

Leveraging HIV Programs to Deliver an Integrated Package of Health Services: Some Words of Caution

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Abstract: Over the past decade, HIV programs have been successfully scaled up in many developing countries, leading some to wonder how the investments made into HIV infrastructure could be leveraged to deliver additional health services. Although the concept is appealing from many perspectives, integrating additional health services into existing vertical HIV infrastructure may not mitigate some of the challenges these programs have introduced in implementing countries. In addition, this approach to integration may countervail parallel efforts of the global health community to strengthen health systems and improve aid effectiveness. It might also undermine the HIV programs themselves. International donors and health system planners should carefully consider whether the benefits outweigh the potential costs of these well-intentioned integration efforts.

Key Words: HIV/AIDS, health systems, integration, country ownership, aid effectiveness, health service delivery

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INTRODUCTION

For almost a decade, the global health community has made a strong commitment to make HIV/AIDS interventions available globally. Donor assistance for HIV programs increased rapidly, and millions of people are now accessing comprehensive HIV services, even in very poor countries.^{1–4} Per capita income is no longer a valid excuse to deny life-saving treatment and care to people living with HIV.

Due to health system constraints and also to the perceived urgency of rapidly scaling up services, many of these programs were initially built as largely vertical programs, with limited integration into health systems.^{5–7} (As others have noted, it is difficult to characterize any program as being purely vertical or purely horizontal. The author uses the term vertical to describe any program that is largely implemented by a specialized team of health workers who are dedicated to a particular program, and is usually disease-specific.) Perhaps as a result of the success of these scaled-up efforts and perhaps also because of concerns

over the “exceptional” attention that has been given to HIV relative to other health conditions,^{8–10} some groups are now asking how previous investments in HIV programs might be leveraged through integration to deliver other health services.¹¹

Reviews of integration definitions, frameworks, and experiences in other disease control areas suggest that there is no standard definition of the term “integration.” Nor is there agreement about how successful previous integration efforts have been in achieving their goals.^{12–14} Conceptually, 2 basic strategies could be adopted to integrate HIV programs: Either they could be further integrated into health systems (eg, primary health care) or they could be used as a platform to deliver a broader set of integrated health services (eg, maternal child health services, tuberculosis services, diabetes care).

Many studies have evaluated the experiences of the former type of integration. A recent review¹⁴ of these studies concludes that there has been heterogeneity in the extent and success of these experiences. However, there has been much less research into the latter form of integration, and that is the focus of this comment. Some of the articles presented in this supplement explore the question of *how* HIV programs might be able to deliver additional non-HIV health services. The purpose here is to provide some words of caution on *whether* HIV programs should be expanded to provide additional health services.

INTEGRATED VERTICAL PROGRAMS ARE STILL VERTICAL PROGRAMS

Vertical programs have been developed for the implementation of a number of disease-specific programs, based on the argument that such programming is likely to be more effective than expanding existing health care systems (the “horizontal” approach). Vertical programs may find it easier to attract donor funding and may be necessary in countries whose health systems are weak.¹⁵ However, vertical programs may also distort local health priorities, undermine country ownership, and have negative spillovers on health systems, and in addition may not be sustainable in the long run.¹⁵ Whether the benefits of vertical programs outweigh the costs of such structures has been a long-standing debate in global health.¹⁶

Efforts to develop an integrated package for a group of neglected tropical diseases (NTD) may provide a useful example of previously vertical programs that were integrated into a combined program in hopes of improving program coverage and generating important efficiency gains. Although a recent evaluation¹⁷ of these integration efforts suggests that

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such efforts have been largely successful at achieving at least the first of these goals, many observers^{18,19} have been quick to point out that in the long run these programs' sustainability and their ability to achieve elimination will ultimately depend on the extent to which they are integrated into health systems.

The individual disease control programs selected for inclusion into the integrated NTD package shared a common activity—mass drug administration of preventive chemotherapy. But the control programs also included a number of nontreatment interventions, including provision of clean water, health education, and surgical interventions. A key challenge to integration of the NTD programs was maintaining a focus on the program activities that were less amenable to integration.^{20,21} If HIV programs were to expand to include other health services, a critical question would be how well nonoverlapping activities would be prioritized. Some critics²² have already argued that HIV programs have focused too little on prevention, which might be further exacerbated with the addition of other health components. Similarly, the integration of other health services into the delivery models developed for HIV may mean sacrificing elements to “fit” into existing HIV platforms.

Integration might also pose risks to HIV programs' effectiveness. At present, these programs attract more funding per measure of morbidity and mortality than any other disease.¹⁰ Although this fact may explain why other disease control efforts have been advocating for integration with HIV programs,²³ it also raises the question of whether integration would result in less money for HIV services. There may even be a risk that additional health services may dilute the message of HIV exceptionalism at a time when future funding streams for HIV are uncertain. Plus, increasing the complexity of HIV programs through the addition of other health services may limit the speed of future scale-up efforts and might diminish the effectiveness of existing programs because of the decreased focus on HIV-specific outcomes.

HEALTH SYSTEMS ARE STILL WEAK

Part of the original rationale for developing vertical HIV programs was that health systems in many developing countries were weak. Although more attention has been given to the concept of health system strengthening in recent years,²⁴ it is not clear that such efforts have significantly strengthened health systems in lower-income countries, which continue to face formidable challenges, including a critical shortage of trained health professionals that has been seen as a critical barrier to most scale-up efforts.²⁵

The addition of new health services without sacrificing the quantity and quality of HIV services will require additional resources. Even if donors were willing to finance these expansions—a true *if* in the current economic climate—the expansions would create new demands for an expanded skilled health workforce, which may take years to develop. Existing health workers would also need additional training. Human resource policies, such as task shifting, have not solved the human resource shortage.²⁶ In addition, if providing additional health services is added to the workloads of current health professionals, task shifting may be less feasible.

Another criticism of the vertical nature of the HIV scale-up is that such efforts may have limited the development of national ownership over programs and the accountability of local officials to citizens for the delivery of these services.²⁷ The integration of other disease control programs into existing HIV structures will do little to alleviate these obstacles to country ownership, a principle embedded in both the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.²⁸ Careful attention to these concerns is required, particularly if the expansion of vertical programming is considered. To simply make vertical programs responsible for a greater proportion of the global burden of disease without ensuring local ownership would seem to counteract current efforts to strengthen health systems and improve aid effectiveness.

CONCLUSIONS

A number of unique circumstances during the early years of the HIV epidemic may have justified the exceptional response to this disease.²⁹ Although other diseases have also been described as spreading at “epidemic” proportions³⁰ and cause significant global morbidity and mortality, it is not clear that the same emergency (vertical) approach is justifiable—or desirable. Given what we know from previous integration efforts and given what we understand of the impact of HIV programs' scale-up, health systems planners and international actors must consider carefully the potential benefits and the potential risks of integrating other health services into HIV programs—in particular at this time. Although it may certainly be the case that additional health services could be delivered using HIV infrastructure, insights into the lessons of HIV scale-up should be used to try to minimize potential unintended distortionary effects on the rest of the health system.

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