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HIV/AIDS Can Strengthen Health Care System in Nigeria, A Myth? The Geography of AIDS Programming and Health Systems Strengthening

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Abstract
This paper is an attempt to contribute to the ongoing debate of health systems strengthening from HIV/AIDS programmes. In the Nigerian context, this debate has ensued from recent efforts to scale up AIDS treatment and the doubts surrounding the ability of the existing health care system to be able to effectively accommodate and deliver such massive roll out plans. At the global scale, this paper implicates the vertical and unintegrated approach and activities of donor funded interventions as partly responsible for the Nigerian failing health system and the system'sinability to accommodate plans for AIDS treatment scale-up. At the national level, failure to frame the right kind of intervention policies and strategies; lack of political will and reduced health expenditure are some factors discussed. With much a global evidence of weakening and failing national health systems of developing countries primarily from donor funded AIDS interventions and programmes; there is an ensuing myth or the inability to see that HIV/AIDS can strengthen health systems if certain policy and programmatic strategies are deployed. This paper therefore, sheds light on such possibilities by providing a spatial account of country-based evidence of national health systems strengthened from AIDS programming across the geographies of Sub-Saharan African countries and other developing countries that have successfully achieved this feat.

Among the salient issues raised in the light of current efforts to scale up national coverage and access to HIV/AIDS treatment in Nigeria, is the ability of the existing health care system to effectively deliver roll out plans. This has opened up new frontiers of debate in both the academic and policy terrain in the Nigerian AIDS discourse. Donor funded HIV/AIDS programs and their activities have beenpartly implicated on the deteriorating state of many developing countries national health systems through their vertical approach to interventions and the concomitant impact. With global evidence of the negative impact of HIV/AIDS programmes across most of developing countries health systems (Biesma et.al, 2009; Pfeiffer et.al, 2008; Pfeiffer, 2003),there has been an ensuing myth or the inability to see that HIV/AIDS programming can indeed strengthen health care systems.

Among the plethora of crucial questions by academics and policy makers that have trailed the spate of recent efforts to scale up treatment in Nigeria are: "can the country's current infrastructure accommodate such an expansion; and is the concomitant development of an adequate infrastructure possible" (Ailuogwemhe and Sankale 2006)?While it can be argued that these kinds of questions are legitimate, they do misconstrue what an ideal model of health intervention should be. Such questions blindside the fact that an important component of health intervention is health systems strengthening (HSS) and both elements should not be seen as asymmetrical. Additionally, such questions raise superficial arguments and representations that disembody the major underlying causes of the country's failing health care system in specific relation to AIDS interventions.

After more than three decades of the first onslaught of the AIDs epidemic in Nigeria(Nasidi and Harry, 2006) and the ever burgeoning presence of HIV/AIDS International Non-Governmental Organizations (INGOs) on the Nigerian health scene, health systems capacity should be an obsolete issue. The longevity of the presence of the AIDS epidemic and a long history of interventions on the Nigerian health domain should have culminated in a national health infrastructure adequate to accommodate an effective delivery of roll out treatment plans. But this is not the current reality of the Nigerian health care system.This is partly because the ideological underpinnings and the logics of both local and internationalhealth interventions have been faulty.

Health infrastructure is a sine qua non to effective treatment or health service delivery (Windisch et.al, 2011)no doubt. However, the design of AIDS policies and programmes particularly at the national levelhas neglectedhealth systems strengthening (HSS)mainstreaming as an integral component of AIDS programming to create the necessary infrastructure for an accompanying intervention partly because of the way health interventions have been framed and consequently, designed. Such framings have produced an unintegrated approach to HIV/AIDS programmes with health interventions and HSS conceptualized as mutually exclusive categories. An obvious implication has been the production of vertical and unintegrated national HIV/AIDS programmes and by implication, a fragmented and weak national health care system.

This paper is an attempt to contribute to the increasing debate of whether HIV/AIDS programmes can strengthen health care systems of the developing world. Drawing on the spatial health geographies of developing countries particularly in Sub-Saharan Africa, specific evidenceand possible ways that HSScan be achieved are cited, basedon this paper'soverarching argument that HSS from AIDS programmes is not just a myth. With particular emphasis on Nigeria, theargument is also made that HIV/AIDS programmes canimpact negatively on national health systems by providing a spatial account based on country evidence while recommending multiple ways that HIV/AIDS

intervention programmes can be leveraged upon to improve and strengthen health systems in recipient countries.

HIV/AIDS Programming and Impact on National Health Systems

Although the Nigerian health care system was ranked by the WHO in 2000 as one of the worst in the world(Ailuogwemhe and Sankale, 2006), the AIDs epidemic and efforts to control it through preventive and treatment approaches have further exposed weaknesses in the health system(Piot et. al, 2009). Efforts to control the epidemic have been scaled up yet progress has been hampered by the fundamental crisis in the national health system given the recognition that effective health interventions including AIDS are circumscribed in the capacity of an existing health care system(Alubo 2002). Paradoxically, the nature of HIV/AIDS intervention programmes has been implicated as a crucial element in the current health systems crisis of most developing countries(Biesma et.al, 2009). Nonetheless, two major issues come to bear on AIDS programming and weakening national health systems. First is the role of donors and their mode of operation in recipient countries and how these have impacted local programmes and Non-Governmental Organizations (NGOs) activities on national health scenes(Pfeiffer et.al, 2008; Pfeiffer 2003). A second issue is the role of national governments and the manner in which they have constructed their intervention strategies, and coordinated their HIV/AIDS programmes basically lacking intersectoral collaboration(Ogbogu and Idogho 2006). These issues are discussed below.

At the global scale, international or donor agencies with access to power and control of global resources define the process and parameters of interventions and how resources are to be distributed and allocated(Kabeer, 1994). Therefore, it becomes natural or expected to assume that such flow and distribution of global HIV/AIDS resources will reflect donor priorities and channeled to developing countries that represent donors' interests and not necessarily on the basis of need (Taylor and Rowson, 2009; Birn et.al, 2009; Kabeer, 1994). The problem with such HIV/AIDS intervention model is that, it is inherently asymmetrical. Developing countries therefore, have little autonomy in determining their own policy or AIDS interventiontrajectories as long as the power and resources are concentrated in the hands of these donor agencies.

These issues have been manifest in the developing world particularly sub-Saharan African countries in diverse ways that negate the benefits of global health interventions on national health systems. In Nigeria for example, it is a common knowledge that a large proportion of HIV/AIDS interventions are donor funded and most of the funds are directly channeled to Non-Governmental Organizations rather than to the public national health sector through their Ministries of Health(Pfeiffer et.al,

2008). Bureaucratic and administrative bottlenecks, public sector corruption and other structural inadequacies have been identified as factors that cause donor agencies to bypass government health agencies to non-state health actors(Ogbogu and Idogho, 2006). In Nigeria, a review of donor driven HIV/AIDS programmes shows that more than 70% of these programmes are managed by local NGOs(Ogbogu and Idogho, 2006). This poor perception of the national public health system has created a chasm between NGO funded and national funded AIDS programmes leading to the development of the current nature of most HIV/AIDS programmes operated as parallel to local primary health systems.

Rather than strengthen the existing public health systems, the lack of harmonization between the private to alsoinclude Faith Based Organizations (FBOs) and public health sector AIDS programmes have undermined the strengthening of national health systems(Pfeiffer et.al, 2008). Even in situations where international funds for AIDS programmes have been channeled through the Ministries of Health, the programmes are usually not integrated into existing national programmes(Biesma et.al, 2009; Yu et.al, 2008). Most donor funded programmes require separate accounting, implementation and, monitoring and evaluation systems even within national systems(Biesma et.al, 2009). A good example is Zambia which is supported by fifteen major donor agencies but all require separate reports and meeting times from the government officials(Global Health Watch, 2008). Donor policies in Mozambique and Uganda have also been shown to have placed more burdens on existing health systems due to their parallel reporting and information requirement systems(Bellagio Conference Report, 2008). Also, there are legitimate concerns that the Country Mandated Coordinating Mechanism (CCM) which runs as the independent main coordinating body of the Global Funds Programme in many countries including Nigeria may undermine national AIDS coordinating bodies in recipient countries(Bellagio Conference Report, 2008). Although the CCM comprises a partnership with private and public health sector bodies, there is the possibility that countries may be reluctant to question donor priorities when they are not in sync with national interests because of fear of losing funding(Jaffe, 2008). Frequently also, the implementation of donor funded HIV/AIDS programmes requires a separate workforce and attract workers from the already impoverished public sector through higher wages(Pfeiffer et.al, 2008), and further impoverishing public health systems.

The first rapid assessment report of AIDS programming in Nigeria also provides key insight to this disconnect between private and public sector HIV/AIDS programmes. The USAID funded report which assessed four NGOs and twelve FBOs Antiretroviral (ARV) programmes that developed parallel to the National Antiretroviral Programmes reported no formal linkages between these programmes and also, a lack of coordination and communication gap even within the different programme

units(Partners for Health Deliver and Policy Project Report, 2006). While there has been some improvement overtime in terms of intersectoral collaboration(GHAIN, 2012) in Nigeria, the country has yet to determine the right mix of policies and programmatic approach in tackling the epidemic(Odutolu et.al 2006). The country has basically tagged along recommendations dictated by international bodies and donor agencies at the forefront of the epidemic alternating between a non-integrative unilateral health sector response and multisectoral approach(Odutolu et.al, 2006). For example, Nigeria's acceptance of PEPFAR's emergency plan which was unilateraland narrowly focused on abstinence programs with a total neglect of commercial sex workers(El-Sadr and Hoos, 2008) despite the high prevalence rate among this risk group in the early phase of intervention. Similarly, PEPFAR's vertical and disease specific programme and strategies on HIV/AIDS may undermine national or donor priorities on other diseases as well as programmes on Malaria and Tuberculosis (El-Sadr and Hoos, 2008). PEPFAR's specific disease strategies have also being argued to undermine long term goals of an inclusive health care system(Marchal et.al, 2009). This is due to the existing evidence that health systems strengthening can be achieved through donor programmes that integrate interventions in a manner that increase the uptake of other health services because of the general spillover effects(Walton et.al, 2004). An analytical survey of Rwanda's HIV/AIDS integrated programme showed a significant increase in utilization of 17 out of 22 non-HIV related services in 30 primary care centers(Bellagio Conference Report, 2008).

Vertical programmes and the lack of integration of other programmes within the national health systems have been a foundational problem since the inception of Nigeria's national HIV/AIDS programmes. Even with the deployment of a multisectoral approach, programmes have run parallel with little integration at the different tiers. For example, the three tiered health system is such that each has its own political and administrative structure with a lack of harmonization with instances where unhealthy competition and duplication of efforts have been reported(Ailuogwemhe and Sankale, 2006). This is further compounded by other government agencies that run separate AIDS prevention and treatment programmes like the military hospital(Ailuogwemhe and Sankale, 2006). A possible reason is that relatively little capacity is needed to develop disease specific or vertical interventions as opposed to the more complex programme design needed for integrated interventions(Windisch et.al, 2011). The long term implication has been a proliferation of HIV/AIDS policy and implementation plans, duplication of efforts and lack of coordination and harmonization of programme strategies. The large scale private unregulated health sector comprising private hospitals and NGOs has further deteriorated its already weak national health system.

Further addressing the role of NGOs in national health systems, Paul Farmer, a foremost medical anthropologist emphasized the uncomplimentary roles of NGOs in his address of the American Public Health Association when he stated that most NGO activities in Africa have often been conducted at the expense of the public sector(Pfeiffer et.al, 2008). In many situations, there are critical policy tensions and programme goals between national and NGO intervention programmes. Furthermore, due to their non-state status, investments in health systems strengthening are not usually a key component of AIDS programmes designed and implemented by these NGOs(Pfeiffer, 2003). Given donor preferences of deployment of AIDS funds mainly through non-state health organizations, the number of NGOs globally increased from the 6000 to 26, 000 in the 1990s(Pfeiffer et.al, 2008). At the same time in Nigeria, local NGOs privy to donor preferences were "quick to set up shop"(Ogbogu and Idogho, 2006) to scramble for available donor funds. Driven by competition for funding resources from international donor agencies, these organizations outdo themselves in terms of performance outcomes and project goals(Basu et.al, 2012). This market driven approach of NGOs expectedly has very low propensity to place the goal of broader systems health strengthening at its core. There is thus, a greater likelihood for them to engage in activities that could potentially be detrimental to the public health sector in the process of trying to meet donor specific targets. Where NGO programmes have been linked to local health systems, such linkages have mostly been cosmetic and largely unsustainable(Pfeiffer et.al, 2008).

Just as external assistance on AIDS to developing countries has failed to strengthen health systems, countries governments have also not provided good financial stewardship towards their national health systems through their AIDS programmes. Poor and unsustained political commitment especially by African governments towards AIDS programming is evident in two ways. Firstly, there has been a lowered budget committed generally towards health financing with an increasing over dependence on external Development Assistance for Health (DAH) especially on HIV/AIDS programmes. There is empirical evidence that the share of direct government public expenditure on health in DAH countries has decreased over time due to diversion of funds to other sectors(Lu et.al, 2010). A statistical analysis of data sources for developing countries shows that for every $1 of DAH to governments, the Ministries of Finance reduce health allocation by $0.43 to $1.14(Lu et.al, 2010). Perhaps, this is a failure on the part of these governments to recognize that developmental assistance on health and even donor funds on AIDS programmes are primarily meant to complement already existing efforts or the situation is just a case of plain corruption and misappropriation of donor funds for personal gratification(Ejughemre, 2013). In 2006, PEPFAR accounted for US$150 million in Zambia's budget on HIV/AIDS control compared to the country's much lower budget of US$136 million(Bernstein and Sessions, 2007). Similarly in Rwanda, PEPFAR's HIV expenditure of $103million in the country in 2007 was almost equal to the total government expenditure on

health(Jaffe, 2008). In Nigeria, donor funds for HIV/AIDS through the Global Funds Progammeincreased dramatically from 2003 to 2009(Ejughemwre, 2013). Coincidently in 2003, the country recorded a shortfall in its health expenditure as only 3.2% of the annual budget was allocated to health(Odeyemi and Nixon, 2013). Additionally, between 2003 and 2004, the Nigerian HIV/AIDS programme, NASCP suffered setbacks due to poor national budgetary allocation resulting in the inability to recruit professional staff, conduct training programmes and perform service delivery which are key components of health systems strengthening(Partners for Health Deliver and Policy Project Report, 2006). Similarly, Nigeria is not one of the 5 of 53 African countries that has achieved the target of 15% annual budget commitment to health expenditure, a consensus reached at the Abuja summit held in 2001 by African governments with dire implications for both equity and quality of its national health system(Bellagio Conference Report, 2008; Odeyemi and Nixon, 2013). The burden of strengthening national health systems has thus, overtime been shifted to the public but disproportionately affecting the poor through cost recovery mechanisms like the Bamako initiative that prioritizes out of pocket payments on drugs for AIDS and other diseasesin most sub-Saharan African countries (Richard et.al, 2011).

More fundamentally, the way knowledge around development thoughts are constructed and by whom is a premise for the way development projects are framed, designed and implemented(Kabeer, 1994). This mainstream development thought is also applicable in the policy making arena. Therefore, reductionist AIDS policies and intervention modelsthat preclude health systems strengtheningas a key component of health interventions by those in power and levels ofhierarchy further exacerbate the problem.

HIV/AIDS and National Health Systems Strengthening

Despite the many clarion calls for health systems strengthening, there still remains a lack of clarity and contradictions about what really constitutes health systems strengthening(Global Health Watch, 2008). WHO has defined HSS as "building capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and outcomes"(WHO, 2006). WHO's six building blocks that define health systems strengthening are health service delivery; human resources for health (HRH); medical products, vaccines and technologies; information; leadership and governance; and financing(PEPFAR, 2013). Over time, there has been a growing recognition of the importance of health systems strengthening among key global health players. In recent times, the Bill and Melinda Gates Foundation, PEPFAR and the Global Fund Programme are now among major investors in health systems strengthening focusing on key components of health systems like human resources, infrastructural development, monitoring and evaluation(Piot et.al, 2009). An integrated approach especially in the light of current treatment scale up

efforts in Nigeria by PEPFAR and the Global Fund Programme would be to tie these programmes to important elements of its national health system.

The first step therefore to establishing an alternative HIV/AIDS intervention framework is to rethink and reconceptualize the process and design of health intervention models that preclude HSS. Nigeria can strengthen its health system by reframing its policies and strategies for health interventions whether for local or international by articulating a system of intervention that mainstreams at least a component of the six WHO's HSS building block particularly for medium to long term intervention.For example, the recent scale up of treatment plans in Nigeria should not be deemed independent of health care re-structuring and strengthening. Persistent mis-conceptualization of programmatic strategies especially at the policy and planning level will continue to reestablish the terrain for non-integrative strategies that have long undermined the Nigerian public health sector.

Haiti, the world's poorest nation provides strong evidence that integrating HIV/AIDS with public sector health systems can indeed strengthen national health systems. In a pilot project conducted in rural Haiti by David Walton, Paul Farmer and others, an AIDS model was developed to integrate tuberculosis treatment and STIs since these diseases overlapped(Walton et.al, 2004). Results from this integrated pilot project showed that this synergy and non-disease specific focus strategy boosted the overall efficiency of the primary health care sector. It maximized the health service delivery model, one of WHO's HSS building blocks which stimulated the uptake of tuberculosis treatment and other health services. For example, DOTs became DOT-HAART as the health workers used a combination of antiretroviral therapy and antituberculosis drugs. Counselling for STIs became counselling for AIDS and tuberculosis which greatly reduced stigma and consequently, increased uptake of care. The study further showed that initiating an integrative AIDS programme not only boosted staff morale but it increased the flow and distribution of medicines and vaccines to other diseases and dramatic improvements were seen in the overall quality of its primary health care.

In regards to the HSS building block of medical products, vaccines and technology, in Nicaragua, an integrated AIDS programme through the provision of laboratory and diagnostic equipment did not only increase the overall capacity of the existing health system to provide effective laboratory procedure for HIV testing, but also the processing and storage of blood samples collected for other diseases(Piot et.al, 2009). Nigeria therefore, must revise its policies and programmatic approaches to HIV/AIDS whether in national or donor funded programmes. The country must devise smart and effective means and strategies to collaborate with donor agencies in a manner that fosters the achievement of its national priorities and overall health systems goals.

Two key HSS building blocks which have posed as an impediment to the Nigerian health system that the country must address to achieve national HSS are leadership and governance; and health systems financing. Health expenditure is a function of political will and commitment on the part of the national government if existing national programmes are to strengthen the public sector health system. Firstly, there is a dire need to coordinate the existing fragmented national AIDS programmes in order to mitigate the negative effects of multiple financing systems operating independently at different tiers(Warren et.al, 2013). Fragmentation and management of financial resources maybe detrimental to accountability and transparency(Warren et.al, 2013). This may increase corruption due to multiple and independent accounting systems at the different tiers as operational in Nigeria. Secondly, the national government must make a firm political commitment to allocate sufficient funds to support or complement existing donor interventions and not regard DAH or other donor funding as the main source of allocation forhealth expenditure. PEPFAR may not necessarily invest on long term development of social and physical health infrastructure or some identified key components of HSS that do not meet the country's programme requirement due to the emergency nature of their programmes. Nonetheless, this should stimulate a mandatory challenge on the part of the national government to complement such efforts by committing financially to such health system priorities. A strong political commitment that is sustainable over time as evidenced by other countries that have successfully scaled up treatment and strengthened their failing health infrastructure is what Nigeria must adopt and this is not impossible.

Addressing the HSS building blocks of leadership and governance; and financing, Brazil provides a strong evidence of a patchy health care system that was also strengthened to accommodate massive treatment efforts due to a staunch political will that harnessed and mobilized its country's human and capital resources(Rosenberg, 2001). Bringing the success stories nearer home, South Africa remains a counter evidence to the Nigerian situation where despite the initial denial of the AIDS crisis and inaction, has achieved tremendous strides and progress in curtailing the epidemic under the strong leadership and governance of the late Nelson Mandela. South Africa post-apartheid after a long neglect of the AIDS scourge, became politically committed and prioritized health care reform along with roll out of ART programmes and have attained great strides in challenging the epidemic and strengthening its national health system(Fisher and Rigamonti, 2005).

Finally, Nigeria must provide strong leadership and governance in harmonizing, managing and coordinating all its HIV/AIDS programmes whether national or donor supported. It must regulate especially the private health sector and provide strict monitoring to NGO activities so that they align with the country's goals

and priorities which should include HSS. A starting point would be for the country to develop an NGO code of conduct that addresses the prevailing NGO problems as they undermine national health priorities and strictly enforce it. This could address local concerns of the ongoing parallel or vertical programmes of NGOS, wage differentials between the private and public health sector and other issues of health system fragmentation.

Conclusion

The Nigerian government needs to step up and take the reins of leadership in coordinating its HIV/AIDS programmes rather than relinquish total power and control to external agencies to dictate the agenda on what is good for its national health. One way of doing this is to garner political and financial will and reduce its overdependence on donor funded HIV/AIDS initiatives in ways that provide some leverage and control over its national HIV/AIDS intervention strategies.

The country must make a drastic shift from its quick impact intervention model and short term fixes to its health challenges and focus on more long term sustainable goals that prioritize health systems strengthening. In the light of funding challenges, it could design medium or long-term integrated interventions that help to build and strengthen the capacity of its health workforce and physical infrastructure.

That HIV/AIDS can strengthen health care systems is neither fictitious nor a myth, provided there is a strong political will. This is conventional wisdom. The current HIV/AIDS situation opens up new pathways and spaces for health care strengthening if the Nigerian government would take advantage of ongoing international aids to control the epidemic by making a political commitment to framing the right kind of strategies. Nigeria can take advantage of current local and international efforts on HIV/AIDs mitigation to achieve this feat by aspiring to mainstream the WHO's six HSS building blocks as part of national and donor priorities on AIDS programming.

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