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Viewpoint

# International institutions, Global Health Initiatives and the challenge of sustainability: lessons from the Brazilian AIDS programme

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**Summary** The sustainability of successful public health programmes remains a challenge in low and middle income settings. These programmes are often subjected to mobilization–demobilization cycle. Indeed, political and organizational factors are of major importance to ensure this sustainability. The cooperation between the World Bank and the Brazilian AIDS programme highlights the role of international institutions and global health initiatives (GHI), not only to scale up programmes but also to guarantee their stability and sustainability, at a time when advocacy is diminishing and vertical programmes are integrated within health systems. This role is critical at the local level, particularly when economic crisis may hamper the future of public health programmes. Political and organizational evolution should be monitored and warnings should trigger interventions of GHI before the decline of these programmes.

**keywords** international agencies, programme sustainability, political factors, HIV/AIDS

## Sustainability of public health programmes and the controversial role of international actors

Recently, the director of the 'neglected tropical diseases' department at WHO highlighted a major issue, which concerns particularly low and middle income countries: how to manage a successful public health programme in order to ensure its sustainability, defined as 'the long-term ability of an organisational system to mobilize and allocate sufficient and appropriate resources for activities that meet individual or public health needs and demands' (Olsen 1998). The issue of sustainability is highly relevant (Ooms 2006; Gruen *et al.* 2008). Many examples in the history of public health show that the success of a public health programme resulting from an effective strategy, a strong mobilization and a temporary gain of human and financial resources may have its own perverse effect. After achieving significant outcomes, the public health issue often becomes a second-rank priority. Demobilization may occur, leading to the decline of the programme.

The history of control programmes of some major endemic infectious diseases illustrate this issue: Chagas disease in Latin America (Schofield & Kabayo 2008) African trypanosomiasis (Kuzoe 1993; Smith *et al.* 1998), tuberculosis in developed and less developed countries, particularly in New York city during the 1980s (Brudney & Dobkin 1991; Landesman 1993; Paolo & Nosanchuk 2004), malaria (Kidson & Indaratna 1998) and schistosomiasis (Liang *et al.* 2006) in Asia. For example, after a strong mobilization at all administrative levels (federal, state and municipal), which led to a decline of tuberculosis in New York City by the end of the 1960s, local authorities planned the eradication of the disease and began to reduce the financial and human resources allocated to the tuberculosis programme. The number of tuberculosis clinics fell from 24 to eight, personnel employed in the municipal health services was reduced, there were no outpatient units. This political and administrative demobilization took place in the context of a fiscal and social crisis and the emergence of HIV/AIDS.

Thus, among other factors (environmental, biological and social), political and organizational factors play an important role in the sustainability of a programme. The fight against many infectious diseases seems to be subjected, in many instances, to a cycle of political mobilization and demobilization. Mobilization is characterized by involving stakeholders (political, medical, administrative and non-governmental leaders and sometimes, media) putting an infectious disease on the top of the public agenda. Mobilization leads to the definition and implementation of a public policy focused on the disease perceived as a sanitary and/or social threat, and allows gathering human and financial resources. By contrast, demobilization is characterized by a change in the perception of the disease, which is no longer considered as a priority because initial public objectives may have been reached and major demands from NGOs may have been met, in a context of scarce resources, competing health issues and/or emergence of new threats.

This political cycle is often linked, at the organizational level, to the alternation between vertical and horizontal programmes. Mobilization on a specific disease generally leads to the set-up of a vertical programme, defined as a centralized, highly specific, one-disease targeting programme, mobilizing large financial and human resources (Mills 2005). In the context of demobilization, a specific programme may be maintained formally but progressively looses its own resources which are allocated to other health issues, or a progressive 'horizontalization' of the programme may occur, which means the integration of the programme components and tools of a public health policy within the health system, with an approach focused on the health of populations as a whole. This horizontalization tends to jeopardize the sustainability of the programme, particularly in case of strong discrimination persisting against the disease and the patients, because the previous high focus of managers and health workers involved on a single disease disappears, health workers of the horizontal structure are not specifically trained or experienced in managing this specific disease, the previously dedicated resources are mixed with other resources and can be reallocated according to the perception of health priorities.

The international actors, mainly UN institutions (WHO, World Bank, UNICEF, UNHCR) and global health initiatives (GHI) (defined 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') (Brugha 2008), play now a major and increasing role in the conception, implementation and funding of infectious diseases control programmes. Therefore, their potential impact, positive as well as negative, on the sustainability of these programmes deserves special attention.

Research contributions have highlighted several negative impacts on international actors on health programmes. At the macro-economic level, adjustment policies implemented by international institutions such as the World Bank during the 1990s would have weakened national health systems of low and middle income countries (Parker 2002). At the health programme level, the priorities, strategies and interventions of international actors could contribute to the destabilization of national and local programmes (Hardon & Blume 2005; Ooms 2006; Gruen *et al.* 2008), mainly by providing excessive financial resources and too ambitious objectives regarding the weakness of the health systems, by mobilizing scarce human resources recruited from primary health care (PHC) and other programmes, and by postulating that the programme will be sustained by the national authorities after the discontinuation of the international funding.

The analysis of the cooperation between the World Bank and the Brazilian AIDS programme, which is considered as a model for low and middle income countries, may lead to complementary results as it shows the positive impact of international actors on the sustainability of health programmes, allows identifying some conditions of this positive impact, and suggests recommendations for international, national and local policy-makers.

## An example of successful cooperation: the cooperation between Brazil and the World Bank and its impact on the sustainability of the Brazilian AIDS programme

Brazil is now recognized as a model for mitigating the HIV epidemic, due to a successful prevention policy associated with universal access to free antiretroviral (ARV) treatment, implemented within the public health system (Systema Unico de Saude, the SUS). The SUS, created in 1988 according to the principles of equity and the universal right to health care, played a major role in the building of the Brazilian AIDS program. This programme has been based since its beginning on public and non-governmental mobilizations, particularly mobilization of AIDS-specific NGOs targeting primarily vulnerable groups (men having sex with men, sex workers, drug users), for advocating health rights, promoting the prevention by messages adapted to the specificities of each of these groups and distributing condoms, as a complement to national prevention campaigns. The political and administrative mobilization allowed building specific structures of prevention (including anonymous testing centers), diagnosis and care devoted to HIV patients, negotiating with

pharmaceutical industries significant reductions of ARV price, and producing in the country several ARV drugs. To set-up this successful response, the role of international actors, especially the World Bank, was highly significant (Le Loup *et al.* 2008).

### Cooperation and sustainability in the context of a vertical programme (1993–2002)

Since the end of the 1980s, Brazil has negotiated agreements with several international public and private institutions. The most significant was concluded with the World Bank. During the period 1993–2002, two loan programmes, named 'AIDS I' and 'AIDS II', have been approved by this institution, in 1993 and 1998. These loans had direct and indirect effects on the sustainability of the Brazilian AIDS policy (Le Loup *et al.* 2008).

A major direct effect was the strengthening of local and national public AIDS infrastructures, within the SUS. AIDS II supported the implementation of 145 specialized AIDS care units, 66 hospital-based units and 50 home-based units, all belonging to the SUS. In parallel, 180 NGOs were funded by AIDS I and 700 NGOs by AIDS II. These supports created a powerful incentive for vulnerable groups and NGOs to commit themselves, in terms of prevention and assistance, to the fight against the epidemic and to lobby the public AIDS programme and political authorities.

These loans had also major indirect effects. Although the World Bank focused, during the 1990s, on prevention rather than care and discarded free access to ARV as a non-cost-effective strategy, the support given to the creation and development of Brazilian NGOs primarily dedicated to advocacy indirectly sustained the social pressure to obtain free and universal ARV treatment. At the same time, the development of laboratories and clinical training of physicians facilitated the implementation of these treatments in Brazil. Even if the Brazilian AIDS programme and the World Bank advocated the decentralization of HIV/AIDS activities, these loans also gave also a stronger political authority to the national AIDS programme, among other actors of the AIDS policy, after the crisis that threatened its existence from 1990 to 1992. Finally, a major effect of these loans was to give a mid-term perspective to the Brazilian AIDS programme and policy, independent from the Brazilian political and financial context, characterized at the end of the 1990s by difficulties in public finance at the federal and state levels. The support of the World Bank positively affected the stability of the national AIDS policy and contributed to maintaining during the 1990s the 'exceptionalism' of the AIDS issue in Brazil, sharing with other actors a common will to maintain AIDS as an exceptional sanitary and human rights problem, justifying exceptional resources, despite divergences between the Brazilian Aids programme and the World Bank about the best way to mitigate the epidemic (a policy associating prevention and universal access to ARV treatments *vs*. a policy focused on prevention).

### Cooperation and sustainability in the context of the decentralisation and horizontalization of the AIDS programme (since 2003)

After 2002, Brazil entered a new phase regarding the organization and sustainability of HIV/AIDS programmes. At the beginning of 2000, contemporary to the successful policy of prevention and universal access to ARV, the epidemic was globally mitigated, with an overall HIV seroprevalence stabilized at 0.6% of the Brazilian population.

The epidemic remained 'concentrated' but slowly spread to small municipalities in the interior of the country, and among the poor population. These new trends fuelled the implementation of a new policy to foster the decentralization of the Brazilian HIV/AIDS policy. This decentralisation, advocated by the Brazilian AIDS programme and by the World Bank since AIDS I, gave municipalities a stronger role in AIDS policy. An objective was to enhance the local integration of AIDS prevention and care programmes within the health system. As the epidemic in Brazil reached more socially and geographically marginalized populations and poorer municipalities with limited health resources, the decentralization coincided, in these municipalities, with a weaker capacity of AIDS stakeholders to lobby policy-makers.

The implementation of this policy promoted by the Brazilian AIDS programme with the support of the World Bank followed different paths at the local level (Le Loup *et al.* 2009). The main path, particularly in the south-eastern part of the country, was 'normalization', after the period of exceptionalism of AIDS policy and in a context of low discrimination against people living with HIV. The local AIDS programmes developed closer relations with the whole public health system (SUS) and delegated to primary health care (PHC) important functions of prevention and care. The AIDS programmes thus benefited from the large coverage of the poor population by PHC and the efficient care of the AIDS patients by other tertiary levels specialities. This integration became possible because NGOs themselves, funded by local authorities, tended to be more institutionalized and to modify their priorities, from advocacy to delivery of services. This normalization – i.e the strong integration within the health system with a decline of advocacy at the local level – may jeopardize the

sustainability of the AIDS programme, because the control of the AIDS epidemic becomes a lower priority for the majority of actors and local policy-makers of the public health system, and because the lobbying of NGOs has declined.

Alternatively, particularly in municipalities of northern and north-eastern states, a second path was the isolation of AIDS programmes, due to the lack of coordination and integration with other components of the public health system. This lack of integration prevented the coordination with other health actors, notably PHC, and, as a consequence, negatively impacted the coverage of the poor population and the response to the new trends of the epidemic. In this context, AIDS stakeholders, particularly NGOs, tried to maintain locally the exceptionalism of the AIDS, in a context of persistent discrimination, in order to mobilize increasing financial and human resources and to overcome shortcomings of the public health system. However, in many places, persistent discrimination and weak political support from local political authorities threatened the sustainability of the programme.

How did the cooperation between the World Bank and the Ministry of Health affect the sustainability of AIDS programmes in these local contexts? As noted above, the World Bank has strongly advocated since AIDS I the decentralization of the Brazilian AIDS programme. In the meantime, the World Bank and the Ministry of Health clearly highlighted the risks inherent to the process, and the need for a strong monitoring, at the local level, and for specific measures and programmes to sustain the process. Even if, initially, the World Bank and Brazilian Ministry of health planned to mount only one loan, a third agreement called AIDS III was concluded in 2003, and a process is ongoing to prepare a new loan called AIDS SUS which will cover the period 2010–2014. Therefore, the successful Brazilian AIDS programme will have beneficiated in 2014 from World Bank support for more than 20 years.

AIDS III was fully focused on the challenge of sustainability in the perspective of the ongoing decentralization and horizontalization of the Brazilian AIDS programme. As described in the project appraisal document of 2003 (World Bank 2003), the World Bank and the Brazilian AIDS programme analysed critical risks for the sustainability of the project (p. 42) and suggested to classify the 27 states of the country according to technical and financial risks in order to adjust the grants to the local needs in term of sustainability (p. 56). The technical risk was defined as 'a state's capability in terms of possessing the necessary staffing, systems for patient follow-up functioning, NGO partnerships established, prevention activities with high-risk groups underway, and specific activities addressing PMTCT (prevention of mother-to-child transmission).'

In the AIDS III agreement, the strategy to ensure the sustainability was based on the strong support given to AIDS specific NGOs, the training of health professionals of the public health system (AIDS units and PHC) focused on AIDS issues, the promotion and support of the cooperation between AIDS and PHC programmes to improve the coverage of the poor population, and specific support to states and municipalities with the strongest technical and financial risks.

AIDS SUS (2010–2014), as it emerges from discussions and negotiations, will be focused on the cooperation between local AIDS programmes and PHC in the perspective of sustainability particularly in three macroregions of the country with scarce resources and specific shortcomings: north, north-east, and east-center. A group of health workers belonging to the 'Health Family Program' dedicated to primary health care, with a more specific approach of health issues (pluridisciplinarity, close relationships to the neighbourhood, mobility) than other primary health care workers, will be strongly involved in the diagnosis and care of HIV/AIDS patients, particularly pregnant women. In parallel, the cooperation between World Bank and the Ministry of Health has led to projects aiming at improving the other components of the health system, particularly primary health care, with projects such as Qualisus or Family Health project.

## Which lessons can be drawn from the Brazilian AIDS experience in terms of health programme sustainability?

First, the cooperation between the World Bank and the Brazilian AIDS programme indicates some perspectives in terms of political and organizational monitoring of public health programmes. The first months and years after major successes of the programme are at risk of loss of sustainability and deserve special attention. Some 'red-flags' may inform the policy-makers of sustainability loss, before the deterioration of the epidemiologic situation: absence of disease-specific NGO or lobbying group and a loss of advocacy by NGOs, important local political instability, high turn-over of health workers, rapid emergence of other and concomitant diseases. In addition to the epidemiologic monitoring, an organizational and political monitoring must be implemented to plan relevant interventions of international actors, fitted to the local needs in order to insure the programmes' sustainability. This monitoring must be performed not only at the regional and state level, but also at the municipal level.

Second, the interventions of international actors must be adapted to the type of threat, depending of the path of the AIDS policy at the national and local level. The international

actors may influence through the Ministry of Health the decisions of local policy-makers by giving them the guarantee of multi-annual funding they need to set up the sustainable programmes. This commitment may allow the modernization of PHC and enhancing its cooperation with infectious diseases control programmes, and clearly highlight a health issue as a top priority. International actors may also give local NGOs and some vulnerable groups a multi-annual funding, independent from the local authorities, allowing them to lobby these authorities and advocate health issues without being dependant from local public funding. International actors may also incite local health professionals, notably PHC professionals, to involve themselves in a specific health issue, due to the benefits (in term of career, research, professional training) they can offer to them. A key point regarding the success of cooperations with international institutions is the fact that funding from these institutions should not be limited to NGO's but benefit to a broad range of stakeholders as it was the case with the Brazilian AIDS programme.

Third, as in the case of AIDS in Brazil, international actors may have a positive impact on the sustainability of national and local public health programmes, during their different phases, at four levels: political, organizational, social and financial. Their interventions are especially important when the national and local context is characterized by strong internal instability or constraints, due to economic, financial or political crisis. In this context, the involvement of international actors to maintain stable objectives is critical. Therefore, international actors may plan interventions in two circumstances: in general when demobilization begins after the successes, specifically when political and organisational red flags reveal high risks of sustainability loss.

This positive impact of international actors may occur even if the strategies of the different actors to mitigate the health problem present some divergences. In this respect, the negotiation and implementation of AIDS I was illustrative with, finally, the World Bank shifting from a policy mostly focused on prevention to a strategy of prevention and universal access to ARV treatment promoted by the Brazilian AIDS programme. A key point of this evolution was the fact that the Brazilian authorities within the AIDS programme had a clear view of the policy and strategy they wanted to implement all along in the 1990s, based on both prevention and access to treatment, with an important role devolved to NGOs. Finally, to ensure efficient sustainability of health programmes and health outcomes, a major issue should be to link local mobilization and advocacy on one hand, and, integration within the health system ensuring the coverage of the poor population, on the other.

## Conclusion

The Brazilian response to the AIDS epidemic gives other countries some lessons of pragmatism, far from debates about the relative benefits of horizontal *vs*. vertical public health programmes (Kidson & Indaratna 1998). The most important impacts of international actors may be to monitor organizational and political evolution of programmes, and to give policy-makers a political signal and a multi-annual incentive to maintain local level health programmes, and to ensure efficient social control by NGOs in a context of scarce resources, competing issues and, in some instances, political instability. Decentralization is a double-edged sword (Khaleghian 2004; Le Loup *et al.* 2009). International actors may help use the tool of decentralization successfully, in order to enhance the sustainability of health programmes, as shown by the example of the Brazilian AIDS programme. Some changes in the approach of sustainability by the Global Fund have been highlighted (Ooms & Hammonds 2008). Breaking the deleterious cycle of mobilization–demobilization to achieve sustained outcomes of national and local public health programmes is now the major task for these international actors, as the initiatives to control major and neglected diseases are winning important successes and the dark clouds of international economic crisis are reaching low and middle income settings.

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