COMPASS

HLSP NEWSLETTER | ISSUE 12 | APRIL 2011

Financing for immunisation needs to find a balance between price and supply security

MAKING THE MOST OF MEDICINE MARKETS

ONE THIRD OF THE WORLD'S POPULATION IS UNABLE TO ACCESS ESSENTIAL MEDICINES due to high cost or low availability. *Compass* spoke to Cheri Grace, HLSP's Lead Specialist in Access to Medicines, about the complex science of making medicine markets work for poor people.

Your work is mostly for donors, with a heavy emphasis on markets and the private sector. This is an interesting but surprising interface, how did you get into this specialism?

I have worked in the pharmaceutical industry, corporate finance, academia, and grassroots development. Access to medicines allows me to bring these different experiences to the strategic challenges HLSP is asked to address. My work has spanned the full continuum: from consumer to provider to producer. My early work for the Ministry of Health in Morocco helped me understand people's needs, while my private sector work and training gives me the perspective of pharmaceutical producers.

CONTINUED ON PAGE 2

HLSP

What is the role of access to medicines within a health system, and how important is it?

Obviously it is very important, and not just because of the direct health benefits of preventing and treating disease. Medicines and other health technologies enable individuals to remain productive, contribute to the welfare of families and benefit the whole economy. They also help save on hospital costs. The availability of medicines and vaccines is a key reason why people use health services, so investing in medicines is a crucial issue for governments, donors, and households.

Governments in developing countries spend up to 40% of their health budgets on medicines – only human resource costs are higher. In low income households, medicines are often the largest family spending item after food. Health technologies also make up a significant portion of global health initiative grants: around 50% for the Global Fund and 70% for the Global Alliance for Vaccines and Immunisations (GAVI).

Despite all these clear reasons for improving access to medicines, and the fact that it is one of the six building blocks of WHO's health systems framework, I think it remains a relatively neglected area. I was surprised by how few sessions focused on medicines at last year's conference on Health Systems Research in Montreux and I also thought that the health technologies section was the weakest chapter in the major Lancet review on the impact of Global Health Initiatives on health systems.*

"Medicines enable individuals to remain productive, contribute to the welfare of families and benefit the whole economy."

Your primary interest is how to use public funds to shape medicine markets to take into account the needs of poor people. What is your approach?

I find it very helpful to view the market in two, related dimensions – 'static' and 'dynamic' access. Strengthening static access means short term interventions for affordable access to existing products, for example developing supply systems, regulation in public and private sectors, and adequate financing. But it is just as important to think about dynamic access so that longer term interventions to ensure incentives for investing in development and production capacity are in place.

It is also important that static market interventions do not distort or reduce access in the longer term. It is now well known that during the early years of the GAVI Alliance, pressures to keep prices low drove vaccine producers out of the market. UNICEF, the major procurer, has consequently emphasised a balance between price and supply security.

There are now similar pressures on unit price for insecticide treated nets and first line antiretroviral drugs which may be having unexpected consequences. I'll be presenting work at this year's International Health Economics Association conference to illustrate the potential risks posed by donations and differential pricing, from a dynamic access perspective.

HLSP's work has covered a range of interventions for managing and promoting dynamic access with public funds. We have evaluated and analysed different aspects of product development partnerships (PDPs), a 'push' model that brings together public and private players to develop new drugs for treatment and prevention. PDPs have now brought eleven new technologies to registration and we are starting to see impact: the delivery of 20 million doses of Meningitis A vaccine in just a few months, 56 million children reached with Coartem D – the first high quality antimalarial especially formulated for children.

The Bill and Melinda Gates Foundation is one of the major funders of PDPs, but has recently reported a likely funding shortfall in taking all current portfolio products to registration. HLSP carried out a study for Results for Development to assess the feasibility of a pooled fund to attract new donors, such as investment banks. We found that this type of mechanism might be attractive, especially if focused on late stage portfolios – where success is more likely.

You have been involved in the formative stages of many groundbreaking initiatives, what are your highlights?

I've been privileged to have been involved in facilitating donor support for some of the most innovative and challenging initiatives. I was impressed by the technical rigour of the Institute of Medicine's proposal for a global subsidy to reduce prices for antimalarial medicines – the Affordable Medicines Facility for Malaria – and did all I could while working within DFID to facilitate further due diligence on the concept. HLSP colleagues have continued to support the process and the Facility was launched in 2009.

I was also involved in the formative stages of the international drug purchasing facility, later to become UNITAID, and I continue to be involved as a member of the Proposal Review Committee. Work on Advanced Market Commitments was interesting from a technical standpoint and I also enjoyed many of the people I met. Most recently, HLSP was awarded the independent evaluation of GAVI's International Finance Facility for Immunisation (IFFIm).

* An assessment of interactions between global health initiatives and country health systems. World Health Organization Maximizing Positive Synergies Collaborative Group. Lancet, 373 (9681): 2137–2169, 20 June 2009.

MORE INFORMATION ONLINE

Contact: **cheri.grace@hlsp.org** or visit: **www.hlsp.org/accesstomedicines**

A better picture – the TRF is supporting Pakistan's Maternal, Newborn and Child Health Programme

FLEXIBLE SUPPORT TO PAKISTAN'S HEALTH SECTOR

THE TECHNICAL RESOURCE FACILITY (TRF) in Pakistan has been managed by HLSP since 2009. This five year, £16.8 million technical assistance project funded by DFID and AusAID is designed to complement DFID's financial aid to the Government of Pakistan's Maternal, Newborn and Child Health Programme (MNCHP) as part of its efforts to achieve MDGs 4 and 5. The emphasis for the TRF is on providing technical assistance that is demand driven by the MNCHP, as well as supporting strategic assignments that are transformational rather than purely transactional.

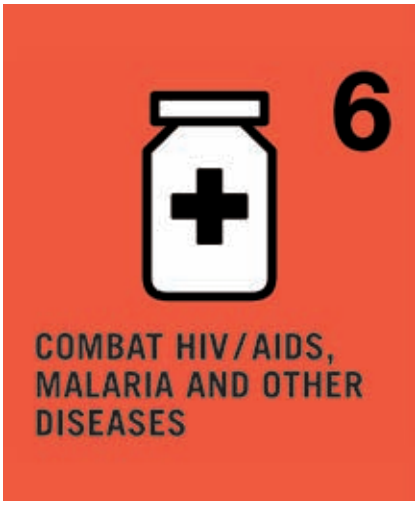
Through its first workplan the TRF has initiated 34 technical assistance assignments focused largely on developing strategies and guidelines and strengthening systems such as procurement, monitoring and evaluation and financial management. The TRF has begun building the capacity of the MNCHP in technical assistance procurement by providing guidance in developing terms of reference and consultancy management, and will be organising structured training to further develop these skills.

TRF assignments have supported broader health sector issues as well as the MNCH programme. These include an assessment of the Community Midwife training initiative and development of options for the deployment of Community Midwives trained by the programme; a Third Party Evaluation of the People's Primary Health Care Initiative; Strategic Planning for the National Programme for Family Planning and Primary Healthcare and development of a Health Strategy for the Government of Khyber Pakhtunkhwa Province.

The next TRF workplan will build on the first phase of assignments, in particular helping government implement strategies and recommendations at provincial and district levels. The TRF will also increase its focus on the provinces. This is in line with the Pakistan Government's 18TH Constitutional Amendment, passed in 2010, which gives the provinces greater autonomy and responsibility for health service delivery.

MORE INFORMATION

Read about the TRF's evaluation of the Pakistan People's Primary Health Care Initiative in more detail on page 4.



PROGRESS REPORT

AHEAD OF LAST YEAR'S MILLENNIUM DEVELOPMENT GOAL (MDG) SUMMIT, countries prepared reports documenting progress towards the 2015 deadline. HLSP has recently been awarded a UNAIDS contract to review country MDG reports. The study will extract valuable information on how countries report on national HIV responses and will draw out synergies between AIDS and other MDGs, in particular those relating to women and children's health. This is the first time this kind of analysis has been undertaken. The findings will be disseminated to UNAIDS country staff to promote further discussion and action on the UN's 'AIDS plus MDGs' agenda, which aims to strengthen links between HIV and the other MDGs. This work builds on a previous HLSP case study undertaken in preparation for the MDG Summit which examined evidence of links between Rwanda's response to HIV and progress towards the other goals.

COME AND VISIT US!

HLSP AND ITS SISTER COMPANY, HEALTH & DEVELOPMENT AFRICA, will be exhibiting at the fifth South African AIDS Conference in Durban. This year's conference will take place on 5–7 June and explores the theme of 'Leadership, Delivery and Accountability'. For more information visit: **www.dirasengwe.org/5thsaaidsconference**

HEALTH CARE FOR THE PEOPLE

The Pakistan People's Primary Health Care Initiative seeks to address the needs of the country's growing population

PAKISTAN'S PEOPLE´S PRIMARY HEALTH CARE INITIATIVE (PPHI) is probably the largest primary health care contracting arrangement in the world. Today PPHI is responsible for the management of primary health care in around 2,500 facilities and has been adopted by 82 of the country's 135 districts. Such a large endeavour required a thorough external evaluation. Three years after PPHI's launch, the Technical Resource Facility, which is run by HLSP and funded by DFID and AusAID, was commissioned by the Government of Pakistan to manage its evaluation.

Why contract out health care?

Until PPHI was established in 2005, Pakistan delivered the overwhelming majority of primary health care through a network of government facilities. Although it increased access to essential health care for 110 million people in rural areas, this public sector model soon encountered major challenges.

It was proving difficult for the government to appoint and retain medical officers in rural facilities, to maintain about 5,000 facilities in proper working condition, ensure supplies of drugs and equipment, and supervise facilities' performance and functioning. In spite of these, and other challenges, at the time there did not seem to be many alternatives to this model. Pakistan did not have a large number of non-state health care providers, particularly in comparison with neighbouring countries like India or Bangladesh.

How does PPHI work?

Following a successful pilot in Punjab, the PPHI contracting model was launched by the federal government in mid-2005. Under the PPHI model district governments can contract out primary health care facilities to provincial entities known as Rural Support Programmes (RSP). RSPs are private development organisations specialising in social work, in sectors such as agriculture, water, education and now, under PPHI, health care. Most of their funding comes from the government.

Under contracts between the RSPs and the district governments, the PPHI receives the same funds that the district government would have transferred to the district department of health. By using the budget flexibly and by strengthening managerial practices and supervision, PPHI is expected to fill up many rural staff vacancies by providing additional staff incentives and allowances, particularly to medical officers and Lady Health Visitors. The federal government gives additional financial support to cover management and the cost of rehabilitating health facilities.

Key evaluation findings

The evaluation results show that in three years PPHI has achieved marked and rapid increases in staffing levels and in availability of drugs and equipment. These have had a positive impact on service delivery, enabling higher provision of curative, preventive and health promotion services.

These are very encouraging results, but the evaluators have also shown that facilities need to deliver more and better maternal, child, neonatal, postnatal and family planning services. The number of users, while increasing, still remains low when compared to the needs of a country with very high maternal and child mortality rates.

The evaluators also argue that the PPHI model needs to become better integrated within district and provincial governments. It is also recommended that these bodies reduce their involvement in delivery, and instead pay more attention to improving their competence in overseeing government and private health care providers' performance.

MORE INFORMATION ONLINE SOON

The evaluation report will be made available on the HLSP website. Contact: **institute@hlsp.org**

DELIVERING QUALITY NOT QUANTITY

Supporting the next generation of midwives – quality training needs a strong infrastructure

THE PRESENCE OF A SKILLED ATTENDANT AT DELIVERY is considered one of the key interventions to reduce maternal mortality. As part of the renewed effort to accelerate progress towards achieving MDG 5 (improving maternal health), training of skilled attendants is being scaled up globally. Rapid and successful scale up of training for high quality care needs to be backed by a strong and supportive infrastructure. However supportive systems for training and professional development are often weak and, in the haste to train, they frequently remain inadequately addressed.

In 2010, HLSP was involved in assessing the quality of Pakistan's Community Midwife training through the DFID-funded Technical Resource Facility. Pakistan is one of those countries attempting to increase the number of skilled attendants. In 2007, it established a National Maternal, Newborn and Child Health (MNCH) Programme with a community midwifery component to train 12,000 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 more than 8,700 young women on the course.

Assessing training quality

Although the review's initial results appeared positive, several training challenges were identified, as well as gaps in clinical learning and difficulties in providing regular supportive supervision. Training challenges included: finding girls with the course's required educational standards in more remote and underserved areas; providing adequate student accommodation, particularly for married women; achieving adequate levels of clinical learning and ensuring trainers' competence. The latter was a concern in clinical areas in particular, where staff rotate and may be unfamiliar with the students' specific learning needs, given that they are a new cadre of staff.

Gaps in clinical learning were shown by the significant number of students who had not achieved the number of deliveries required to sit the exam. In addition there was limited capacity among graduates to transfer theoretical knowledge to clinical care.

Lessons from Pakistan

The Pakistan experience offers useful lessons. One is that in order to achieve quality training of large numbers of community midwives, the underlying supportive infrastructure needs to be strong. This requires substantial and long term investments. Countries aiming to scale up training may consider phasing the number of students until the supportive infrastructure is in place to achieve quality training – or reduce targets, and find immediate interim solutions to improve quality.

COMMUNITY MIDWIFE TRAINING IN OTHER CONTEXTS

Sri Lanka and Malaysia have demonstrated significant progress in reducing maternal mortality. Midwife training in both countries was high quality, with emphasis on clinical skills, rigorous examination processes and close supervisory and support practices from skilled nurses and midwives. Health providers were supported by a strong health system and both countries introduced systems for maternal death reviews, a means to improve case management in which midwives, community, facility staff and state officials participated.

Student accommodation must be of reasonable standard and numbers of students at any training institute must match the school's capacity to provide the required theoretical and clinical learning. In Pakistan, better supervision for newly deployed graduates will largely depend on their integration into the primary health care system, which will allow them to easily call on the support of primary health providers. Community midwives should periodically rotate through secondary level facilities to enable continual professional development.

Following the assessment of training, an action plan was drawn up in consultation with the Federal and Provincial levels' MNCH programme staff, the Pakistan Nursing/Midwifery Council and heads of community midwife schools and affiliated clinical facilities. All of these organisations are keen to address the training challenges. Key actions will include the revision of the community midwife training curriculum, design of short training of trainer courses for clinical staff and development of a model for continual professional development for graduates and tutors.

MORE INFORMATION

The Community Midwife training assessment was carried out with DFID funding as part of wider support to the National MNCH Programme. Contact: **sarah.dobson@hlsp.org**

GLOBAL ROUND UP

CHINA

GROCERIES AND NEEDLES IN YUNNAN PROVINCE

No ordinary village shop – Ms Zhan distributes HIV prevention materials to her clients

MS HAN SHUAI ZHAN'S VILLAGE SHOP doesn't just offer groceries. Since 2009, her store in Dengxiu Village at the crossroads of China and Burma distributes needles and syringes to local drug users. She is one of eight outreach workers selected by Ruili County AIDS Bureau in Yunnan Province, China. As well as providing clean needles and syringes from her shop, she hands out education materials on safe injecting practices and HIV prevention.

Ms Han was trained with funds from the Yunnan Cross Border Project, which began in November 2009. The project is funded by the HLSP-managed Technical Support Unit of AusAID's HIV/AIDS Asia Regional Program (HAARP). Its overall aim is to control the spread of HIV among drug users and their partners along Yunnan Province's international borders by supporting effective harm reduction interventions.

> *"At first I didn't want to get close to people who inject drugs. I have a son and I was afraid of the influence on him. But after a year there has been no negative influence."*

In its first year the project has managed to reach a remarkable number of drug users. By the end of 2010, the project was already reaching over 1,248 Burmese and Vietnamese clients at key border sites.

Today, Ms Han is regularly visited by 18 drug users. Her clients will wait until shoppers have left the store before coming in to exchange their needles and syringes. When Ms Han is not available her son covers for her.

The project is not without challenges. While the store's secondary role is discreet, the villagers are aware of its existence. Not all approve, saying that her work condones drug taking. Ms Han takes it in her stride: *"I say to them that I'm not supporting drug use, this is disease prevention. It's easier for me to answer them, because at first I had the same opinion and questioned why needles should be distributed."*

For more details about HAARP and the cross border project visit: **www.haarp-online.org**

THAILAND

THAILAND EVALUATES ITS HIV RESPONSE

FOR THE FIRST TIME the Thai Government is funding an evaluation of its 2007–2011 national HIV response. This will be conducted by a consortium led by Mahidol University, Thailand, contracted by the Thai National HIV/AIDS Evaluation Secretariat Office and the Ministry of Public Health.

HLSP's consultants will provide the international context for the evaluation and quality assure the reports. The evaluation will be overseen by a panel of senior figures in health and HIV from Thailand.

This evaluation is HLSP's first piece of work for the Thai Government and builds on the presence established through our Bangkok office.

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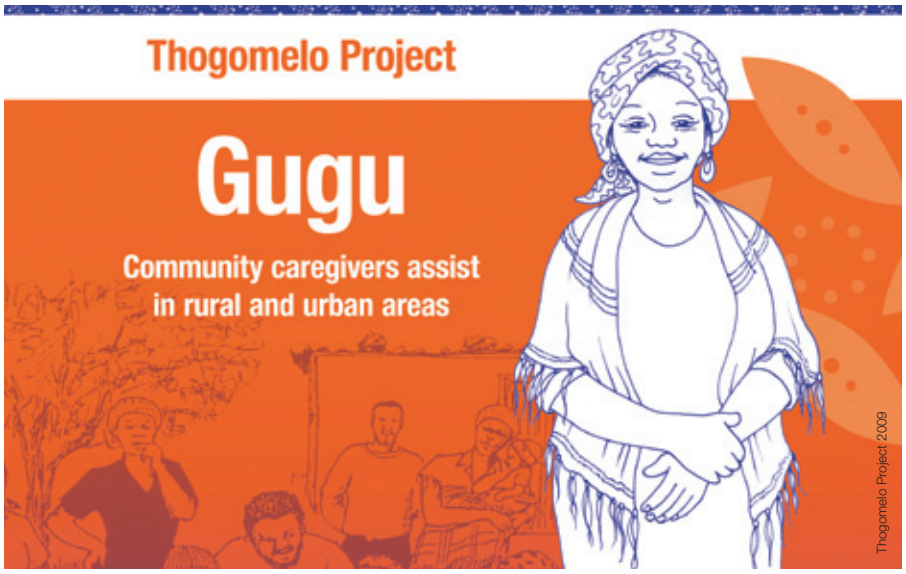
80-90%

OF THE THAI AIDS PREVENTION AND CONTROL PROGRAMME IS DOMESTICALLY FUNDED

(Source: UNGASS Country Progress Report, Thailand 2010)

SOUTH AFRICA

CARING FOR THE CARERS



Thogomelo Psychosocial Support Skills Development Programme Learning Aid

THE SOUTH AFRICAN CHILDREN'S ACT (2005) gives community caregivers a vital role within the community response to vulnerable children. Yet their own psychosocial wellbeing, which is so critical in effectively responding to children, is seldom prioritised. Caregivers face multiple stresses in the context of HIV, poverty, and high incidence of child abuse, neglect and exploitation.

The USAID-funded Thogomelo Project offers psychosocial support to the individual caregiver and promotes caring organisational environments to foster their wellbeing. And, by enhancing child protection skills, it empowers caregivers to respond effectively to vulnerable children and to become agents of change in the often under-functioning child protection system. HLSP's sister company Health and Development Africa (HDA) is part of a consortium led by the Programme for Appropriate Technology in Health. HDA is the technical lead for child protection as well as providing day-to-day project management.

'Thogomelo' is a Venda word meaning 'to care for' – the project offers the first accredited psychosocial support and child protection training for community caregivers in South Africa. The project works closely with the National Department of Social Development and the Health and Welfare Sector Education and Training Authority, South Africa's skills development regulatory body. Its aim is to facilitate entry level jobs and a career path for this hitherto unrecognised component of the social welfare workforce, estimated at over 60,000 members. Training is delivered nationally by provincial training service providers sub-contracted to the project. The ultimate beneficiaries are vulnerable children, whose quality of care is improved by addressing the psychosocial wellbeing and child protection skills of their caregivers.

To date the project has trained over 1,000 learners; documented two case studies of emerging good practice in the development of accredited curricula and training service provider capacity; and disseminated various multimedia materials on child protection policy and legislation, referral and psychosocial support.

The Thogomelo project runs until 2013. It adds to HDA's growing portfolio in project, research and policy work in the field of vulnerable children.

Contact: **Sam Cutshwa scutshwa@hda.co.za** or visit: **www.hda.co.za**.

GLOBAL

FINANCING SCALED UP HIV TREATMENT

With five million people and rising on antiretroviral therapy, sustained financing of HIV treatment presents a huge challenge. In February, Nel Druce, HLSP Institute's Deputy Director, was rapporteur at the high level Wilton Park conference on HIV financing. The conference brought together individuals from government ministries, donor agencies, civil society and the private sector to address issues such as improving value for money by making services more efficient and effective.

The final report will be available at: **www.wiltonpark.org/en/reports**

GROWING EXPERTISE IN EVALUATION

HLSP CONTINUES TO BUILD ITS EVALUATION PORTFOLIO both at a country and global level. Our experience includes conducting thematic evaluations as well as process and performance assessments. Recent or ongoing assignments include:

- Evaluation of the International Finance Facility for Immunisation (IFFIm) – GAVI Alliance;
- Evaluation of the Australian Aid Program's Contribution to the National HIV Response in Papua New Guinea – Office of Development Effectiveness, AusAID;
- Third Party Evaluation of the National TB Control Programme, Pakistan – DFID;
- Annual Review of the Improving Maternal, Neonatal and Child Survival Programme, Bangladesh – AusAID;
- Mid Term Review of UNFPA's Global Programme to Enhance Commodity Security;
- Monitoring and Evaluation of TB Reach Grants – WHO;
- Third Party Evaluation of the People´s Primary Health Care Initiative (PPHI) – Government of Pakistan, funded by DFID and AusAID.

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SUPPORTING NATIONAL DISEASE STRATEGIES

THE NATIONAL STRATEGY APPLICATION (NSA) is a new funding approach developed in response to country requests for the Global Fund to Fight AIDS, Tuberculosis and Malaria to further streamline its funding mechanisms. In 2010, HLSP provided intensive support to the preparation of the Second Wave of National Strategy Applications.

NSA funding requests centre on a current national disease strategy relating to AIDS, TB or malaria, and related national documentation such as the operational plan.

Before submitting an application to the Global Fund, the national disease strategy must have had an independent joint assessment against an internationally agreed set of criteria or 'attributes of a sound national strategy', developed by the International Health Partnership (IHP+). In addition, there is a simplified application form to the Global Fund. The Global Fund is implementing the NSA approach through a phased roll out, which began in 2009 with the 'First Learning Wave'.

HLSP was contracted to support the design and development of materials, systems and processes to assist the 'Second Wave' of NSAs. This was based on lessons learnt from the first wave. It was also part of a move towards an open invitation for expressions of interest, greater country ownership and leadership, and increasing engagement of other donors and United Nations technical agencies.

Two HLSP technical specialists and a consultant worked with the Global Fund's Strategy and Policy Team in Geneva from August to December 2010. One team member continues to provide support to the Global Fund on the preparation, implementation and reporting on the joint assessment of the national strategies.

The Global Fund announced the Second Wave of NSAs in January 2011.

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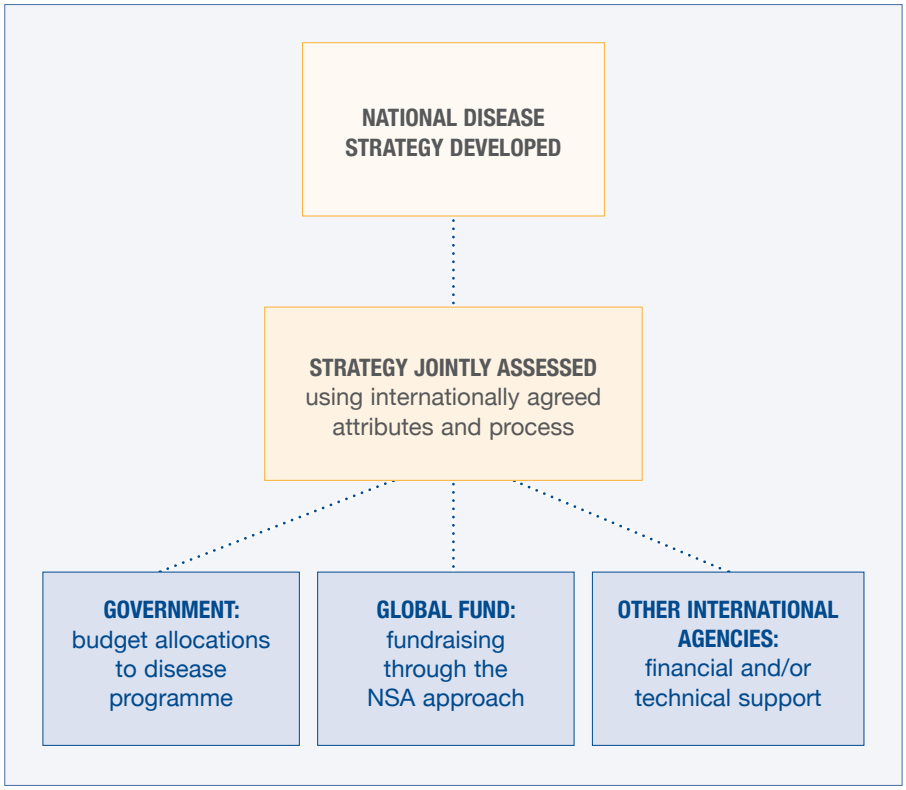
HOW IT WORKS – THE NSA APPLICATION PROCESS



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.

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