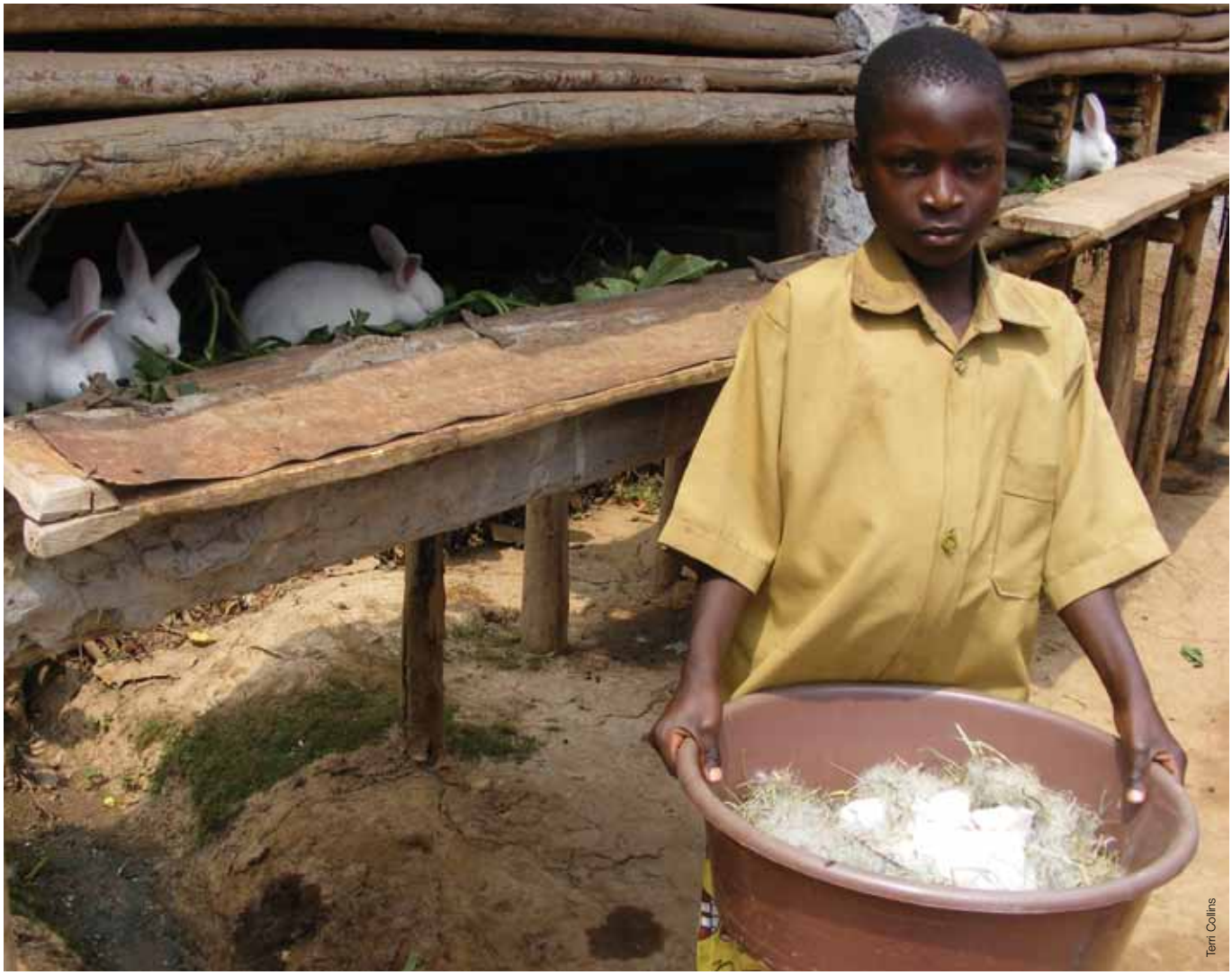
COMPASS

HLSP NEWSLETTER | ISSUE 11 | OCTOBER 2010



Aaron and his rabbits – in Rwanda AIDS money enables vulnerable children and their families to live healthy, independent lives

ALL TOGETHER NOW

THERE IS GROWING DISCUSSION about the interdependence among the Millennium Development Goals (MDGs), in particular how the AIDS response is linked to achieving the other goals. Ahead of September's MDG summit, HLSP's Terri Collins travelled to Rwanda to investigate these links.

Aaron Manirarora is a bright-eyed six-year old who carefully tends his wooden hutches filled with small white rabbits. Four years ago his mother, Serapia, became ill and was diagnosed as HIV positive. Rejected by her husband, she returned to the tiny hillside home of her elderly mother in Rubaya near the Ugandan border. With no source of income and little land, the family struggled to make ends meet.

In 2007, Aaron's community identified him as a 'vulnerable child'. He was recruited into an orphans and vulnerable children (OVC) project, which used AIDS resources to provide him with a basic package of health care, education, nutrition and social welfare services.

CONTINUED ON PAGE 2

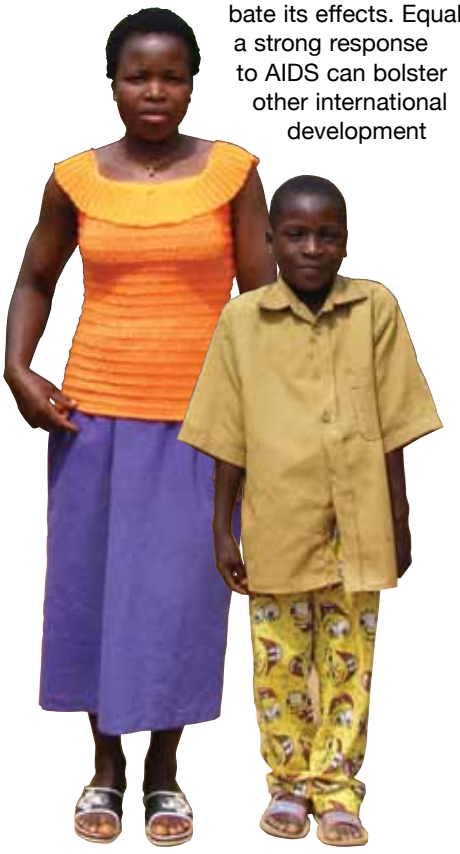
Turning rabbits into cows

As part of an income generation initiative, Aaron received one female rabbit. The rabbit soon began to produce a clutch of offspring every two months. Aaron and his mother now sell the rabbits for a regular source of income. Recently, Serapia bought a cow using a loan from a cooperative for people living with HIV and money from the sale of rabbits. This cow now provides the family with milk for consumption and sale.

The story of Aaron and his family is a concrete example of a joined-up approach to OVC care and support. By focusing on households and skills-building, and making links to a 'cluster' of cooperatives and HIV interventions, the programme has made a sustainable impact on three generations.

AIDS and MDGs: a two way street?

Rwanda's successful approaches to supporting orphans and vulnerable children illustrate the potential links between MDGs. It has long been recognised that the AIDS epidemic can undermine countries' social and economic development, while lack of development can exacerbate its effects. Equally, a strong response to AIDS can bolster other international development goals – contributing to the alleviation of poverty and hunger (MDG 1), increasing school attendance (MDG 2), promoting gender equality (MDG 3), as well as decreasing maternal and child mortality (MDGs 4 and 5). In the same way, strong programmes to address these development challenges can increase the impact of the AIDS response. Many practitioners now suggest that encouraging these links could increase the efficiency and effectiveness of development programmes.



Rwanda has been making good progress in facilitating such links. It is estimated that contributions from the AIDS response to MDG 1 amounted to 10% of all 2007's AIDS spending, increasing to 14% in 2008. In 2007, AIDS resources supported 816 microfinance projects with over 33,000 beneficiaries and the Global Fund Round 7 award provided a comprehensive package of services for 18,620 OVC. Although many benefits have been social, rather than economic, important efforts are now being made to sustain economic impact and extend support to Rwanda's 1,350,800 OVC (many of whom have been orphaned or made vulnerable as a result of the 1994 genocide). In 2008, AIDS spending on education for OVC reached over $3 million and the Ministry of Education has partnered with AIDS practitioners to integrate AIDS education into all teaching curricula.

Similar 'AIDS plus MDGs' collaboration is taking place in the Ministry of Gender and Family Promotion, which introduced important legislation to protect young girls and women from domestic and sexual violence, and sexual harassment. In addition, AIDS spending on Prevention of Mother to Child Transmission (PMTCT) and paediatric antiretroviral therapy reached an annual total of $7.5 million in 2008, and appears to have supported a 3% reduction in under-five mortality since 2003.

What can we learn from Rwanda?

Rwanda's unique history and context means it may not be possible to replicate the 'model' elsewhere, however the experience does offer some important lessons.

WHAT IS 'AIDS PLUS MDGS'?

There is a strong argument for continued investment in HIV, particularly as a force for accelerating other MDGs (4 and 5) which cannot be achieved without tackling HIV. UNAIDS has mobilised around these important links with the 'AIDS plus MDGs' initiative. Launched at the MDG Summit in September 2010, the initiative recognises and seeks to build on the links between HIV and the other MDGs.

A strong and technically sound National Strategic AIDS Plan has provided an opportunity to articulate the potential of service integration, strategic partnerships and links between policies and sector plans. The plan has been an important tool for mobilising development partners and other stakeholders.

Rwanda has taken great steps to avoid parallel systems and to integrate public and non-governmental service delivery. For example the State does not differentiate between AIDS orphans and children orphaned by the genocide. This can assist programme integration and referral, and support more efficient use of human and financial resources. Furthermore a focus on meeting the full spectrum of people's needs and family-centred approaches can provide strong drivers for service integration.

The Rwandan AIDS response has been cutting edge in moving beyond a conventional disease response to embrace a more multisectoral, multidisciplinary approach that addresses both causes and effects.

Today, Aaron continues to attend his local primary school. Asked what he would like to be when he grows up, he reflects: "When I grow up I would like to be the local Social Affairs Officer… so I can help other children like me."

MORE INFORMATION ONLINE

To read the full report visit:
http://data.unaids.org/pub/Report/2010/20100917_rwanda_aids_plus_mdgs_en.pdf
Contact: **terri.collins@hlsp.org**

39%

AN ESTIMATED 39% OF ANNUAL TB CASES ARE MISSED BY NATIONAL HEALTH SYSTEMS AND TRADITIONAL TB SERVICES

(Source: www.undp.mn)

THE STOP TB PARTNERSHIP'S TB REACH INITIATIVE focuses on those who have limited or no access to tuberculosis (TB) services. Its aim is to promote early and increased detection of infectious TB cases and ensure timely treatment.

The first wave of funding was announced in January 2010 and has been disbursed to 30 applicants, including Ministries of Health, National TB Programmes, NGOs and private sector organisations worldwide, from Afghanistan to Zimbabwe.

HLSP has been contracted by the Stop TB Partnership/World Health Organization (WHO) to assess the performance of each grant, including suggesting possible reasons and solutions for underperforming grants.

MORE INFORMATION ONLINE

Contact: **martine.donoghue@hlsp.org**
Visit the TB website at:
www.stoptb.org/global/awards/tbreach

WELCOMING HDA

Staff from HLSP meet HDA in their Johannesburg office

HEALTH & DEVELOPMENT AFRICA (HDA) JOINED US as our new South African-based health and HIV specialists in August 2010. HLSP and HDA have worked together for many years, including on DFID's Strengthening South Africa's Revitalised Response to AIDS and Health programme.

HDA provides technical assistance and project management across Southern and Eastern Africa. Its 45-strong team, headed by Saul Johnson, includes epidemiologists, health economists and experts in health systems and aid finance. HDA has a particular focus on improving the lives of vulnerable children and their carers in the community, and manages two long-term USAID-funded projects in this area.

"We are very excited to be working with HLSP to expand our work in the Africa region. HDA has a passion for improving the health and well-being of the people of Africa, and this is something we share with HLSP."

HDA was recently awarded the contract to manage the UNAIDS Technical Support Facility (TSF) for Southern Africa for a further two years. The TSF provides access to timely, high quality short-term technical assistance to National AIDS Commissions, Ministries of Health and other partners involved in scaling up national HIV responses.

Together, HLSP and HDA will be able to provide a unique range of development services in Africa and beyond.

MORE INFORMATION ONLINE

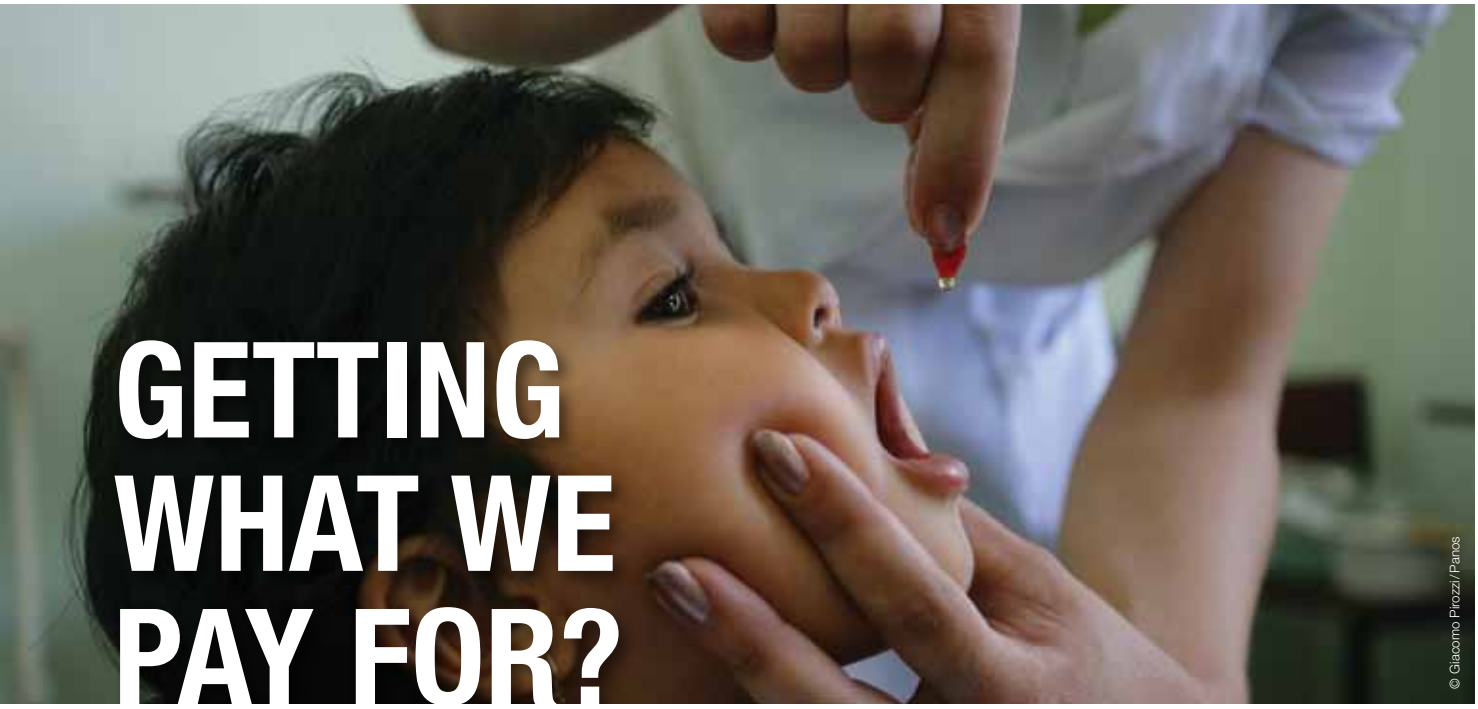
Visit the HDA website at:
www.hda.co.za and for the TSF visit:
www.tsfsouthernafrica.com

HOW DO I LOOK?

WELCOME TO THE ALL NEW COMPASS. Following HLSP's rebrand in July 2010, we have revamped our newsletter too. We hope you'll find this updated design both accessible and interesting. Please send any comments to: **compass@hlsp.org**

NEW DIRECTOR FOR HEALTH AND EDUCATION

ANDY BROCK will lead Mott MacDonald's international health and education operations from January 2011. Andy has worked for HLSP's sister company Cambridge Education for 20 years and more recently headed up our combined health and education operation in Asia Pacific. In his new role he will manage both HLSP and Cambridge Education's international work. This provides an opportunity to strengthen our regional bases, in particular in Africa and Asia. We will also be looking to work more closely with our education colleagues. For information on Cambridge Education visit: **www.camb-ed.com**



GETTING WHAT WE PAY FOR?

Results based funding agreements linked to MDG 4 often include numbers of children fully immunised

LACK OF A RESULTS FOCUS is seen by many as a major reason behind disappointing outcomes of past aid efforts. As donors look to scale up support while demonstrating results, results based funding (RBF) is receiving increased attention. HLSP recently reviewed a number of these approaches, including forms of budget support and mechanisms managed by global health initiatives.

RBF is an umbrella term for a number of approaches trying to link funding more closely to results – such as numbers of children immunised. Put simply, it means the funder decides beforehand the precise results it will pay for, and only releases payment (to an agent) when they are achieved. In contrast, traditional aid funds tend to be released irrespective of results. The key challenge with RBF lies in ensuring that the incentives of funder and agent are aligned to ensure delivery of results.

But does it work?

Given the variety of approaches, it is not possible to simply tell whether RBF 'works'. Our review finds some promising experience, but many approaches are new and, as such, unproven.

All too often funding for health is not focused on the most cost effective and equitable interventions. Merely using new approaches will not change this and RBF may just help deliver the wrong results more efficiently (or inefficiently if it does not work).

> *"All aid is supposed to deliver results – otherwise why would we do it? Results based funding is just one way of trying to link funding more closely to results."*

RBF should not be considered as an easy way for donors to show taxpayers what their money delivers. Used alone RBF might allow easier attribution, but might also reduce the chances of achieving results. These are usually achieved through a 'package' of approaches, and changes in the wider system and several complex factors can affect progress.

Another key question is whether RBF is simply rewarding those who are already *able* to deliver results, rather than helping those who are *trying* to do so. There is a risk of falling back into traditional conditionality rather than introducing more balanced, joint efforts to find out how to improve results.

There are also doubts as to whether some of the benefits identified to date can be sustained or scaled up. At worst, results based funding might be the 'sticking plaster' that prevents health systems from collapsing, but in effect postpones the public sector reforms necessary to address problems more comprehensively.

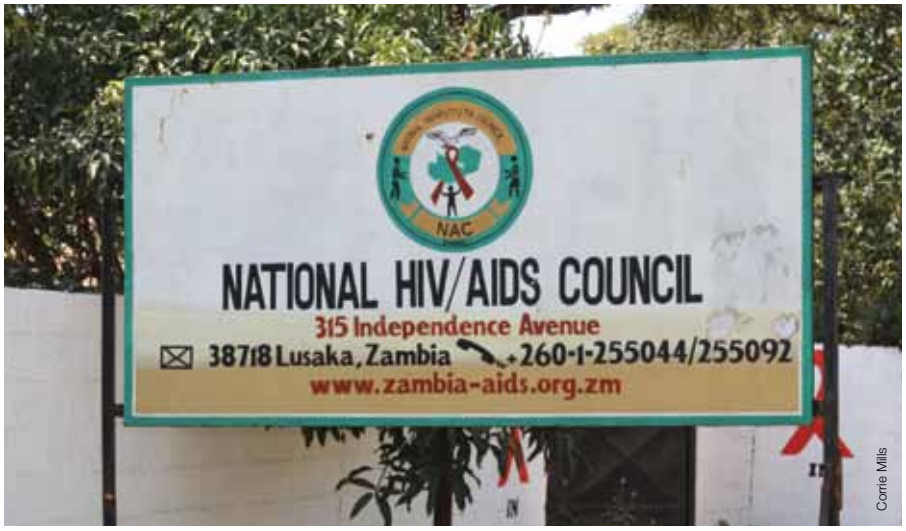
RBF: part of a package

Overall, the approach to RBF should be open-minded but cautious. Good design is essential and progress will need to be closely monitored and evaluated. RBF might work better in some settings rather than others and should be considered as part of a package of reforms, not as a single stand alone measure.

MORE INFORMATION ONLINE

Results Based Aid and Results Based Financing. What are they? How do they work? Have they delivered results to date? (Mark Pearson, forthcoming) will be online at: **www.hlsp.org/resources**

COORDINATING THE AIDS RESPONSE



This is how we do it – NAC arrangements vary from country to country

MOST COUNTRIES HAVE A NATIONAL COORDINATING AUTHORITY FOR HIV – the National AIDS Commission (NAC) – as well as a Country Coordinating Mechanism (CCM) established by the Global Fund to Fight AIDS, TB, and Malaria. While CCMs have made positive contributions, they have not fitted easily into pre-existing structures and are still widely perceived as Global Fund entities. Recent analysis by the HLSP Institute has focused on how countries are refining their coordination of health and HIV structures to better suit their contexts.

Donors and global health initiatives are encouraged to align as much as possible with pre-existing structures to reduce transaction costs and avoid inefficiencies. Recently there have been calls for greater integration of CCMs and NACs.

The vast majority of countries studied by the HLSP Institute had separate CCMs, and varying degrees of integration with existing structures. Two main approaches are apparent, each with pros and cons. In the first, CCM governance and other functions are becoming more closely associated with those of the NAC; in the second, CCM functions are becoming more integrated with broader national health and development coordination mechanisms. In some cases, integrating CCM membership and oversight functions with national health coordination mechanisms has strengthened country ownership, participation in decision making, grant oversight and joint results frameworks. In other cases, combining CCM and NAC functions has narrowed the NAC's focus to CCM functions, rather than the broader remit of a national AIDS authority.

As the Global Fund scales up support for the national disease programme's plan (National Strategy Applications, NSAs), institutional arrangements between CCMs and NACs are likely to further change. Conflicts of authority may arise over the ownership, participation and accountability of national strategies (resting largely with NACs) and the NSA process, funding and implementation oversight (resting largely with CCMs). Alternatively, NSAs may be a catalyst for improved dialogue and integration between the two entities. Either way, a more nuanced approach to appreciating institutional arrangements within the NSA context will be required.

The HLSP Institute presented a poster on this topic at the XVIII International AIDS Conference, July 2010. A perspectives paper in the Journal of Global Health Governance is forthcoming, as part of a special issue on Global Health Governance and the AIDS Response.

Contact: **clare.dickinson@hlsp.org**

IN BRIEF

MAPPING USER FEES FOR HEALTH CARE

The forthcoming World Health Report 2010 will focus on fair and sustainable health systems financing and social health protection as a means to achieving universal coverage. The report has been preceded by increased interest in removing user fees. The latest country to introduce reforms is Sierra Leone, which made health care free for children under five, pregnant women and lactating mothers last April.

Despite the existence of many advocacy documents and case studies, there are few synthesis studies on reforms and point-of-use payment arrangements internationally, especially for those interested in making comparisons. A new HLSP Institute paper, based on work commissioned by DFID in 2009, includes summary information on fees and health financing for 49 countries in Africa and Asia.

Mapping user fees for health care in high-mortality countries: evidence from a recent survey (Sophie Witter, forthcoming) will be online at: **www.hlsp.org/resources**

HLSP TECHNICAL FORUM

This year's annual HLSP Technical Forum took place in London in September. HLSP staff and consultants from Africa, Asia and Asia Pacific came together to discuss emerging issues in both our work and the development world.

Points of discussion included use of new communication technologies for health, how to get research into policy and practice, and contracting out for service delivery.

WWW.HLSP.ORG/INSTITUTE

The HLSP Institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health.
Contact: **institute@hlsp.org**

SOUTH AFRICA
CLEARING THE BACKLOG

A heavy load – South Africa had an extensive backlog of drug applications

A CRISIS AT THE SOUTH AFRICAN MEDICINES REGULATORY AUTHORITY in 2008 threatened the availability of new medicines in the country. The Medicines Control Council had a backlog of around 4,500 drug applications, some dating back to 2001.

Thousands of boxed documents filled the corridors and offices of the National Department of Health (NDoH). These included applications for many new antiretrovirals needed in the HIV treatment programme, as well as TB, diabetes and antibiotic drugs. The new Minister of Health, Dr Aaron Motsoaledi, blamed the crisis on staff shortages, and financial and systemic problems.

In 2009, under an HLSP project, a crack team of 50 consultants, technical experts and clerks moved in to help process the backlog. New systems were devised and an electronic document management system installed. Thousands of inactive files were archived to off-site storage, and just under 10 kilometres of state of the art shelving were installed to hold the remainder and facilitate document retrieval.

This injection of funding and technical expertise enabled the medicines regulatory authority to audit the backlog and reduce it to around 1,500 applications. In July 2010, the Minister told the South African press that all applications for antiretroviral drugs had been reviewed and 65 had been fast-tracked through the system.

Legal and other work has also begun on the creation of a new body, the South African Health Products Regulatory Authority, to replace the beleaguered Medicines Control Council. The big challenge now is for the NDoH to take over the work and ensure that it is sustained with adequate funding and personnel.

The Backlog Project began under the DFID-funded Rapid Response Health Fund in 2009 and continued under the current programme, SARRAH (Strengthening South Africa's Response to HIV and Health), both managed by HLSP's Pretoria office.

For more information contact: **john.wilson@hlsp.org**

PAKISTAN
ASSESSING THE QUALITY OF COMMUNITY MIDWIFE TRAINING, DFID

MATERNAL MORTALITY IN PAKISTAN is still unacceptably high. Increasing the country's numbers of skilled birth attendants is one of the key components of the Government's maternal health intervention.

In 2007, the community midwives training programme was introduced to train young rural women to provide antenatal care, safe delivery and referral for emergency care, and postnatal care in their local areas. By April 2010, the programme had enrolled over 8,500 midwives and HLSP was involved in assessing the quality of the training provided. The review was contracted by the National Maternal Newborn and Child Health Programme through the DFID-funded Technical Resource Facility, managed by HLSP.

The team found that in some provinces it had been challenging to recruit women with the required education levels. Also many married women were unable to stay overnight during their training, which was exacerbated by accommodation shortages. Lack of full-time residence compromised the midwives' clinical training – as they missed night-time rotations in hospitals when most deliveries take place. Overall the midwives had encouraging levels of theoretical knowledge. However, analytical skills and clinical experience, both essential for managing and referring obstetric complications, were weak.

On the basis of the report's findings, the government has adopted an action plan. Community midwives represent a big investment for the maternal health programme and it is hoped that, with support from a well functioning health system and some improvements in training, they will contribute to a significant decrease in Pakistan's maternal and neonatal mortality.

For more information contact: **sarah.dobson@hlsp.org**

MONGOLIA

REDUCING PERSISTENT CHRONIC MALNUTRITION IN CHILDREN, ADB

Despite great gains tackling child mortality in Mongolia, nutrition remains a problem

8.3%
MONGOLIA'S POPULATION UNDER FIVE

1 in 5
CHILDREN HAS STUNTED GROWTH

70%
DECREASE IN INFANT MORTALITY RATE BETWEEN 2000 AND 2006
(Source: www.undp.mn)

MONGOLIA HAS MADE STEADY PROGRESS on improving maternal and child health. By 2008 it had achieved both Millennium Development Goals (MDG) 4 and 5, to reduce child and maternal mortality respectively.

Yet, child malnutrition remains a significant problem. One in five children has stunted growth and an equal proportion suffers from iron deficiency anaemia. Causes of child malnutrition in Mongolia range from mothers' poor knowledge of child feeding practices to low family income and limited variety of food products.

In May 2010, the Asian Development Bank (ADB) contracted John James, HLSP's child health and nutrition expert, to provide two and half years' support to the Mongolian Ministry of Health to improve the nutritional status of children under three.

The inception report found that the Government of Mongolia and Ministry of Health had made significant progress addressing child malnutrition. However, a number of challenges remain, not least redressing the significant regional variation in children's nutritional status.

The report also pinpointed a need for improved nutritional training for health workers and further community education to tackle inappropriate, and often calorie-deficient weaning diets. For more information contact: **john.james@hlsp.org**

GLOBAL

POOLED FUNDING FOR NEGLECTED DISEASES R&D, GATES FOUNDATION/R4D

POOLED FUNDING may be a way to maximise research and development (R&D) funds for neglected diseases. The premise is that donors put money into a common pool and resources are allocated to the most 'promising' and 'high priority' R&D.

HLSP is working with Results for Development Institute (R4D) on a Gates Foundation-funded assessment of three proposed funding mechanisms. The team have examined whether the proposals are likely to attract new money and/or whether they are likely to improve efficiency and effectiveness of resource allocation for neglected disease R&D.

The overall aim of this work is to help donors and policymakers decide whether these pooled funding mechanisms are an appropriate way to accelerate R&D for neglected diseases.

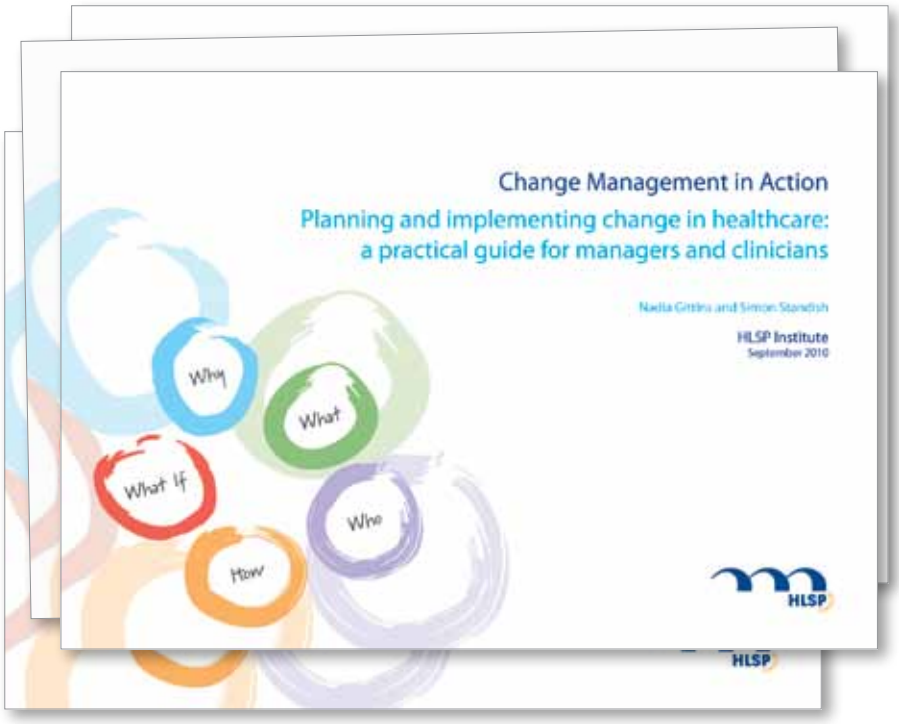
For more information contact: **cheri.grace@hlsp.org** or visit: **www.healthresearchpolicy.org**

GLOBAL

ASSESSING PARTNERSHIP INITIATIVES, NORAD

NORAD (The Norwegian Agency for Development Cooperation) intends to evaluate its support for reducing child mortality and improving maternal health. The key challenge is the idea that a *pure* impact evaluation is not possible. Not all impact can be measured and it is often costly to do so. Yet, non-measurability does not imply lack of impact. Ahead of the evaluation, HLSP is assessing the extent to which partnership interventions can be reliably evaluated. The team will develop scenarios to identify the pros and cons of different approaches to measuring impact.

Contact: **nicolas.avril@hlsp.org**



CHANGE MANAGEMENT IN ACTION

THE HLSP INSTITUTE has developed a practical, jargon-free guide to the key steps and tools of change management.

Change management as a discipline is widely recognised across the private and public sectors of high income countries. Yet, it has been used less frequently in the context of developing and middle income countries.

This new publication draws on HLSP's practical experience applying change management tools and techniques with organisations in countries ranging from Nigeria to Russia. This approach has been synthesised into a simple framework called 'The five wonders of change'. The guide is illustrated with project examples from HLSP's recent programme, which supported doctors from Iraq to bring change to their health care services.

The guide focuses on the tools that participants from HLSP-managed programmes found most helpful – from assessing the need for change through to developing a risk assessment and plan.

This new resource is aimed particularly at senior clinicians and health care managers who would like help in thinking through, planning and then implementing changes to their health care services locally. It provides practical assistance in a way that assumes no prior theoretical background to what is often called 'change management'.

> *"My whole way of thinking has changed, and this has helped me with the various projects that I have been carrying out in my hospital"*
>
> Participant in the Iraqi Clinical Training and Development Programme

WWW.HLSP.ORG/RESOURCES

Change Management in Action. Planning and implementing change in health care: a practical guide for managers and clinicians can be downloaded from:
www.hlsp.org/resources
Contact: **nadia.gittins@hlsp.org**

HLSP
WORKING TO IMPROVE WORLD HEALTH

HLSP provides technical assistance in the health sector, programme management and policy advice to international agencies and national governments in developing countries. Our expertise ranges from health systems strengthening to cross-cutting issues related to aid effectiveness.

We have experience working with both the public and non-state sector and in fragile states. Our services are tailored to reflect not only our client needs but also those of the country in which we are working.

Through the HLSP Institute, we share our knowledge and experience and contribute to policy and debate on global health issues and development practice.

HLSP is supported by an in-house team of technical specialists and 8,000 external consultants offering a broad range of health sector skills including health policy and planning, sector financing, governance, gender, and capacity development.

CONTACT US

HLSP head office
Sea Containers House
Upper Ground
London
SE1 9LZ
United Kingdom

T +44 (0)20 7803 4545
F +44 (0)20 7803 4502
E enquiries@hlsp.org
W www.hlsp.org

HLSP is a member of the Mott MacDonald Group.

Compass Issue 11, October 2010
Printed on recycled paper
Previous issues are available at:
www.hlsp.org/compass