Politics of Tuberculosis and HIV programme Integration in Ghana

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Abstract
The need to integrate TB and HIV control programmes has become critical due to their interface at the clinical level and the need for optimal use of resources. In developing countries such as Ghana where public health interventions depend on donor funds, such calls have become more urgent than ever. However, its implementation will depend largely on attitudes of implementers. This paper explores the views of stakeholders on the integration of tuberculosis and HIV in Ghana. Using a qualitative data collection approach, respondents were purposively selected from four regions with the highest reported tuberculosis cases. Two general views emerged: support for and opposition to integration. Supporters argued on shared clinical and social constructions and reducing financial and functional duplications. Those opposed cited increased workload, clinical complications, leadership crisis, and “smaller the better” arguments to support position. Although a policy for TB/HIV integration exists, lack of clarity of direction and unwillingness of some programme managers to collaborate have resulted in disjointed health care for co-infected patients. Underlying the debate is an unspoken unwillingness of implementers to cede some or all-institutional “autonomy” for active, broad-based planning, implementation, monitoring and evaluation of programmatic goals.

Key words: Tuberculosis; HIV/AIDS; Integration; Ghana
Introduction/Background

The positive relationship between HIV and TB is widely acknowledged, as an estimated one in four AIDS-related deaths each year worldwide is attributed to tuberculosis (Corbett et al., 2003; Loveday & Zweigenthal, 2011). The positive association between tuberculosis and HIV has meant that the effective prevention of the two conditions is dependent on each other (Loveday & Zweigenthal, 2011). Sonnerberg et al., (2005), for instance, have observed that the chances of the onset of tuberculosis heighten within the first years of HIV infection. The situation becomes precarious among HIV patients with low CD4 count and without timely interventions the incidence of TB will remain high (Loveday & Zweigenthal, 2011). And in Africa where the mortality rate from HIV-related tuberculosis cases is over 20 times higher than in other world regions, reducing the dual burden of these twin epidemics requires that implementers of TB and HIV programmes collaborate (UNAIDS, 2012).

In response to the double burden of TB and HIV, the WHO, first in 2004 and subsequently in 2012, has called for closer ties between TB and HIV programmes, targeting at least, functional integration (WHO, 2004; 2012). The calls to integrate TB and HIV programmes are intended to improve the diagnosis, treatment, and outcome of dually infected patients (Abdool-Karim et al., 2004). Furthermore, the stigmatising consequence of this framing of a new disease makes integration necessary (Sánchez, 2010).

Although the benefits to integrate TB and HIV programmes are clearly set out (e.g. Friedland et al., 2007; Nunn et al., 2007; Howard & El-Sadr, 2010), studies on specific interventions and their successes are limited (Friedland et al., 2007). Among them are studies, which have reported the contributions and feasibility of integration of TB and HIV programmes in a rural Kenyan community (Shaffer et al, 2012) and one in rural South Africa (Gandhi et al., 2009). The debate on integration of health programmes is neither new nor unique to tuberculosis and HIV. There have been the debates over the integration of maternal and child health in the 1980s (Allman, Rohde & Wray, 1989; Mayhew et al., 2000) and currently on the integration of reproductive health and HIV (Windisch et al., 2011). The opponents of integration have identified operational, clinical and managerial challenges.

This paper contributes to the debate on the integration of tuberculosis and HIV programmes in Ghana by focusing on the views of stakeholders in the two control programmes. The objective is to explore the evidence from Ghana for a better understanding of specific considerations associated with integration of tuberculosis and HIV programmes integration.

Methods

The study involved 21 respondents selected from NTP and NACP staff at the national, regional, district and facility levels in the four regions with the highest reported TB cases in the country were targeted for in-depth interviews (IDI). The selection of the 21 respondents
for the IDIs was informed by the adequateness of those involved (Charmz, 2003) and the level of saturation associated with such studies (Creswell, 1998; and Guest et al., 2006). Mason (2010) has observed that studies reporting saturation often employed ten (10) to forty (40) interviewees.

Selection of the individual respondents was done purposively from national to hospital/facility levels (Table 1). Data collection and transcription were done concurrently in order that iterative discussions with other participants could be done. Ethical clearance for the study was sought from the Institutional Review Board of the University of Cape Coast. Table 1 provides a summary description of where respondents were selected.

<table>
<thead>
<tr>
<th>Categories of respondents</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>National AIDS Control Programme</td>
<td>3</td>
</tr>
<tr>
<td>NTP officers</td>
<td>3</td>
</tr>
<tr>
<td>Regional TB coordinators</td>
<td>4</td>
</tr>
<tr>
<td>Regional AIDS coordinators</td>
<td>4</td>
</tr>
<tr>
<td>NTP District/Metro Coordinators</td>
<td>2</td>
</tr>
<tr>
<td>NACP district coordinators</td>
<td>2</td>
</tr>
<tr>
<td>NACP facility coordinator</td>
<td>1</td>
</tr>
<tr>
<td>NTP facility coordinator</td>
<td>1</td>
</tr>
<tr>
<td>TB-related NGO</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

*Source: Fieldwork, 2012*

**Results**

Seven years into the integration, the situation was such that the ideal expected had not been achieved. Within the groups were those who supported the purpose of the integration, and those who opposed the initiated programme.

**Support for integration**

Respondents’ opinions on integration were solicited. The specific question posed was “What are your views on integration of tuberculosis and HIV? There were some participants who felt that integration held the keys to successful policies and projects implementation so far as tuberculosis and HIV/AIDS controls were concerned. The arguments of the group were along two broad dimensions: the clinical interface and shared social constructions and the duplications of efforts and dissipation of energies and resources.
Clinical interface and Shared Social Construct

The individuals who supported integration argued that the clinical interface was enough reason for the two programmes to collaborate. Person living with the virus had a high probability of being infected by TB. It has been estimated that about 59% of persons living with HIV were also living with TB (Ghana Health Service, 2007). And as pointed out by one of the respondents: ‘even with the Global fund, the project is for HIV, TB and malaria. Why can’t we collaborate?’

Optimization of efforts and resources

Among some respondents, their support for the integration emanated from the need to avoid and/or to eliminate duplication of activities, efforts and resources. This need to collaborate is particularly important in this period of the dwindling of resources at the international level and the allocation for programmes. In 2011, of the forty-four ($44) million funds that were needed for the programme in the country, only $27 million was secured, representing 60% budget funded. Out of the $27 million funded, Global Fund (GF) provided 64% while Government of Ghana provided 32%. Funding for 2012 is estimated at $24 million dollars, indicating a shortfall of 11%. Out of the $24 million available, the GF is providing about 54% ($12,960,000) while GoG provided the remaining 46% (11,040,000)\(^1\). The argument of GF in particular is for optimal use of resources.

Opposition to integration

Reasons often cited to oppose TB/HIV integration were possible increase in workload, clinical complications involved in TB/HIV management, leadership crises and biases and increase in stigmatisation of TB as a result of joint TB/HIV service delivery. The core argument of some of the opponents was that integration would not be able to ensure ownership and that the system may not pay attention to specialization in an integrated system. Thus:

*I would not support integration completely. If you give work to ’Mr everybody, Mr nobody does it’. At the national level, we need specialist who can keep the standards. Running disease programme is not same as administration (planning) where you can put one person in charge (NTP respondent, IDI).*

Increase in workload

Some respondents thought integrating tuberculosis and HIV services could potentially increase staff workload. They felt that, patients of the respective conditions need enough attention and emotional support. As a result, allowing “one or few” people to provide their needs would overstrain staff. Concern was expressed at the levels at which integration need to occur thus:

\(^1\) [www.who.net/tb/data](http://www.who.net/tb/data)
Full integration (planning, governance, financing, service delivery, information system and demand generation) is possible but I am yet see anywhere it has been practicable. If you look at the dimensions of the two programmes, the work involved is **huge** (NTP respondent, IDI).

**Clinical complications of TB and HIV**

Data from the respondents showed that some of the participants envisaged clinical difficulties in integrating service delivery. For instance, the time span within which TB can be cured and the lifetime dimension for managing HIV differ. In that case, there was no need to integrate the two. As pointed out:

Integration is not possible at the moment because TB and HIV have different mechanisms at the clinical level: whereas TB can be cured within six to eight months after diagnosis and initiation of treatment, HIV is not like that. It is a lifetime condition with intermittent opportunistic infections, treated and continue with ART (NACP respondent, IDI).

**Leadership crises and biases**

Most of the respondents who opposed full integration of TB and HIV argued that biases could arise if a specific leader is more interested in one disease than the other. They contended that it is possible to have a programme manager who is more passionate about tuberculosis control than HIV. The same can occur for HIV over TB. There was also the fear that HIV programme, which has a high profile, could take over TB. Such conflicting interests could consequently jeopardise efficiency and targets of each disease:

The danger is that, if you have a programme manager who is biased towards either HIV or TB, the other disease will suffer because of his/her passion towards that disease (NTP respondent, IDI).

**Discussion and conclusions**

Generally, the voices of support for integration of TB and HIV services in Ghana were far less than the voices of opposition. The main reasons for supporting integration of whatever kind were that it would improve coherent and logical clinical management and stigma against people infected with tuberculosis and HIV. The responses re-echoed the concerns raised about leadership and biases towards one or the other of the programmes. It is apparent from the responses that the technical policy for TB/HIV integration is different from what is actually happening. Coordination, which is more about sharing information, is handled in an uncoordinated manner. As one “neutral” respondent observed, “the integration between TB and HIV in Ghana is very weak. Each seems to exist on their own, right from national through health facilities. Separate monitoring and supervision are done, there is poor information sharing; the joint TB/HIV Working Group is dormant; they meet once a while. Actually, the coordination and collaboration is not good at all.

Emerging from the analysis is the differentiation between collaboration and co-ordination from the opponents of integration. This can hold the key to the next line of
action on the integration debate in Ghana. It appeared that people were more comfortable with co-ordination of programmes without losing control over professional arena and area of operation.

The funding situation also calls for action. Presently there are uncertainties surrounding Global Fund funding for tuberculosis and HIV in the country. In the case of HIV, the Fund’s support for NACP activities has reduced considerably. Conditions for funding of tuberculosis in Ghana have also been tightened. Active integration of greater proportion of each programme’s functions, in our opinion provides some amount of opportunities for sustaining TB and HIV control programmes in the country.