIV infection: a study of injecting drug users in Ukraine found a higher incidence of HIV in female users than in male. Women interviewed said that as the stigma facing female injecting drug users (IDUs) was greater than that facing men, they were less likely to access prevention services, which would identify them as IDUs (10).

In some countries it is considered inappropriate for a woman to travel on her own to access care. For example, in the Indian state of Uttar Pradesh, 80% of women require their husbands' permission to visit a health centre (11).

The emergence of Global Health Initiatives

There have been two major, noteworthy changes in global health over the past decade. First, development assistance for health has increased hugely: it is estimated to have risen by 26% from US$6.4 billion in 1997 to US$8.1 billion in 2002 (12). The mechanisms through which aid is being delivered have also expanded, from grants and loans provided through bilaterals, multilaterals and the World Bank between the 1950s and 1990s, to include general budget support to governments and performance-based funding in the 2000s (13).

Second, the traditional donors in health (UN organisations or bilateral agencies) no longer dominate international health policy as they did until the 1980s (14).[vi] Furthermore, the number of partnerships at the global level has proliferated enormously. These are extremely diverse in nature, scope and size (15) but often involve a partnership between the more traditional development actors, such as multilateral agencies, and new actors, such as private sector corporations, or philanthropic entities such as the Clinton or Gates Foundations (16).

Some of these partnerships are called Global Health Initiatives, but nomenclature is problematic. Brugha (17) defines them as 'a blueprint for financing, resourcing, coordinating, and/or implementing disease control across at least several countries in more than one region of the world'.

The three Initiatives examined in this review for their impact on equity differ in structure:

1. *PEPFAR* (the US President's Emergency Plan For AIDS Relief), initiated in 2003, is referred to as a GHI largely because of its disease focus (on HIV/AIDS) and its global remit.[vii] Initially set up over a period of five years,[viii] as a government initiative its budget is dependent on annual approval by the US Congress. PEPFAR is coordinated by the Office of the US Global AIDS Coordinator in Washington, DC. While funding can be received by a range of organisations in recipient countries, most is channelled through existing US agencies in the countries where it is active. There is little policy discussion on strategy at the country level, and the approach is largely top–down, from Washington, DC to the country level.[ix]
2. *The World Bank*, on the other hand, is a multilateral organisation, which introduced its *Multi-country AIDS Programme (MAP)* in 2000 in 29 countries in Africa. It is distinguished as a special initiative, and follows distinct structures within the Bank (World Bank, 2006).[x] The aim of the World Bank MAP is to scale up the provision of HIV related treatment, care and prevention services, through the provision of funds to government and civil society (20).[xi] Country-level activities funded by the MAP have to be aligned to the respective country's government's strategy. A national HIV/AIDS coordinating authority (e.g. National AIDS Councils) and a strategic plan or framework are preconditions for countries to receive MAP funding.
3. *The Global Fund to Fight AIDS, Tuberculosis and Malaria* (the Global Fund or GF) is a funding mechanism rather than an operational agency. It has no country presence, and operates through a small secretariat in Geneva. Countries apply for funds, through a Country Coordinating Mechanism (CCM), an independent, multi-partner body operating at the national level. Applications for funding are judged by a set of Technical Review Panels that make recommendations to the GF Board. Funds are awarded to one or more principal recipients (who may be government departments, national AIDS councils or civil society organisations) at the country level, and are overseen by a local fund agent, an independent auditor of expenditure and activities (Global Fund to Fight AIDS, TB and Malaria, 2003). Funds are released on the basis of performance. By 2007, 136 countries had received GF funding (1).

Global Health Initiatives and impact at country level

Certain general characteristics about the effects of GHIs can be observed. By focusing on their strategies with regard to gender equity, this paper suggests that GHIs have an impact through their policies and programmes, and through the processes that govern their policy design and implementation. PEPFAR's policy to ensure equitable access to ART for women serves as an example. It has directly resulted in gender-equitable access to such treatment. The Global Fund's Country Coordination Mecha-

nisms have shown the potential of this process to empower women, by providing new political spaces and by acknowledging their importance in the political process.

However, GHIs also have unintended impact on gender inequities. Through the absence of guidelines that require a gender focus, the World Bank MAP neglected the opportunity to include gender equity concerns as part of MAP-funded national frameworks and programmes (22). All three GHIs are vertically shaped around one or more specific diseases. This has impacted on other parts of the health system, including human resources, and on the kinds of services available. Evidence from Ethiopia (23) suggests that, due to a neglect of sexual and reproductive health services in responses to HIV/AIDS, these may have worsened. This is also a concern in relation to the impact of PEPFAR funding.

GHIs need to consider social inequities, including gender inequities, in designing context-specific programmes, to ensure that these are equally accessible to women and men. For example, ensuring opening hours of a health facility that provides ART, that take into account their circumstances, will allow female farmers to access these services; and similarly the provision of health services that enable mobile male workers, such as truckers, to receive treatment. Ensuring equity of access to health services is, however, merely addressing the symptoms of underlying social inequities that determine access to health. These include poor access by women to economic resources and their experiences of sexual violence. While all three GHIs examined here have acknowledged the need to address the underlying causes of inequity, their policies and funding so far fall short of fully addressing these.

GHIs also need to ensure that they do not directly impact negatively on gender equity. For example, despite a focus on the issue, PEPFAR funding requirements are potentially resulting in inequities. The focus on faithfulness in marriage, its condemnation of sex work and preventing the integration of services with comprehensive sexual and reproductive health services for all women, may increase inequities. PEPFAR may thus undermine the efforts of its own programmes to be more gender equitable, and to successfully fight HIV/AIDS.

The World Bank, while having HIV/AIDS components in its other policy instruments, has not integrated an analysis of its causes into broader development policy, as the impact of its economic reform programmes on education shows. While increasing efforts are being made to alleviate the impact of the epidemic, it is still not addressing the root causes of inequities of access to health in its planning. The Global Fund was designed as a purely financing mechanism for what would be a country-driven process. Consequently, it is limited to issuing guidelines and norms and does not collect or request data to determine if women or marginalised groups have equitable access to services that it supports.

Comparative advantages

Each of the three GHIs examined has a very distinct structure and set of policies or operational guidelines that impact on equity in a variety of different ways. These different structures interact at the country level, and one of the main challenges is to ensure that this interaction is 'harmonised' and maximises the positive impact of resources. However, in practice, the 'harmonisation and alignment' agenda (24, 25) has paid little attention to ensure gender and marginalised population equity is not sacrificed in pursuit of numbers-driven treatment targets (26).

The most obvious difference between these three Initiatives is that PEPFAR, as a bilateral initiative, is more top–down, directive and proscriptive; and opportunities for influencing and cooperating with it are limited. The World Bank and Global Fund rely on countries to define strategies that are then funded or supported. This has an impact on the ways in which they can foster or address inequities through their funding. The dilemma for them is that their more bottom–up approach, supporting countries to develop policy frameworks and strategic plans which they then fund, has been an impediment to ensuring funds are targeted to addressing gender and other equity concerns.

PEPFAR and the World Bank have their own country-level oversight for implementing structures, whereas the Global Fund is a funding mechanism, working exclusively through local partners. This impacts on the kind of support and funding each agency is best able to provide. The World Bank for example is well placed to support and strengthen health systems, as well as to ensure that the impact on equity in access to health is considered in other areas of development planning, including poverty reduction strategies.

The World Bank and Global Fund structures appear more successful than PEPFAR in drawing on stakeholders' knowledge in programme development, by requiring proposals and strategies to be developed at the national level according to their respective guidelines. The Global Fund, despite shortcomings, has been most successful in using its policy-making process as a potential tool for empowerment and enabling country-led programming.

PEPFAR is the only GHI examined here that sets numerical targets globally and nationally, and monitors gender balances in people reached. Its approach has been, in effect, to set up parallel monitoring and evaluation (M&E) systems. The dilemma for the World Bank and Global Fund is that, where they have monitored outputs, they have relied on national M&E systems. The weakness of these systems and countries' failure or inability to collect data that are disaggregated by gender and other important stratifying factors (socio-economic status and access to services) has resulted in a failure to monitor the impact of the GHIs, and disease control scale-up more generally, by equity criteria.

Overcoming this obstacle and strengthening countries' systems capacity to monitor outcomes and impact will require more joined-up action by the WHO (as the normative UN agency) and the World Bank (as the agency with a particular remit for country systems strengthening). This needs to be supported by more effective conditionalities from the major funding agencies (including the Global Fund) to ensure that strategies target inequities and that systems monitor their effectiveness. It will also require a willingness among donors, especially PEPFAR, to sacrifice the rewards of attribution that parallel monitoring provides. However, ultimately, it is countries that need to take the initiative in establishing (and if necessary demanding support for) programmes that address the underlying determinants of marginalisation, including that of women; and then monitor their effectiveness.

This discussion has concentrated on the impact GHIs have on gender equity, and a number of recommendations are made here on how to address this issue more effectively. These do equally depend on the overall effectiveness of individual health partnerships or initiatives. They therefore need to be addressed together with other recommendations for greater overall effectiveness of GHIs.

Ultimately, none of the GHIs examined will achieve their aims of successfully responding to diseases like HIV/AIDS, TB and malaria, unless wider issues of social inequity are addressed. It is therefore imperative that social equity concerns are reflected throughout all GHI policies, funding and processes.

Strategies for action – key recommendations

These recommendations refer in some instances to gender inequities specifically, but can be applied to all other socio-economic factors that might determine access to health. They form an initial step for an advocacy strategy to ensure equity in access to health services and ultimately in health outcomes.

1. *Address explicitly the causes of gender inequities in access to health.* GHIs need to ensure that all interventions funded and implemented address the gender inequities that might determine access to health services, and ensure that programmes and processes are equitably accessible to women and men. Programmes and funding also need to address the causes of social inequity, such as gender inequity. This includes gender violence, a lack of women's access to economic resources and the full guarantee and protection of their rights.
2. *Assess Interventions' impacts on social inequities*. All policies and programmes should be checked for their potential longer-term impact on social inequities before being implemented. Such assessments need to be country-driven and participatory, including all sections of a population.
3. *Include measurements that are sensitive to gender and other inequities when deciding targets.* This includes targets of numbers of people to be reached by Global Health Initiatives, and targets set such as the Millennium Development Goals. Where GHIs do not have a global target, an equitable global target, to be reached through cumulative programmes funded, can be a strategy to foster more equitable programmes.
4. *Enhance the uniform collection of gender-disaggregated data.* To enable monitoring of equity in access to services and participation in political processes, disaggregated data need to be collected, and should be specifically gender disaggregated, including for the provision of health care services, prevention services and political process.
5. *Use policy-making processes for empowerment.* The policy design and implementation processes can address gender inequities by creating new political spaces for public debate, participation and empowerment. GHIs need to ensure their policy processes are open, and that they can capitalise on opportunities for redressing inequities. This includes equitable representation in policy processes and funding for capacity-building that will enable meaningful participation.
6. *Address GHI impacts on health systems and human resources.* Global Health Initiatives need to address the system-wide impact of their programmes and funding to avoid verticalisation and distortion of health systems and human resources. This is essential to ensure that access to health services does not become less equitable as a result of GHI interventions. Particular attention needs to be paid to their impact on sexual and reproductive health services.
7. *Harmonise to build on comparative advantage.* To ensure equitable access to health services, programmes and interventions, to provide services to as many people as possible, and to ensure that programmes do not create inequities, GHIs need to coordinate their activities at the national level and draw on each other's comparative advantage, Clear communication flows to all groups and stakeholders is a vital first step in this.
8. *Integrate social equity in access to health in other development policies.* Strategies that address gender and other inequities in health need to be cross-referenced throughout all development assistance to ensure programmes funded and implemented by Global Health Initiatives are not undermined by the effects of other development assistance. This needs to go beyond having a disease-specific component or focusing on the impact of a health crisis on development, and ensure that the causes of social inequities that determine access to health are considered and addressed.
9. *Monitor and evaluate GHIs' impact on social equity.* All M&E frameworks should have an indicator assessing intervention successes and failures in addressing social inequities.

i. This figure is the estimate for all funding for HIV/AIDS in 2006, not only funding leveraged from GHIs (UNAIDS, 2006).
ii. According to UNAIDS the majority of new HIV infections are now occurring in women, and 95% of people living with HIV/AIDS globally are living in the global South.
iii. They respectively account for PEPFAR – 21%, World Bank/UNAIDS – 22%, Global Fund – 21%(Global Fund to Fight AIDS, TB and Malaria, no date).
iv. For the purpose of this discussion, equity or inequity needs to be differentiated from equality or inequality in access to or attainment of health. Inequalities mean differences between different groups without making judgements as to their fairness. Inequities refer to a subset of inequalities that are deemed unfair (Evans et al., 2001).
v. Equity of access to health services is not the same as equity in health outcomes. Differences in outcomes arise through socio-economic circumstances external to the health sector, or indeed to variations in quality of health services provided. Access to health services is affected by many factors, including social and economic status (including 'race' or ethnicity), demography (gender or age) and geography.
vi. This was in part a response to disillusion with perceived stagnation and bureaucracy in the UN agencies, and the growth of civil society organisation activity (Buse & Walt, 2000).
vii. PEPFAR has a specific focus on 15 designated countries, mainly in Africa, but also works in over 100 countries (www.pepfar.gov).
viii. At the time of writing in October 2007, PEPFAR was in the process of being renegotiated by Congress with a possible doubling of funds to US$30 million being discussed (Gupta & Selvaggio, 2007).
ix. Primary partners implement PEPFAR's strategy at a country level. These include national and international non-governmental organisations (who receive the majority of funding), and to a lesser extent host governments. Other 'primary partners' include private contractors or universities that win contracts to implement aspects of PEPFAR's country strategy. Some primary partners provide grants to local 'sub-partners' who receive funding on a competitive basis (Office of the Global AIDS Coordinator, 2006).
x. Following the completion of the MAP as a programme, the World Bank was consulting throughout 2006/7 on the next phase of its HIV/AIDS Programming.
xi. A total of 49,000 NGOs directly received funds through the MAP (World Bank, 2006).

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