Summary

One major public health success has been the scale-up of HIV services, with worldwide 17 million people on treatment at the end of 2015, out of nearly 37 million people living with HIV at that time. This high number of people on treatment was unthinkable at the start of the 21st century when antiretroviral drugs were hardly available nor accessible for people in low- and middle-income countries. In more recent times, therefore, the key question had become how to sustain this success.

With nearly two-thirds of people with HIV coming from sub-Saharan Africa, this region has been most affected. Health staff and facilities were overwhelmed to provide care to high numbers of people with HIV, while most countries in this region also had to cope with severe health system challenges related to drug supply, infrastructure and lack of health care workers. This thesis focuses on strategies to scale-up antiretroviral treatment in contexts with severe health staff shortages. Studies were conducted in project settings with a high HIV prevalence in Southern Africa and may therefore be described as ‘operational research’: results are directly relevant for the programme and may also contribute to local and national policy, by providing information from a ‘real’ setting rather than a constructed study environment.

Decentralisation of HIV care to peripheral health facilities and communities in a Malawian district became an important strategy to make HIV treatment more widely available and accessible for the population (chapter 2). Further adaptations in the organisation of health services were needed, including integrating HIV with reproductive health services, causing a higher uptake of maternity care (chapter 3). During the HIV epidemic, cases of tuberculosis increased and this disease became the leading cause of death in people living with HIV. Scale-up of HIV treatment and integration of HIV and TB services had a positive impact on the number of patients with tuberculosis (chapter 4).

Common causes of staff shortages in sub-Saharan Africa include insufficient number of professional staff being trained, difficulties in attracting and retaining staff due to high workload and poor working conditions, but also illness and death, particularly due to HIV. Among health workers, stigma was a main reason to avoid or delay seeking HIV testing and treatment services. Provision of specific staff health services through a dedicated clinic ensuring confidentiality and quality, led to increased uptake of HIV testing and antiretroviral treatment as well as improved survival among health staff and their dependants (chapter 5).

It also became increasingly relevant to empower people living with HIV. Chapter 6 examined several models of HIV care with a strong involvement of the community and
patients themselves. The aim of these models was to make long-term HIV care easier for both patients and health workers by reducing the number of clinic visits. For example in Mozambique, on a rotational basis, regular drug refills were done by patients for peers in their support group (provided these did not have side effects or other health problems).

Shifting specific tasks from cadres with more professional education to those with less training followed logically. In addition to being a link between health facility and community (chapter 6), lay counsellors have played a key role in expanding HIV testing and counselling and supporting patients in adhering to their HIV treatment (chapter 7, 8). However, the lay counsellor position has often suffered from lack of recognition within the formal health system and absence of sustained financing. We assessed progress in different countries towards realizing formal recognition. In Lesotho, Mozambique, Zambia and Zimbabwe, training curricula, job profiles, structures for supervision and remuneration packages were harmonised by ministries of health and NGOs. In Malawi, HIV testing and counselling tasks were integrated into the job profile of an existing community health worker cadre. Zambia has been the only country that has successfully integrated psychosocial counsellors into its national health system and some of these workers were paid through the national civil servant budget. In most other assessed countries, fiscal barriers limit absorption of new staff and lay workers have been paid through international funds (chapter 7). The evaluation showed that no one size fits all: countries use different strategies to finance and support lay counsellors depending on their context and opportunities.

An increase in international funding towards HIV from the early 2000s onwards and agreed global targets to stop the spread of HIV, and eventually ending the epidemic by 2030, contributed to the high increase in access to HIV treatment. However, nearly half of all people with HIV are still unaware that they are HIV positive and many are thus not on treatment. The majority of these people are not sick and must therefore be reached in different innovative ways, closer to the communities where they live. It is critical to catch people early in their HIV disease progression, ensure they are linked to care and adhere to treatment, achieving low or undetectable levels of the HIV virus in their blood. Where professional health staff are few, it is important to support the use of lay workers in described interventions. The recognition of a dedicated cadre for counselling is needed and requires inclusion of standards for counselling, training and supervision within national guidelines as well as ways for sustained financial support.

We can say that over the past ten years, the HIV response has evolved from a vertical disease specific intervention to a broader health integrated approach. Lessons learned in HIV care are therefore to be fully utilized in the management of other chronic conditions. The new reality around the HIV response with an earlier start of treatment and addressing long term challenges continues to require health system adaptations and flexibility on simplified delivery models and community engagement.