COMPASS

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Community health workers in Sierra Leone visit households to screen for TB

FIGHTING TB IN FRAGILE STATES

DESPITE INTERNATIONAL mobilisation, TB remains a major global health issue with around 8.6 million new cases and one million deaths in 2012. HLSP's Dr Olivier Weil reflects on the additional challenges of TB control in fragile states, and the work of TB REACH.

In the past two decades global interest and commitment to tackling tuberculosis has been high and new funding streams such as the Global Fund, and multilateral partnerships such as Stop TB, have brought about significant progress in TB control. However, an estimated three million TB cases remains undiagnosed and untreated every year. The growing number of multidrug-resistant TB cases is also a cause for global concern.

Case finding or notification has virtually flat-lined since 2007. This represents an enormous challenge to TB control, as case finding is the key to both prevention and treatment.

Fragile states, fragile bodies

A significant number of these undetected cases are thought to be in fragile states, which are characterised by weak governance, poorly performing health systems, and often security and justice challenges.

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Verbal screening for TB, Haiti

Countries caught up in warfare, or emerging from conflicts or natural disasters produce a range of factors that increase vulnerability to TB. Common to these countries is the presence of large numbers of displaced people living in camps or overcrowded informal housing where TB is common. Poverty, stress and malnutrition also undermine the body's ability to fight infection.

Not only are these populations more vulnerable to TB, but they are less likely to be diagnosed or treated, as National TB Control programmes tend to be weaker in fragile states. Factors here include insufficient trained health workers and frequent stock-outs of drugs and reagents. Difficult and dangerous travelling conditions also hamper access to health care facilities. Countries with internal conflict may experience additional factors: for example large prison populations, where overcrowding and lack of ventilation create pockets of high TB prevalence.

Once diagnosed, patients in fragile states may struggle with adherence to a six-month treatment regimen: displaced people are often mobile, and drug stock-outs present an inevitable challenge.

None of these factors are unique to fragile states, however they are more likely to be present and in greater number, leading to exploding TB epidemics, accompanied by missed diagnosis and the looming threat of multi-drug resistant TB.

HLSP along with the Royal Tropical Institute (KIT) have been monitoring and evaluating TB REACH through its first four years.

TB REACH

The challenges of stagnant case detection and the increasing prevalence of multi-drug resistant tuberculosis alerted the global community to the need for a change in global TB strategy. Thus, in 2010, the TB REACH campaign was launched with the specific aim of increasing case detection and reaching the 'missing three million'. It targets people living in poverty, with limited or no access to TB services, with a range of innovative approaches designed to overcome the barriers to case detection. So far the programme, funded by the Canadian government and managed by WHO, has supported 143 innovative TB projects across 46 countries with a CAD$120million grant.

Several of the countries receiving grants are classified as fragile states, where a range of innovative programmes are improving case detection and treatment of TB.

Community-based TB control

Haiti is still in recovery from years of conflict and the devastating 2010 earthquake, which caused the displacement of 1.5 million people and serious damage to Haiti's already weak health and TB infrastructure. Hundreds of thousands of people live permanently in tented camps and informal settlements in and around the capital city Port-au-Prince. Fuelled by poverty, malnutrition, HIV and overcrowding, Port au Prince is the epicentre of the TB epidemic in Haiti, which already has the highest TB burden in the western hemisphere.

One of the projects funded by TB REACH in Haiti operates in the Canaan camp, which is home to 60,000 internally displaced people. The *Mache Chache* project ("Go and seek") uses trained community volunteers and leaders who are close to the people, to go door-to-door (or tent-to-tent) to verbally screen residents. People who have been coughing for more than two weeks are identified and supported through diagnosis and treatment.

Community health workers thus provide a link between the health facility and population, as well as actively find new cases. Previously, passive case finding meant that people would only present at the hospital once they were really ill with TB – and most likely having infected some ten other people in the camp. In another project in a remote area of Sierra Leone, community health workers also do contact tracing, the first such programme in the country.

A TB REACH project in Afghanistan takes different approach to improving case detection by routinely screening children – a highly affected group – attending the paediatric hospital and general practitioners' clinics.

Promising beginnings

TB REACH is finding ways to address the critical and vital needs of fragile states by helping countries to build local capacity for TB control.

While the project is yet too new for comprehensive results there are already signs of success. An evaluation of the first year of funding showed that TB REACH projects were able to put 25.9% more people on treatment compared with the previous year, equating to improving the lives of 17,223 people.

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SOUTH AFRICA'S NATIONAL SEX WORKER PROGRAMME

ON INTERNATIONAL HUMAN RIGHTS DAY in December, the South African National AIDS Council (SANAC) presented the first ever National Strategic Plan for HIV Prevention and Treatment for Sex Workers at a consultative workshop at the International Conference on AIDS and STIs in Africa. Co-funded by the Global Fund, PEPFAR, the National Department of Health and SANAC, the programme aims to reduce the spread of HIV by making sexual health services accessible and empowering women to stay safe through knowing their legal and human rights.

HLSP's sister company HDA was commissioned to produce a special edition of its Amaqhawe project magazine to celebrate this landmark event. The Amaqhawe project aims to reduce HIV infection among sex workers in Mpumalanga province through risk reduction training and innovative communications such as a quarterly glossy magazine.

The special edition of the Amaqhawe magazine was given to sex workers attending the consultative workshop from all over the country. The magazine comprised favourite articles from previous editions as well as those aligned with the National Strategic Plan, including an interview with Dr. Fareed Abdullah, CEO of SANAC.

MORE INFORMATION ONLINE

Contact: **margaret.roper@hda.co.za**
View the magazine here:
http://bit.ly/P6LdSM

SUPPORTING PROGRAMMES IN PAKISTAN

UK AID'S PROVINCIAL HEALTH AND NUTRITION programme in Pakistan aims to improve the health and quality of life for women, children and the poor by increasing the coverage and utilisation of health services in the Punjab and Khyber Pakhtunkwa provinces.

HLSP has recently been awarded a contract to manage components of the programme. This includes technical assistance to develop innovative and evidence-based effective policies related to reproductive, maternal, newborn and child health and nutrition and to improve public financial management. The programme also includes the development of "roadmaps" to enhance the health sector's capacity to implement effective programmes.

This builds on our existing work managing the DFID Technical Resource Facility in Pakistan **www.trfpakistan.org**

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DEVELOPMENT POLICY IN AUSTRALASIA

THE AUSTRALASIAN AID AND INTERNATIONAL DEVELOPMENT POLICY WORKSHOP, held in Canberra this February, brought together researchers from across Australia, the Pacific and Asia working on aid and international development policy to share insights and promote collaboration. Jackie Mundy, HLSP specialist and Director of the Health Resource Facility for Australia's Aid Program, presented on the challenges of financing health care in the Asia Pacific region as many countries struggle to achieve universal health care coverage.

The presentation was based on a study, authored by HLSP health specialists Dan Whitaker and Veronica Walford with Benedict David from the Australian Department of Foreign Affairs and Trade (DFAT).

The paper examines the impact of the changing burden of disease on health financing, trends in domestic financing and external development aid for health, and the changing configuration of aid providers in the region including the future role of non-traditional bilateral donors.

MORE INFORMATION ONLINE

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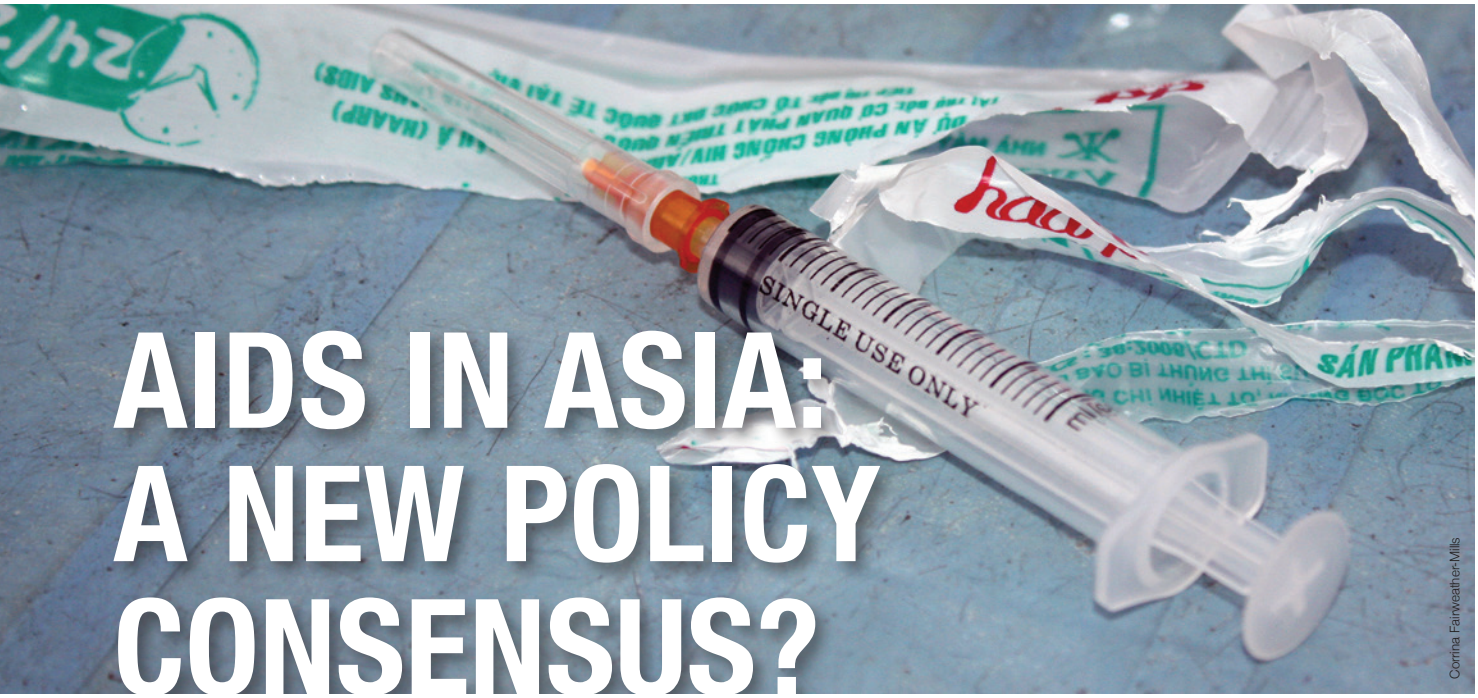
The paper is available at:
www.hlsp.org/Home/Resources/HealthfinancingAsiaPacific.aspx



AIDS IN ASIA: A NEW POLICY CONSENSUS?

HIV/AIDS Regional Programme (HAARP) social marketing has made branded needles available for people who inject drugs in Vietnam

DESPITE INTENTIONS to intensify HIV responses in Asia, many countries are struggling to refocus their resources and programmes to where it matters. In this context, a 'strategic investment approach' may potentially improve the efficiency and effectiveness of existing and future HIV resources. But to really have impact, a reorientation of the regional 'policy consensus' on HIV, and the prevailing multisectoral architecture for the response, needs to change.

These are the key findings of an independent, multi-donor strategic assessment of the HIV response in ten Asian countries discussed in a recently published HLSP Institute/HRF paper.

Better alignment

The paper argues that better alignment between the region's investment in HIV and the epidemiological realities are necessary to reverse the epidemics in the region. While Asia's HIV burden is largely concentrated among key populations, such as sex workers (SW) and their clients, people who inject drugs (PWID) and men who have sex with men (MSM) as well as their intimate partners, substantial volumes of funds continue to be misdirected to generalised programming and prevention activities for low risk populations; this against the backdrop of high dependency on diminishing donor funds in some countries.

This analysis is supported by a recent systematic review by Craig et al, of 91 studies of HIV interventions in Asia and Eastern Europe which demonstrated the cost-effectiveness of programmes targeting populations at highest risk – such as SW, MSM and PWID – than those aimed at the general population.

'Investment thinking'

The Institute paper argues that a 'strategic investment approach' which targets affected populations through an integrated public health response should contribute to ending HIV epidemics in Asia. Revising the unwieldy multisectoral AIDS architecture may also bring additional efficiency gains. A critical starting point for these reforms is the development of strong and dynamic regional leadership that can develop a shared vision and commitment to an agenda for change.

A UNAIDS investment framework tool has been designed to assist countries to revise their national HIV plans – gearing strategies and spending towards high-impact programmes for key populations in the most-affected geographical areas. Strategies to address bottlenecks, maximise outcomes and optimise resource-use are critical to this approach, as is the expansion of domestic resources for programming.

According to the UN, to date 14 countries have adopted the investment framework, among them Cambodia and Thailand. The latter has already estimated that an additional US$100 million in high impact interventions for key populations in the next decade will significantly reduce new infections and deaths while bringing economic benefits of $300 million in the form of reduced treatments costs and increased labour productivity. Thailand is also leading a 'service delivery revolution' in which prevention and treatment will be integrated, as HIV services are integrated with other health programmes.

MORE INFORMATION ONLINE

Read the paper: Dickinson C, et al. *Investing in AIDS in Asia: Transforming the Policy Agenda.* HLSP, HRF, February 2014.
www.hlsp.org/Home/Resources/InvestinginAIDSinAsia.aspx

EVALUATING PROJECTS WITH MULTIPLE GOALS: TOOLS OF THE TRADE

Girls participating in a multisectoral empowerment programme in Zambia

EVALUATING THE IMPACT and cost effectiveness of complex programmes in social settings presents challenges. We look at two of the basic tools of the trade: cost-effectiveness and cost-benefit analysis.

Put simply, impact evaluation of a programme in a social setting compares the outcomes achieved by those individuals or groups receiving the intervention against those who did not. While a variety of methods can be used to evaluate impact, from experimental (such as randomised control trials) to theory based, all share the same aim: to allow us to assess whether we can *attribute* the difference in outcomes to the programme.

Suppose that we find that a particular intervention delivers a statistically significant improvement in access to contraceptives. We may still ask if the programme is worth implementing. This raises a variety of issues, but a key one is: how cost-effective was the intervention?

Cost-effectiveness analysis (CEA) allows us to make a direct comparison between programmes with similar outcome indicators. For example, we could compare the cost of two family planning programmes to deliver an increase in contraceptive use, perhaps by calculating the additional Couple Years of Protection provided by each.

Cost-benefit analysis

But what indicators could we use to determine the effectiveness of a more complex programme with multiple cross-sectoral goals? Although different programmes like education, health and farming cooperatives produce very different outcomes, it is still possible to convert these into a monetary value (which is comparable). This approach is called cost-benefit analysis (CBA): we calculate the total costs and benefits to determine the rate of return from the initiative. If the return was acceptable the programme would be adopted. However, monetisation is not always easy and some feel uncomfortable assigning a monetary value to health outcomes.

A related point is that joint projects could bring the benefit of economies of scope, as delivering two interventions together may lead to a reduction in costs compared to delivering each separately – for example, through sharing of administrative staff and facilities. HLSP is considering such issues as part of the impact evaluation of the DFID-funded Adolescent Girls Empowerment Programme (AGEP) in Zambia, which consists of a package of three measures: 'safe spaces' (weekly social meetings for girls), a health voucher scheme and a savings account. Three groups of girls will receive one or more elements of the programme, while a fourth group acts as a control. Other girls' empowerment programmes will be used in a comparative analysis of costs and benefits. This may include assessing whether there are economies of scope gained when full programme packages are delivered, compared to a single intervention.

Value for money assessment, whether by CEA or CBA, is increasingly being carried out as part of impact evaluations. As programmes with multiple outcomes invariably have larger total costs than corresponding programmes with a single expected outcome, determining the cost-effectiveness of joint production of multiple outcomes is a crucial step in recommending such programmes.

STRENGTHENING PRIMARY HEALTH CARE IN SOUTH AFRICA

Photographs by Edwin Wes

Phatheni Clinic, KwaZulu-Natal Province
Dedicated managers who are not required to perform clinical tasks have improved the running of the clinics.

THE SOUTH AFRICAN DEPARTMENT OF HEALTH has embarked on a comprehensive programme to strengthen primary health care services. Eight clinics have been selected as model or 'ideal clinics' and have undergone improvements in all domains including services, infrastructure and supply chain management. Private sector general practitioners are also being contracted to work in the clinics, which are currently nurse-led. Lessons learnt in this process will be applied to all 3632 primary health care clinics in the country. This is part of the country's massive health reform programme which began in 2009. The ultimate goal of the reform is the establishment of National Health Insurance, which is to provide universal access to quality health care free at the point of use, by 2025.

The 'ideal clinic' and 'GP contracting' initiatives are supported by the UK aid and EU-funded SARRAH programme, which is managed by Mott MacDonald/ HLSP. Visit: **www.sarrahsouthafrica.org**

KT Motubatse Clinic, Gauteng Province. Clinic buildings have been refurbished.

Breyton Clinic, Mpumalanga Province
Security has been tightened to protect patients and staff.

Ladybrand Clinic, Free State Province
Signs at clinics are in local languages.

KT Motubatse Clinic, Gauteng Province
Efforts are being made to reduce waiting times in the clinics by having more staff at reception, improving filing systems and dividing patients into separate streams of care.

Garankuwa View Clinic, Gauteng Province. Maternal and child health services have been strengthened.

Efaye Clinic, KwaZulu-Natal Province
Equipment in the clinics is being repaired, renewed and replaced. New emergency trolleys and other equipment have been purchased.

Efaye Clinic, KwaZulu-Natal
New water tanks and generators help clinics cope with service cuts.

Nthoroane Clinic, Mpumalanga Province
There has been a concerted effort to strengthen supply chain management and ensure that appropriate medicines and supplies are available in the clinics.

Ladybrand Clinic, Free State Province
Private sector general practitioners are being contracted to do sessional work in the clinics as part of a new initiative to increase doctor coverage in primary health care facilities.

Myles Ritchie on South Africa's new Office of Health Standards Compliance

COVERAGE AND QUALITY IN HEALTH CARE

HEALTH AND DEVELOPMENT PROFESSIONALS congregated at HLSP's London office in January to examine the challenge of maintaining the quality of health services while expanding their coverage of the population.

Hosted by HLSP in partnership with the Department for International Development (DFID) and the London School of Hygiene and Tropical Medicine (LSHTM), the event was sponsored by the Mott MacDonald DFID Centre of Excellence – a newly established conduit for engagement between DFID and Mott MacDonald (HLSP's parent company) to facilitate information and expertise sharing.

Highlights of the day included a report from Susan Elden, DFID Senior Health Advisor, on the progress of Ghana's National Health Insurance Scheme (NHIS) after ten years of existence. Now at a crucial turning point, the NHIS must secure its financial sustainability for the future while addressing problems including disappointing coverage of poorer, rural populations. Susan identified purchasing and cost containment as the key tools to improve this.

Myles Ritchie, Senior Technical Lead on the HLSP-managed SARRAH programme, related South Africa's ongoing efforts to introduce an Office of Health Standards Compliance (OHSC), which will help protect quality of services as the government moves toward a national health insurance system. Creating this new regulatory regime will be cost intensive and will require highly skilled professionals – but it will play an indispensable role in improving quality of services and tackling the inequitable distribution of health resources. HLSP is supporting the South African government's journey towards national health insurance through the DFID-funded SARRAH programme.

Nick Black, LSHTM Professor of Health Services Research, delivered an inspiring presentation on what had been learned in the UK about defining and managing quality of health care. Re-design of services, socio-behavioural incentives, regulation and patient education were among Nick's favoured methods for improving quality, but he warned that financial incentives and legal action may not be helpful.

The event ended with group discussion sessions that gave attendees a chance to share their experiences of health care systems across the globe that have grappled with quality and coverage issues.

MORE INFORMATION ONLINE

Contact: **nadia.weigh@mottmac.com**
Watch Myles's presentation on **YouTube: http://bit.ly/1dHltlb**

HLSP
WORKING TO IMPROVE WORLD HEALTH

HLSP provides technical assistance in the health sector, and 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 8000 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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