COMPASS

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'Know AIDS, no AIDS' – a sign in India highlights the importance of a targeted HIV response

TRANSFORMING THE HIV AGENDA IN ASIA

AT THE INTERNATIONAL AIDS CONFERENCE in July, findings from a strategic review of HIV in Asia set out an ambitious agenda for governments and development partners. Clare Dickinson, co-writer of the report and HLSP consultant, describes the challenges ahead.

In Asia, the HIV epidemic is concentrated in a few 'key populations' – sex workers, men who have sex with men, people who inject drugs, and their partners. Although this is well known, HIV policy and programming in the region is often more suited to generalised epidemics – where HIV prevalence is over 1% of the whole population.

More general programmes might have been justified when HIV funding was at its height, but as resources dwindle there is a push for more strategic investment. HIV spending needs to be better targeted. Unless programming focuses on these key populations at higher risk, many Asian countries are unlikely to meet their AIDS targets.

HLSP, through the AusAID Health Resource Facility recently completed a strategic assessment of HIV in ten countries on behalf of a group of collaborating development partners working to support HIV in the region*. The aim was to provide advice to partners on opportunities and priorities for future HIV policy, programming and partnership in Asia.

The persistent burden of HIV

The growing number of chronic HIV cases requiring treatment and care places an increasing burden on the health sector, which is persistently underfunded in many Asian countries. Although major funding agencies have brought tremendous HIV gains to the region, the current model is becoming unsustainable. In low and some middle

CONTINUED ON PAGE 2

HLSP

Safely disposing of used needles – although HIV in Asia is driven by key populations such as people who inject drugs, very little funding targets them

income countries, there is a high degree of dependency on external funds for HIV responses. In Lao and East Timor, 95% of HIV funding in 2009 was external; in Indonesia and Vietnam, the figures were 40% and 87% respectively.

Despite economic growth in Asia and evidence that donors in the region are de-prioritising HIV, there appears to be little urgency to develop more sustainable forms of HIV financing. For example, there is minimal evidence that domestic resources are replacing external funding for key populations or that countries are absorbing HIV programme costs into national health budgets or systems. The region's national HIV strategic plans are often aspirational, with large funding gaps and no clear strategy for filling them. Where countries are increasing domestic resources for HIV, funds are usually spent on treatment rather than prevention targeted at key populations driving the epidemic.

Neglecting the concentrated epidemics

Even though the region's HIV epidemics are concentrated, spending on key populations remains surprisingly low. Funds are frequently misdirected – targeting general low risk populations, with less prevention benefit. The Cambodian National AIDS Spending Assessment found that expenditure on key populations for 2009 and 2010 was only 9% and 10% respectively of the total. 'Non targeted interventions' accounted for 41%.

Considerable investment has been made in the architecture to support multisectoral responses, such as National AIDS Commissions. However, this model is now quite outdated and expensive. In 2009, management and administration made up more than 20% of total programme costs in the Philippines, East Timor, Cambodia, Indonesia and Lao. While expanded multisectoral responses may once have been necessary and globally affordable, they are less appropriate in concentrated epidemic and in the current financial climate. External funding has largely created and is sustaining this architecture. Attempts to scale it back are underway in some countries, but changes take time, have significant political costs, and challenge entrenched interests. As yet it is unclear how far partners recognise its weaknesses or have the clout, vision or sense of responsibility to change it.

Transforming the agenda

Countries in the region are often influenced by, and dependent on regional and global frameworks for policy and programme direction. Without significant change at regional level, it will be more difficult for countries to shift direction. A critical starting point is strong and dynamic regional leadership bringing partners together to develop a shared vision and commitment to an agenda for change. The report argues that a shared regional investment and results framework is needed, with agreed and coordinated investments in key areas of reform – HIV architecture, sustainable funding, the future role of civil society, and oversight of external investments to name a few.

Addressing countries' dependance on external funding and the likely shortfall requires evidence-based allocations of existing and future resources. This means prioritised investments for key populations and switching funds out of programme areas (and agencies) that have limited impact. Countries and external partners need to assess the potential to expand domestic financing for health and HIV programmes – testing health insurance and other third party health costs for HIV, supporting countries to transfer the costs of vertical HIV programmes into more integrated health care, and to work with countries on re-allocation strategies based on available funds rather than the 'resource mobilisation' strategies of the last decade.

* AusAID, USAID, ADB, the Global Fund to Fight AIDS, TB, and Malaria, the World Bank and UN agencies (UNAIDS, WHO, UNDP, UNFPA).

SUPPORTING AUSAID'S HEALTH AND HIV PROGRAMME

The Health Resource Facility (HRF) assists AusAID staff to make well informed policy and operational decisions for their international aid programme in health and HIV. The HRF was established to help meet the increased demand for health and HIV expertise as AusAID scales up its regional programme. Managed by HLSP in association with IDSS Australia, HRF services are made available to AusAID staff through the Canberra-based help desk and through the Facility's dedicated website. **www.ausaidhrf.com.au**

MORE INFORMATION

This article summarises *HIV in Asia: transforming the agenda for 2012 and beyond. Report of a joint strategic assessment in ten countries*, Peter Godwin and Clare Dickinson, 2012.

The findings were launched during a panel session at the International AIDS Conference in Washington DC in July 2012 and work has started to implement the recommendations.

EMPOWERING GIRLS IN ZAMBIA

Empowering Zambian adolescent girls to improve their sexual and reproductive health

THE ADOLESCENT GIRLS Empowerment Programme (AGEP) aims to improve sexual and reproductive health for poor and vulnerable adolescent girls in Zambia. Over six years, the UK government is funding the Population Council to test out the 'safe spaces' model.

The programme started in November 2011 and seeks to reach girls in both urban and rural areas. Safe spaces are places where girls can learn and develop social networks. For younger girls (aged 10 to 14) the focus is on building social assets, a base of financial literacy and basic health information. For girls aged 15 to 19, the focus is on financial education, understanding income earning options, and more intensive education on sexual and reproductive health, linked to access to health services through a voucher scheme.

HLSP has been contracted to design and implement an evaluation of AGEP. The first phase includes a technical briefing paper that will feed into the AGEP research component, as well as finalising the evaluation framework and methodology and a communications plan. HLSP will then conduct a mid-term review in 2013/2014 and an end of term evaluation scheduled to begin in September 2015.

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GLOBAL EVALUATION

THE GLOBAL EVALUATION FRAMEWORK AGREEMENT (GEFA) is DFID's new route for the design and implementation of all its evaluation work. HLSP's parent company Mott MacDonald is on the framework leading a consortium that includes American Institutes for Research and the London International Development Centre (incorporating LSHTM, SOAS and 3ie), Results for Development Institute and Westat. The framework presents an opportunity for HLSP to undertake new work, including around climate change. It will also enable Mott MacDonald to build capacity to carry out large-scale and complex impact evaluations – a big growth area in international development.

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HIV EVALUATION IN PAPUA NEW GUINEA

HIV REMAINS A MAJOR development challenge for Papua New Guinea (PNG). In 2009, an estimated 34,000 people were living with HIV – approximately 0.9% of the population. Since 1995, AusAID has made a considerable investment in PNG's national HIV response. But to what end?

To answer that question, the Australian Office of Development Effectiveness (ODE) has conducted a major independent evaluation of AusAID's contribution to the response. This was the first single issue, single country evaluation carried out under ODE.

The HLSP-managed AusAID Health Resource Facility supported the evaluation, which focused on HIV programme activities from 2006. The evaluation found that AusAID has been a major driver of PNG's HIV response. However, the relevance and effectiveness of AusAID's interventions has been mixed.

Going forward, the evaluators recommended that AusAID integrates HIV into broader sexual and reproductive health activities, and intensifies support for PNG champions of the HIV response.

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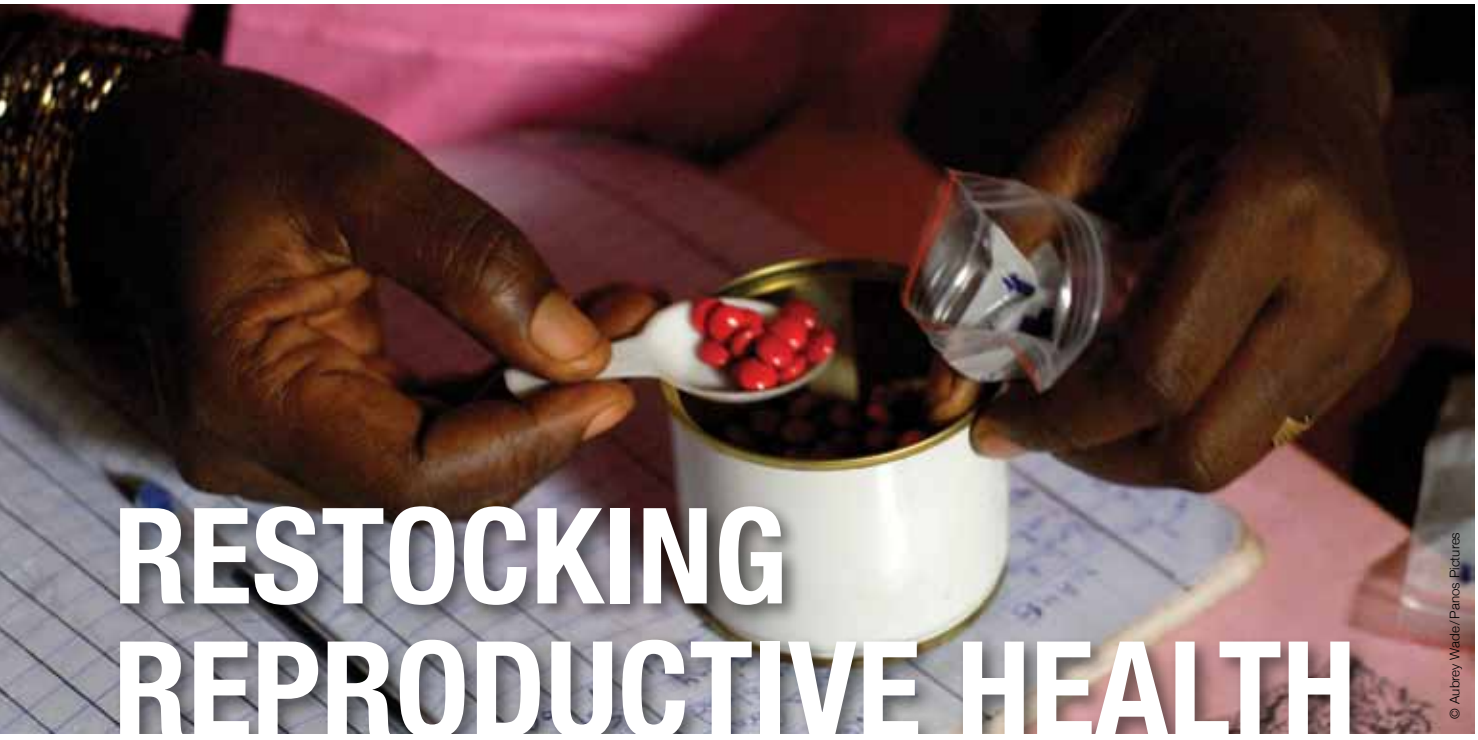
MORE INFORMATION ONLINE

Read the full report: **www.ode.ausaid.gov.au/publications/evaluation-hiv-response-png.html**



RESTOCKING REPRODUCTIVE HEALTH

Dispensing drugs at a maternal and child health clinic in Sierra Leone

FAMILY PLANNING AND REPRODUCTIVE HEALTH supplies are essential to women's good health. Without contraceptives women have unwanted children – often too close together – or may risk back street abortions. When babies are wanted and planned, safe deliveries depend on the availability of essential obstetric drugs. Although these commodities are vital to health programmes in developing countries, there is too little funding for them, supply systems are fragile, and there are still many social and economic barriers to women getting the access they need.

The Reproductive Health Supplies Coalition is a diverse group of organisations – donors, NGOs, manufacturers, technical support agencies and national governments – all committed to universal access to affordable, high quality reproductive health supplies in low and middle-income countries. In 2012, HLSP contributed to an evaluation of the Coalition, to see whether it had improved reproductive health commodity security and to advise on its future development.

The review team concluded that the Coalition's biggest achievement has been fostering joint ownership of the problem of commodity supply and demand. International contraceptive procurement is complicated. Production times can be long and manufacturers don't want to start production until financing is assured. Countries need to be able to forecast accurately – long before stock-outs occur. Meanwhile donor money doesn't always come when it is meant to. These problems lead to small and spasmodic orders, which in turn drive up commodity costs.

Before the Coalition, donors rarely met their suppliers except for commercial purposes. Now all the key players have been brought together to try to smooth out the process. Manufacturers and donors have negotiated better prices on the basis of larger, planned volumes. Countries have been encouraged to forecast in good time to enable donors to take advantage of these prices to ensure users in countries are the direct beneficiaries.

Countries have benefited from other practical initiatives fostered by the Coalition to get contraceptives where they are needed most. For example the Coordinated Assistance for Reproductive Health Supplies Group meets monthly to divert supply shipments away from countries with a surplus to those who face stock-outs.

The evaluators found that the Coalition has had a positive impact on the international aid environment. Family planning is back on the global health agenda thanks in part to the Coalition's advocacy efforts. Members have worked to ensure that contraceptives are recognised as essential to achieving MDG 5 (to reduce maternal mortality). The Coalition's Hand to Hand Campaign (where member organisations commit activities and funding to increase commodity security) was the forerunner of the Family Planning Summit held in London in July 2012, which scaled up donor and country responses to contraceptive shortages.

There are still challenges ahead for the Coalition. Its membership has grown enormously, from a mere handful to over 200, and the original structure of working groups led from the North does not work as well for the enthusiastic country level members keen to take part but lacking resources. However the groundwork for the Coalition moving into the future has been laid.

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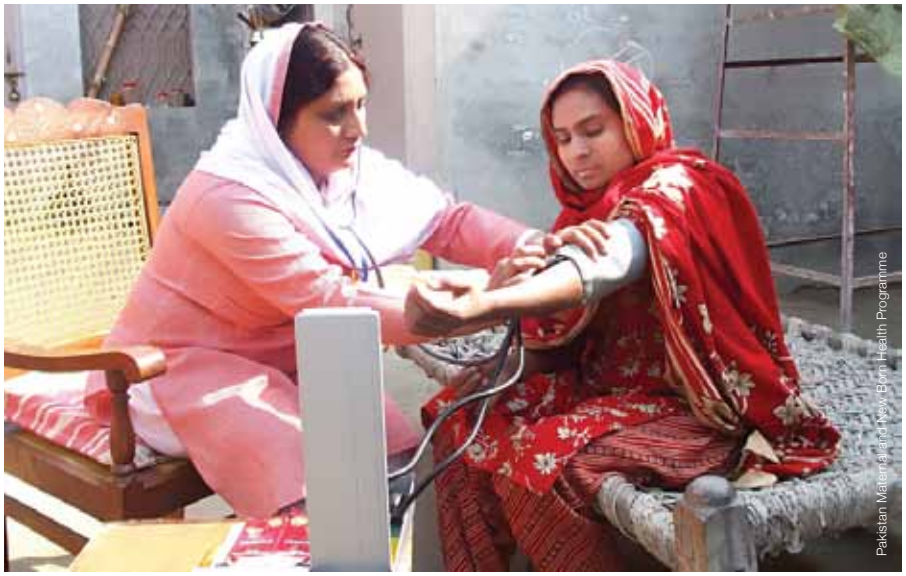
RESULTS BASED FUNDING FOR HEALTH – WILL IT WORK?



A community health visit in Pakistan – the number of antenatal check-ups can be used as a target for results based funding

INTERNATIONAL AID IS OFTEN CRITICISED for insufficient assessment or verification of results achieved. The challenge, however, lies in the practical difficulty of measuring or verifying results, or doing so at a reasonable cost to both the donor and recipient country. In many low and middle-income countries health data is of poor quality and measurement can be very expensive – with the potential to take a substantial chunk out of the aid provided. Moreover, the complex variables affecting health outcomes make it methodologically difficult to clearly attribute health results to an intervention.

To overcome this lack of evidence, interest is growing in new forms of aid delivery, for example results based funding (RBF). This is a generic name given to any programme linking incentives, such as cash, to the delivery of an agreed set of results. There are two main ways of delivering RBF incentives. The most common approach is to target incentives to those responsible for providing or managing health care (such as clinic staff or district health managers) – supply-side incentives. The second approach targets incentives to potential service users or community groups who would benefit from using health care (and currently don't). These demand-side incentives could be used, for instance, to encourage pregnant women to deliver in a properly serviced health facility. They can also reward community workers for ensuring that community members use the right type of health care at the right time.

Earlier this year the Norwegian Agency for Development Cooperation contracted HLSP to evaluate the largest global effort to test the application of RBF approaches in health. Co-funded by the Norwegian and UK governments and implemented by the World Bank, the $575 million Health Results Innovation Trust Fund aims to help the international health community to learn about the practical application of RBF in health and to synthesise and disseminate knowledge. More than 20 RBF pilot schemes are being supported worldwide, implemented by governments from low and middle-income countries in Africa and Asia. Each pilot is adapted to the specific country needs and circumstances, and includes a rigorous impact evaluation to assess whether expected health outputs and outcomes are actually achieved.

Results from the impact evaluations of the first set of RBF pilots – where programme design began in 2008 – are expected by 2013, and then the results of several more impact evaluations will become available from 2014 onwards. Until these results are available it is not possible to tell whether RBF can be applied to health at a reasonable cost or whether it complements other national efforts. At this early stage, the evaluation could only focus on whether the building blocks for a successful learning programme are in place. The evaluation asked: is the programme covering a wide range of approaches in different settings for the lessons to be universally applicable? Are the RBF pilots and evaluations well designed, and do they focus on the desired results? Are efforts being made to include a wide range of government, non-government and aid partners in oversight of the RBF pilots and other activities?

The HLSP evaluation concluded that the building blocks for a successful learning programme are in place. RBF pilots have been well designed in partnership with national governments and donors, and the impact evaluation designs reviewed were scientifically rigorous and appropriate for results verification purposes. The evaluation made a number of suggestions for future improvements, including the need to better document a number of 'hidden' costs and efforts behind each RBF pilot that will condition its success, replicability and sustainability. In any case, the Trust Fund has generated an unprecedented interest in the application of RBF in health.

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MORE INFORMATION ONLINE

Read the evaluation report:
www.norad.no/en/tools-and-publications/publications/evaluations/publication?key=393126
Or visit the RBF website:
www.rbfhealth.org

A LASTING FRAMEWORK OF SUPPORT

In Nepal, the HDRC has supported an economic appraisal of the national family planning programme

IN 1994, HLSP WON its first contract to manage the UK Overseas Development Administration (now DFID) Health Systems Resource Centre. Through a series of contracts, HLSP has provided DFID and its partners with technical assistance and knowledge services in support of pro-poor programmes in health, and more recently education. The HLSP-managed resource centres have evolved – alongside DFID itself – into the most recent Human Development Resource Centre (HDRC), which is run by HLSP and sister company Cambridge Education in association with the Institute of Development Studies. As the HDRC contract comes to a close in October 2012, we look back at 18 years helping DFID to maximise its impact in health and education. Here is a small sample of recent jobs to illustrate the breadth and depth of the support provided through the HDRC.

TOP THREE TOPICS

Since 2004 the most frequent topics for resource centre assignments have been:

1. Health systems strengthening and sector-wide approaches
2. HIV and sexual health
3. Maternal and child health

WORLDWIDE

REVIEWING DFID'S STANCE ON RBF

DFID HAS INCREASINGLY ENGAGED in the debate about results based aid (RBA) and financing (RBF). The HDRC reviewed major DFID-funded RBA and RBF schemes and looked at how these work in different stable and fragile contexts. The review concluded that DFID should adopt a positive but cautious stance in relation to RBA/RBF schemes with a strong emphasis on piloting and rigorous evaluation.

ETHIOPIA

FOCUSING ON RESULTS IN EDUCATION

IN ETHIOPIA, DFID wanted to increase the results focus of its education portfolio. The HDRC investigated how DFID could transfer resources through the General Education Quality Improvement Programme based on pre-agreed results. Recommendations included offering higher incentives to the four emerging regions and basing 'results' on students completing particular schooling levels.

ZAMBIA
TACKLING STUNTING

UNDER-NUTRITION is a persistent problem in Zambia – the national average of stunting in children under-five has reached over 45%. Zambia's National Food and Nutrition Strategic Plan 2011–2015 aims to prevent stunting during the critical 1,000 day period between pregnancy and the first two years of a child's life.

The HDRC was commissioned to develop a 1,000 Critical Days Programme, which included mapping nutrition interventions and recommending a set of specific interventions based on global best practice and the Zambian context. The consultancy team also reviewed the National Food and Nutrition Commission of Zambia's governance and institutional arrangements, and made recommendations for further technical assistance to strengthen the institution.

SOMALIA
IMPROVING MATERNAL AND CHILD HEALTH

CHILD AND MATERNAL MORTALITY rates for Somalia and Somaliland are among the highest in the world. To try to meet the MDG targets for child and maternal health, the government needed to strengthen the health system and implement policies to guide a collective approach to the provision of relevant health services.

In 2009, DFID commissioned the HDRC to develop a draft Maternal, Reproductive and Neonatal Health Strategy, providing guidance to government authorities and their partners on priorities for funding and approaches to implementation.

The strategy identified three key priorities – making pregnancy and childbirth safer; empowering men and women to take informed actions for birth spacing; and promoting beneficial practices to accelerate reductions in maternal and neonatal mortality.

WORLDWIDE
MAKING MALARIA TREATMENT AFFORDABLE

THE MALARIA PARASITE has become resistant to chloroquine, which costs only 10 cents and is widely available. The newer artemisinin combination therapies (ACTs) are extremely effective but much more expensive. More needs to be done to lower the costs of ACTs, so that they can be taken up as the first treatment of choice.

The Affordable Medicines Facility for malaria (AMFm) is a global subsidy mechanism established in order to make ACTs much more affordable in developing countries. The HDRC has provided ongoing support to make the most of DFID's investment in the AMFm. We provided a temporary specialist to the AMFm headquarters in Geneva to assist with improving accountability and transparency of the results achieved through the mechanism.

The AMFm pilot phase began in 2010 in Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Tanzania and Uganda. HLSP's Veronica Walford has provided long term support to DFID on effective design, implementation and evaluation of the AMFm including attending meetings of the oversight committee.

50
Countries where the resource centre has worked

500
Consultants have worked for the resource centre

"HLSP's 18 years of work for DFID have created countless personal and professional opportunities for our specialists and operational staff. My own eight years of involvement have been the highlight of my career. From the feedback we've had, it's clear our services have also been useful for DFID. Our imprint, usually hidden, is most certainly there in a huge array of past and present strategies and programmes and – through the extensive number of business cases we have helped – in future programmes too. Through the resource centres, HLSP is privileged to have supported progress and change in UK aid."

Bob Grose, Director, HDRC

MOZAMBIQUE
VALUE FOR MONEY

DFID MOZAMBIQUE ASKED THE HDRC to assess the performance and results from its past investments in human development in 2005–10. The consultants documented the results achieved and made recommendations on how to improve future monitoring.

The review found that DFID's investments in health, HIV and education had generated a range of benefits – improved policy, aid effectiveness and institution building – and increased the quantity of services for poor people in Mozambique. It recommended that DFID boost its coordination efforts with other donors and enhance government capacity for measuring and monitoring costs in the Ministries of Health and Education.

Sex workers hold up the Amaqhawe magazine at the launch in Mpumalanga

WORKING WITH SEX WORKERS TO PREVENT HIV

GERT SIBANDE DISTRICT, Mpumalanga, has one of the highest rates of antenatal HIV prevalence in South Africa. The district has numerous taverns where trucks stop and local women, who have few employment opportunities, engage in sex work. Despite a clear need for HIV prevention programmes among sex workers in the district, a community mapping exercise – carried out by HLSP's sister company HDA – found that no programmes were targeting this high risk population.

In October 2011, the US Centers for Disease Control and Prevention commissioned HDA to design and implement a five-year programme to reduce HIV infections among sex workers in taverns in Gert Sibande. The programme HDA designed is not only evidence-based but tailored for its target audience.

Following a series of consultative workshops, sex workers named the programme 'Amaqhawe' – an isiZulu word, which approximates to 'those who overcome'. The main component of the programme is risk reduction trainings for sex workers. A selection of sex workers will then be trained as peer educators, enabling them to act as a source of training and support for their colleagues.

The Amaqhawe launch was attended by over 100 local sex workers. The Sex Worker Education and Advocacy Taskforce (SWEAT) drama group put on a short educational play about a sex worker with a sexually transmitted infection. All attendees were given a goodie bag which included a branded mirror and vanity set, male and female condoms, lubricant and the first issue of Amaqhawe magazine. The magazine is one of many planned communication activities to address sex workers' needs.

> *"I love Amaqhawe, it has changed my life and taught me how to protect myself from sexually transmitted diseases. I love Amaqhawe, may it last forever."*
>
> Nobuhle Dlamini, Sex Worker

In August 2012, HDA was invited to present the Amaqhawe project at the First National Sex Work Symposium in South Africa. Kerry Mangold looked at the challenge of developing sex worker profiles to ensure interventions are well targeted, while Sarah Magni discussed how to design programmes that are not only *for* sex workers, but *by* sex workers.

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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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