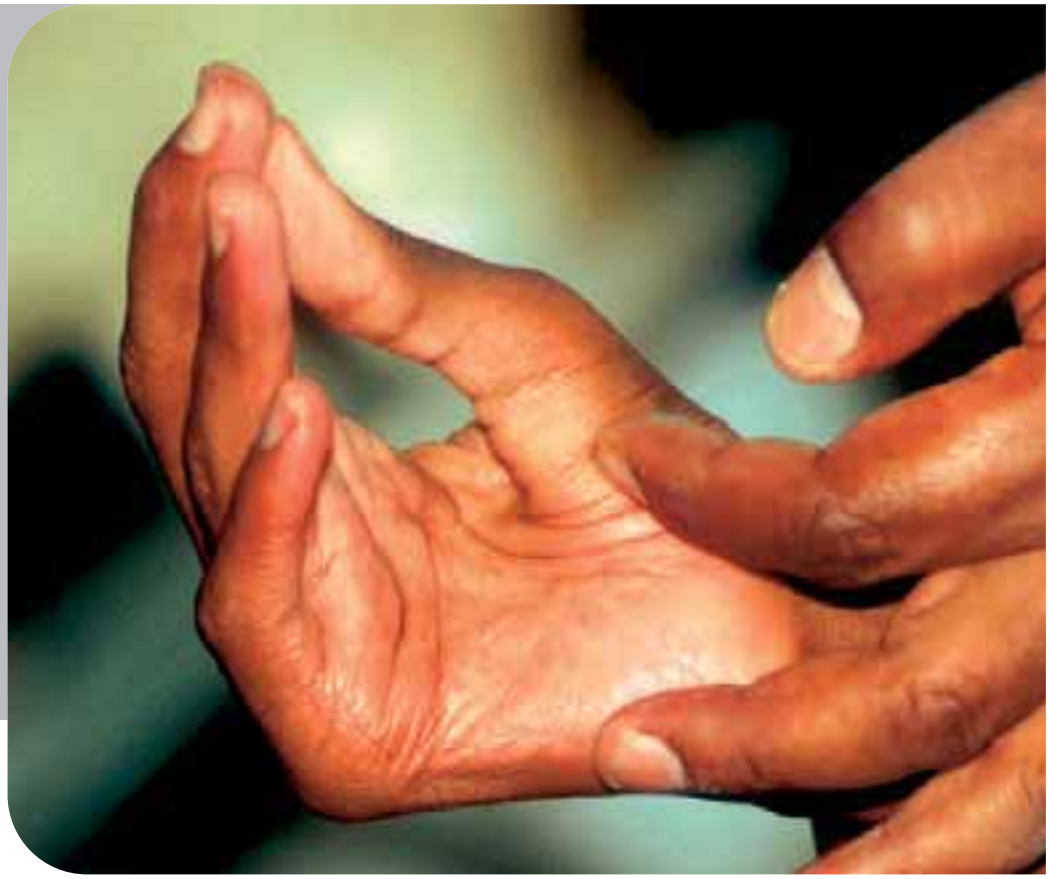


Accelerating action

A technical support guide to develop capacity and to benefit from global health financing

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development

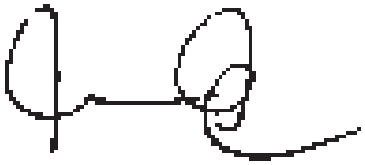
Introduction

Foreword

The enjoyment of the highest attainable standard of physical and mental health is a fundamental human right. However, about one third of the world's population, in particular the poor inhabitants of developing countries, are denied this human right. This translates into disaster for millions of individuals. At the same time, disease is also a major cause of poverty.

For this reason, health issues enjoy a high priority in the Millennium Development Goals: three of the eight goals relate directly to health. AIDS, tuberculosis and malaria kill millions of people every year and hinder development in many regions. Because of this huge challenge, Germany has raised health issues very prominently in the context of its agendas for its presidencies of the EU and the G8 in 2007. Without a doubt, combating these diseases will require a significant increase in funding. In view of this, the G8 has decided to commit an additional $60 billion at the summit in Heiligendamm.

The provision of adequate funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria plays a crucial role in this context. But capacity development is essential to make the money work and to ensure effective scaling up. Building capacity can help make certain that additional funding leads to improved access to quality health services in developing countries on a sustainable basis and that access is provided to poor and key populations at high risk, such as women and children. Therefore, the commitment that the German government has made to global health financing comprises measures for capacity development through the BACKUP Initiative, focusing on diverse levels and partners, such as civil society and international institutions. The GTZ now has four years experience developing and implementing the BACKUP Initiative. The approaches applied by the BACKUP Initiative have been widely noted and have proven to be effective in providing need-oriented, flexible and timely technical support for partners involved in global financing processes and programmes on HIV and AIDS, tuberculosis, malaria and other priority diseases.



Martina Metz
Head of Health Division
Federal Ministry for Economic
Cooperation and Development (BMZ)
Germany

Capacity development is the single most important goal of technical support and it is the mission of our regional organization. To implement programmes that effectively and efficiently address emerging public health and development issues, individuals and organizations increasingly need to develop new capacities, harness new technologies and adopt innovative approaches.

The regional project of SEAMEO TROPMED Network with the BACKUP Initiative provides a good example of technical support for capacity development. Conceived by three partner countries with projects supported by the Global Fund, it was able to address critical human-resource and organizational needs and allow for the efficient and effective implementation of these countries' projects. For example, the initiative provided training in specific areas for implementers, developed tools and guidelines for implementation, and formulated policies to improve Global Fund processes. In addition, the SEAMEO TROPMED project was able to harness and make the most of existing national and regional expertise.

The experience of this project demonstrates the importance of technical support. Furthermore, it underscores the need for careful planning of technical support to ensure that it is appropriate and effective. This guide is very timely, therefore, as it will help partner countries towards more logical planning for technical support.

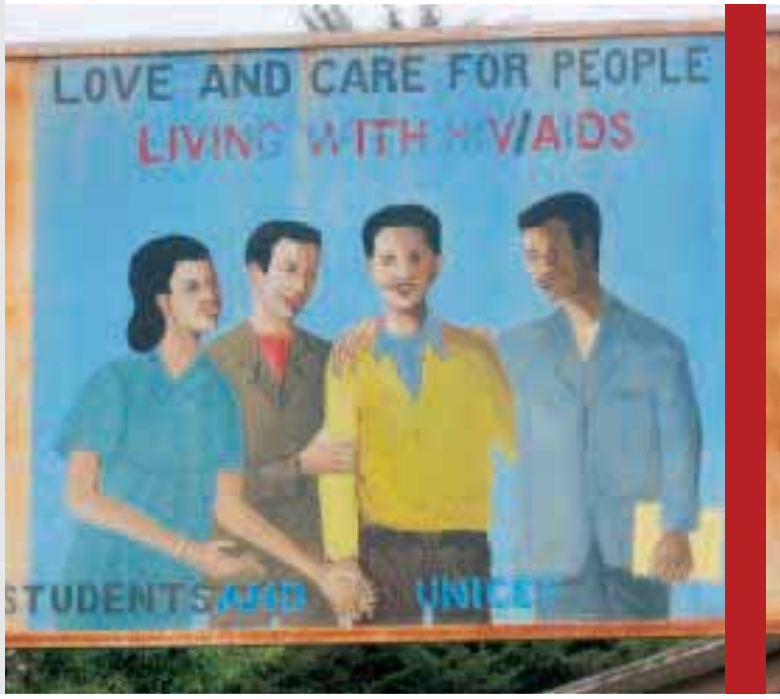
Prof. Dr. Sornchai Looareesuwan
Secretary General/Coordinator
SEAMEO TROPMED Network
Southeast Asian Ministers of Education
Regional Network in Tropical Medicine
and Public Health
Thailand

How to use this guide

Who is this guide for?

This guide is for professionals engaged in programmes or projects that address HIV, tuberculosis, malaria and other major diseases. Specifically, it aims to help those responsible for the development, implementation and monitoring of initiatives that are closely related to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank Multi-Country HIV/AIDS Program for Africa (MAP) and other mechanisms of global health financing.

Readers, therefore, might include government officials, members of coordinating bodies (e.g., Country Coordinating Mechanisms and National AIDS Coordinating Authorities), managers of implementing agencies, such as Principal Recipients of Global Fund grants, and nongovernmental organizations and staff members of academic and educational institutions or of private sector organizations.



What is the purpose of this guide?

The recent sharp increase in global health financing has provided many benefits, but it has also revealed gaps in the capacity of low and middle income countries to implement programmes – and their pressing need for technical support (TS) to fill these gaps. Evidence also indicates that, where TS is available, countries and their health partners often do not use it efficiently, or fail to properly assess their needs for support, leading to poor allocation of resources. Public health programmes also suffer from insufficient information on the quality of TS providers, underutilization of local and regional capacity for TS, poor coordination of technical support and insufficient adaptation of existing modes of delivery[1].

This guide was developed by the BACKUP Initiative of GTZ (see page 16 for details). It provides current information on where technical support for capacity development is most needed, who is able to provide it and how to make best use of it. The guide strives to help readers in three ways:

› Describing lessons learnt about opportunities and challenges related to global health financing in the first four years of the BACKUP Initiative and from its collaboration with partners in 50 countries.

› Providing practical information – tools, resources and the contacts of selected TS providers – to help those in need to boost their capacity in developing, implementing and monitoring programmes and projects and to tap more effectively into rich new streams of global health financing.

› Encouraging a better exchange of information to stimulate discussion and elicit constructive criticism about TS. To this end, the guide is also published on the internet and BACKUP welcomes recommendations and resources from readers to improve and update the guide (backup-initiative@gtz.de).

How is this guide structured?

Apart from this introduction, the guide consists of nine sections, each with information about how to develop capacity in a particular area and where to find technical assistance (TA) for this. The topics covered are as follows: 1) Planning for technical support; 2) Strategic planning; 3) Accessing financial resources; 4) National coordination and management; 5) Empowering civil society; 6) Developing human resources for health; 7) Improving health financing systems; 8) Procurement and supply management; and 9) Monitoring and evaluation. The range of themes has been identified according to the experience of the BACKUP Initiative and its multilateral and bilateral partners. Each section can be read as a chapter in the guide, or read and used on its own.

All sections have a similar structure:

› A short introduction is followed by background information on the topic.

› The text then outlines the principal challenges that partners face in the area, and common needs for technical support.

› Next, each section lists the kinds of technical support available in the given area: information on TS providers, toolkits, manuals, courses and links. BACKUP has made a choice of documents here, not claiming to be comprehensive however. Only the English versions of documents and sources are listed, though many are available in other languages as well.

› Concrete examples follow, illustrating the kind of TS provided by BACKUP and its partners. BACKUP can be contacted for more information. While most examples focus primarily on HIV, the lessons learnt are frequently relevant to other diseases.

› Each section ends with a list of selected readings.

This publication is available in print (booklets for each of the nine sections accompanied by a CD-ROM) and online at www.gtz.de/backup-initiative. The online and CD versions of the text include hyperlinks: terms underlined that provide digital links to further information, online-tools and literature. Readers are encouraged to copy this guide and circulate it widely.

What details does this guide offer about providers of technical support?

The BACKUP Initiative conducted a survey among technical support providers to offer further practical information to the reader. Providers identified included all members of the Development Assistance Committee (DAC) of the Organization for Economic Co-operation and Development (OECD), all other member states of the European Union and a number of international nongovernmental organizations. The survey was sent to 114 TS providers, 38 of whom participated. The criteria used for data collection in the survey were adapted from the Aidspan's Guide to Obtaining Global Fund-Related Technical Assistance (2004)[2]. It elicited information about the kind of technical support provided, the regional focus and the field of expertise.

The information collected in this survey is presented in a detailed table in Annex I. This list reflects only the information provided by organizations interviewed, and is not based on any assessment of the relative strengths and weaknesses of specific TS providers. All providers can be contacted for support in response to specific needs. Once a provider of technical support is selected, its services should be evaluated according to the standards of the selector and, wherever possible, the results of the cooperation made public.

Cross-cutting themes: equity, gender, quality

Three themes inform all sections of this guide and are therefore explained in this introduction: the need to promote equity, sensitivity to gender issues and quality management. Improvements in health care management and programme and project implementation will be unsustainable unless they address these three themes.

Equitable access

Equity in health implies that everyone should have a fair opportunity to enjoy optimal health and, more pragmatically, that no one should be prevented from achieving this. Equitable access to health services means access according to one's needs, rather than one's wealth, social status or place of residence. It also means access to equitable outcomes of services.

Equitable access to health services for all in all countries is still far from being reached. People in rural areas and on the outskirts of cities, in particular, often encounter geographic and financial barriers to equitable access. Other barriers include political and legal barriers related to inadequate guidelines and the enforcement of poorly conceived laws, financial barriers such as user fees at point-of-delivery and the costs of transportation and food. People are also hindered in efforts to access health services by poor infrastructure, and shortages of qualified health care providers, essential medicines and other health commodities. Patients and providers of services may also be unaware of their rights and responsibilities – another barrier. Open discussion of these barriers, within a so-called fair process, can help countries to reach a consensus in addressing health-related poverty and discrimination.

In addressing equity, a range of questions should be considered: for example, whether to focus on urban or rural health facilities, whether to expand access to services for a particular disease or across an entire health care system and whether to invest in vertical programmes for a single disease (AIDS, tuberculosis, malaria, etc.) or in an entire health system. Governments may also need to address such thorny issues as whether to provide treatment, especially antiretroviral therapy, free of charge while keeping user fees for other health services.

Gender sensitivity[3]

Gender issues touch on most topics in this publication. Health services, especially those for HIV, require gender-sensitive communications and health care providers must give special consideration to status and economic inequities related to gender. Such sensitivity helps to reduce the risk of HIV transmission, especially among women who are biologically more vulnerable than men and suffer more often from a low social status. Globally, nearly half of all HIV infections are among women and the burden of the epidemic is increasing among them[4]. Nevertheless, a gender-sensitive approach does not necessarily mean the exclusive promotion of the rights of women, as in some populations (for example, migrant workers) men are more vulnerable to the disease or need to be strongly sensitized to the rights of women. A gender-sensitive approach requires, rather, the adaptation of activities to address the particular needs of women and men under special circumstances.

Gender issues have to be addressed by all TS providers and have to be mainstreamed in all areas. Gender mainstreaming entails addressing gender issues in all approaches and programmes so that men and women enjoy equal opportunities in all areas: socio-economic, political and legal. For example, special programmes have to be tailored for young men to clarify roles and inform them about the risks faced by women.

Quality management[5]

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The topic is now widely discussed, and it is of special importance in settings with limited resources. Efforts to address quality of care aim to improve the health of a population, concentrating on those most at risk according to set standards. When health care improves – and complications and deaths decrease – patients' expectations are met or exceeded and their commitment to treatment is strengthened.

Quality Management (QM) is broadly defined as all procedures explicitly designed to monitor, assess, and improve the quality of care, including tools such as peer review, patients' or health care staff's assessment, audits and tools to elicit feedback. QM helps to close gaps between performance and predefined standards.

In most countries, there are opportunities to improve the quality and performance of the health care system, as well as a growing awareness of the need, and public pressure, to do so. Managing comprehensive QM requires the inclusion in decision-making of all stakeholders (health care managers and staff, patients, relatives, communities and so on) and should include a situational analysis before revisiting quality objectives and taking action. Actions to improve health services and provide equitable access should always be informed by established standards and indicators, with clearly stated activities and responsibilities and approved timelines and budgets. Measures to improve the quality of services should be part of each step in the process of harnessing technical support to develop capacity and should involve entire systems starting at the national level[6]. Good quality management leads to health care systems that are effective, efficient, accessible, acceptable, patient-centred, equitable and safe.

International context

Technical support, as understood today by most health and development partners, relies on countries taking ownership and focuses on sustainable, demand-oriented services. This understanding – promoted also in this guide – reflects changes in international cooperation in the last few years and recent agreements related to public health. The milestones in this process are briefly summarized below; for further details see the glossary in Annex II.

New goals

The United Nations established eight Millennium Development Goals in September 2000, three of which address specific health issues: reducing child mortality, improving maternal health and combating AIDS, malaria and other diseases. The aim of these goals was to stimulate greater financial support for low and middle income countries, to concentrate more on country-led processes and to improve cooperation among all countries. In June 2001 then, a special session of the UN General Assembly culminated in a Declaration of Commitment on HIV/AIDS, which called for increases in international financing for the HIV response and the establishment of the Global Fund, which took place the following year.

The response to HIV was furthered boosted on World AIDS Day 2003, when WHO and UNAIDS announced a detailed plan to provide 3 million people in low and middle income countries with antiretroviral treatment by the end of 2005 – the "3 by 5" strategy. And in June 2005, leaders of the G8 nations and other countries committed to a massive scaling up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it. Finally, the 2006 UN High Level Meeting on AIDS adopted a forward-looking Political Declaration on HIV/AIDS to advance the global response, particularly for scaling up towards universal access, and beginning to halt the spread of AIDS.

New modes of financing and management

Recent years have also witnessed a marked increase in financial support for public health programmes. The amount of Official Development Assistance (ODA: grants, low-interest loans and credits) and other contri-

butions allocated, for instance, to the AIDS response in 2005 came to US$ 8.3 billion, which was nevertheless short of the estimated US$ 11.6 billion needed. In September 2000, the World Bank launched the Multi-Country HIV/AIDS Program for Africa (MAP) to boost efforts in the region of the world with the heaviest burden of the disease. And in 2002, the Monterrey Consensus called on countries to mobilize domestic resources and major donor nations to increase international support for country-led processes responding to all diseases. The creation of the Global Fund as an innovative approach to international health financing the same year reflected this renewed commitment to addressing major epidemics.

Despite increases in funding, donor nations and many low and middle income countries, as well as private corporations at the international and national levels, can still afford to spend much more on expanding equitable health services[7]. New forms of managing and harmonizing development activities and resources are now being adapted to country-specific conditions to meet financing gaps: Sector-Wide Approaches (SWAp), for example, or different modes of funding such as basket funding or budget funding[8] [9].

New ways to harmonize

This increased health funding and new modes of support for low and middle income countries urged international partners to harmonize and better align their collaboration: Growing out of the Monterrey Consensus, the "Three Ones" Principles were launched in April 2004. These encourage countries and their development partners to agree on one action framework on HIV/AIDS, one national AIDS coordinating authority and one monitoring and evaluation system.

Ways of promoting harmonization and better international cooperation were also agreed on in the Paris Declaration on Aid Effectiveness in March 2005. The Paris Declaration defines the framework for international cooperation and emphasizes the alignment of actions by different stakeholders. With the support of UN agencies, a Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors was also established in June 2005 to bundle efforts to respond to the epidemic using annual priority action plans.

1 Making the money work through greater UN support for AIDS responses: The 2006-2007 Consolidated UN Technical Support Plan for AIDS. UNAIDS, 2005.

2 The Aidspan Guide to Obtaining Global Fund-Related Technical Assistance. Aidspan, 2004.

3 Förderung der Entwicklungsländer: Gender und HIV/AIDS. KfW Entwicklungsbank, 2007.

4 Guidelines for Integrating Gender into HIV/AIDS Programmes. WHO, forthcoming 2007.

5 Quality of care. A process for making strategic choices in health systems. WHO, 2006.

6 How to initiate and steer Systemic Quality Improvement: An advisor's guide for the health sector and other social sectors. GTZ, 2007.

7 Funding flows for health: what might the future hold? HLSP Institute, 2007.

8 Harmonising Donor Practices for Effective Aid Delivery. Volume 2: Budget Support, Sector Wide Approaches and Capacity Development in Public Financial Management. OECD/DAC, 2006.

9 Evaluation of General Budget Support. OECD/DAC, 2006/2007.


VIH
SIDA

The BACKUP Initiative

Germany is one of the world's largest contributors of financial and technical support for the socio-economic development of low and middle income countries. The German Federal Ministry for Economic Cooperation and Development (BMZ) oversees the formulation and implementation of Germany's development cooperation policies, and the German Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit GTZ) is one of BMZ's main implementing organizations. GTZ provides technical support to 2700 development programmes and projects in more than 120 countries.

The BACKUP Initiative was established by GTZ in September 2002, shortly after the creation of the Global Fund. BACKUP is an acronym for "Building Alliances – Creating Knowledge – Updating Partners to fight AIDS, tuberculosis and malaria and other priority diseases".

It focuses on:

- Building alliances: establishing partnerships at the international and national levels to achieve synergies and exploit the comparative advantages of different organizations and governments.
- Creating knowledge: supporting knowledge management for evidence-based implementation of national programmes and linking global finance with broader issues of development cooperation.
- Updating partners: developing knowledge and capacity of implementing partners to manage global funding and scale up effective interventions.

In the last five years, global financing mechanisms such as the Global Fund, the World Bank Multi-country HIV/AIDS Program (MAP) and other international initiatives have mobilized significant new sources of financing to assist countries in addressing major diseases. These sources provide opportunities for recipient countries, but those that tap into them often face new organizational and technical challenges. The BACKUP Initiative was established to support partner countries in their efforts to improve the use of these global health financing mechanisms, to scale up programmes that respond to diseases and to improve programme implementation.

As of mid 2007, BACKUP was providing financial and technical support in no fewer than 50 countries. The innovative approach adopted by BACKUP offers prompt support where it is most needed and it is widely considered as a useful new mode of international cooperation. The BACKUP Initiative has close strategic partnerships with UN agencies such as ILO, UNAIDS and WHO, international nongovernmental organizations, and bilateral partners at country level: governments, civil society groups (especially organizations of people living with, and affected by, diseases), academic and educational institutions and private sector organizations.

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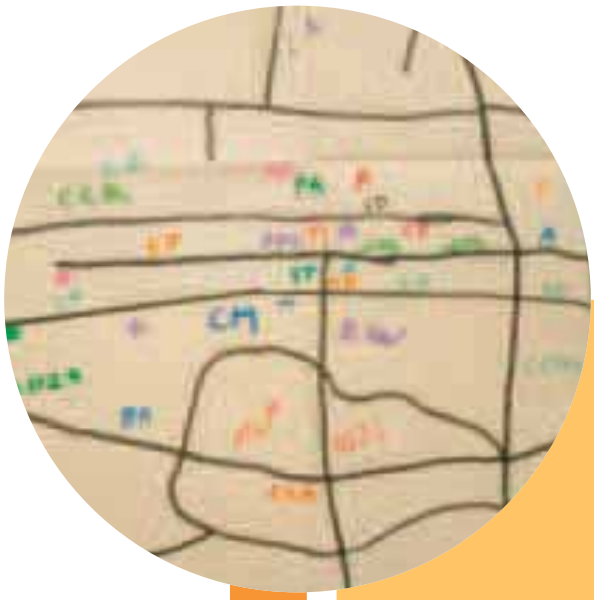
1

Planning for technical support

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development



1. Content and context

This section describes how to assess needs for technical support and defines key features of a technical support plan. It outlines challenges in assessing needs and identifies some major sources of assistance in the process of assessing needs and planning for support. Finally, it gives a recent example from the field.

Why is this topic important? A systematic technical support needs assessment helps a country to identify crucial strategic and operational gaps, and can strengthen its request for support – if the request states clearly how increased capacity will improve programme and grant implementation. Assessing capacity and planning for technical support are critical steps in tapping global health financing sources such as the Global Fund. Eventually, the provision of quality TS helps to boost the performance of health programmes and to improve health outcomes. Without assessing capacity and specific needs and planning for assistance, technical support may be too little, too late and ineffective[1].

Definitions: technical support for capacity development

Capacity can be defined as "the ability of people, organisations and society as a whole to manage their affairs successfully"[2]. **Capacity development** is seen as a process whereby people, organizations and society strengthen and maintain capacity over time. Capacity development is crucial in increasing the effectiveness of aid at country level. On an individual level, e.g. for training, the term **capacity building** is frequently used.

Partners promote capacity development mainly through technical co-operation (TC) or technical support (TS). For the purpose of this guide, the term **technical support** is used and this refers to activities that contribute to a systematic, timely and demand-driven response to capacity needs at country level. Technical support is often provided by expert consultants or advisors over the short- and medium-term. It assists in strengthening individuals in their specific expert areas, makes organizations more efficient and helps to improve political and social framework conditions on a national basis (see box).

Technical support for capacity development comprises three dimensions

- Human resource development through the transfer of knowledge, skills and values and the development of communication systems and networks.
- Organizational development through training of staff, the establishment of management systems and the improvement of work processes.
- Institutional and policy development by improving legal and administrative frameworks for development and cooperation.

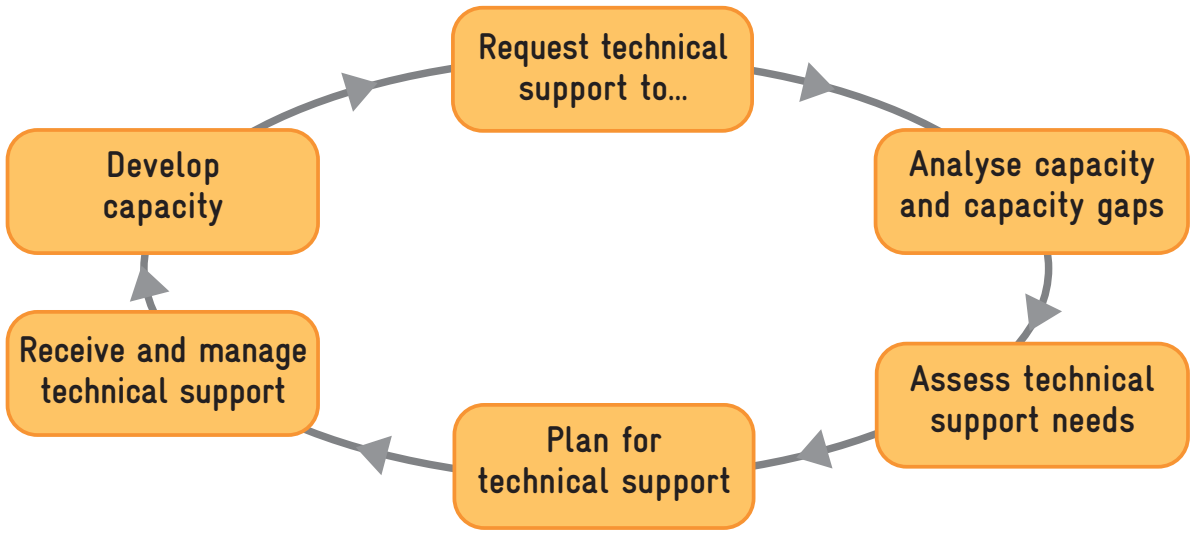
A comprehensive capacity analysis and assessment of needs looks at all three dimensions of capacity development. It includes a systematic analysis of stakeholder capacity in the health sector, and allows organizations to identify the most appropriate technical support and suitable providers in an overall technical support plan. This technical support plan should be:

- Technically sustainable, enabling organizations to provide appropriate, high-quality services;
- Managerially sustainable, allowing actors to plan and manage all aspects of their operations;
- Financially sustainable, enabling organizations to generate enough working capital to continue producing goods and providing services; and
- Politically sustainable, drawing on the support and involvement of community members, gatekeepers, opinion-leaders and decision-makers who can make the plan viable.

A TS plan missing any of these components will be ineffective, unproductive or irrelevant and may, as a result, undermine programme implementation and improvement of health outcomes.

Figure 1 summarizes the different aspects mentioned above from capacity analysis to planning for technical support and capacity development.

Figure 1: Technical support for capacity development



2. Challenges: fear, few resources and poor coordination

Every health system has needs for capacity development to improve health services. Stakeholders in a health system face certain challenges in systematically identifying TS needs and formulating requests for quality TS. Some of these challenges are as follows[3]:

Inadequate technical support needs assessments: Technical support needs, and the expert support required to address them, are often not comprehensively assessed or assessors may overlook relevant factors related to national programmes or health systems. Too often, technical support needs assessments are conducted at only one stage of a grant cycle, or when severe bottlenecks undermine programmes and grant implementation.

Reluctance to admit capacity gaps: Stakeholders are often reluctant to admit gaps in capacity for fear of losing funding. Slow implementation and failure to meet spending targets are usually the first symptoms of weak organizational, technical or financial capacity. If these gaps are not identified and addressed early on, they can lead to poor programme implementation. Similarly, organizations facilitating and providing technical support are often unaware of their own limitations; therefore, they fail to address them in a transparent and practical way – a precondition for the successful implementation of programmes and funds.

Poor coordination of technical support needs assessments and lack of country ownership: Needs assessments and plans are frequently fragmented, uncoordinated and inefficient. They are often rather supply- than demand-led and organizations and governments may refuse to take ownership of them. Technical support plans may also reflect the skills and availability of TS providers, rather than the expressed needs of recipients. Additionally, staff may feel threatened by external experts assessing the capacity of their organization, or view them as intrusive.

Tardy assessments: Recipients have said that TS often comes "too little, too late". Weak capacity is also frequently uncovered during grant implementation or evaluation, when it is too late to correct this. Many weaknesses, however, can be predicted in early assessments of capacity and technical support needs.

Poorly resourced needs assessments and TS plans: Organizations may not allocate sufficient financial and human resources for needs assessments and TS plans to ensure that they are done, and implemented, appropriately or in ways that respond to changing needs[1].

Weak monitoring and evaluation of technical support needs: Technical support needs are usually not systematically monitored, though this is a precondition for identifying further needs and for adjusting technical support plans accordingly. Stakeholders are often reluctant to recognize that assessing technical support needs requires regular follow-up.

3. Technical support: pinpointing needs, framing a plan

A number of agencies provide technical support – or technical assistance, as it is also known – and tools for the analysis of capacity, the assessment of technical support needs, and the development and implementation of TS plans. Below is a list of areas of technical support, with information and links to agencies and tools in each.

Assessing capacity: Technical support is provided for stakeholders to analyse their own capacity, which in turn can help to foster support among staff and partners for the assessment and resulting capacity building. Areas of capacity analysis include the technical and organizational capacity of state, civil society and private sector agencies and their ability to communicate and collaborate effectively among themselves to implement programmes and improve health outcomes. Additional tools include:

- The International HIV/AIDS Alliance produces a range of participatory toolkits for analysing capacity and making TS plans. Though aimed at civil society organizations, these toolkits can easily be adapted for other actors.
  The HIV/AIDS Alliance can also assist organizations in the use and adaptation of these tools, contact TeamCivilSocietyDevelopment@aidsalliance.org.

- The World Health Organization (WHO) has developed an approach to situation analyses for organizations and programmes addressing malaria.

Analysing stakeholder contributions: Technical agencies are willing to fund efforts and provide experts to assist in the assessment of stakeholders and their capacity needs. The following tools can support this sort of analysis:

- A WHO stakeholder analysis.

- Brazil's International Center for Technical Cooperation (ICTC) publishes tools for stakeholder analysis used in Latin America and the Caribbean.

Identifying technical support needs: A general TS needs assessment should take place prior to any technical cooperation planned for a certain programme or project. Expert help is usually offered by the future cooperation partner. Furthermore, donors are now willing to fund assessments of the specific TS needs of health programmes and projects that are financed internationally. Ideally, a first assessment of technical support needs should be carried out prior to proposal writing. In this way, a technical support plan can be incorporated into proposals for funding (see also Figure 2 below). Since there are many stakeholders involved in accessing, managing and utilising global health financing, it is recommended to plan for all boats to rise with the tide, i.e. to assess needs at all levels, rather than expecting capacity to drip down to every level.

There is no single, ready-to-use tool for a comprehensive TS needs assessment; however, a variety of instruments are widely used. These include:

- Terms of reference (ToRs) for TS needs assessments related to programmes funded by the Global Fund: e.g., the ToRs for a GIST mission on Global Fund programme assessment in Niger.

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) initiated regional Technical Support Facilities (TSFs) to assist partners in, among other areas of expertise, identifying TS needs and planning for TS. The TSF for Southern Africa offers, for example, a technical assistance management programme and has published a guide on Managing Short-Term Technical Assistance for HIV and AIDS Programmes. For more information about the regional TSFs, please refer to the list of TS providers in Annex I.

- Two instruments exist for assessing TS needs to clear bottlenecks in the implementation of grants:
The Early Alert and Response System (EARS) of the Global Fund promotes early identification of challenges to programme implementation by facilitating the systematic sharing of information on grant progress within and outside the Global Fund Secretariat. Further information can be found at the Global Fund website. Questions regarding EARS may be sent to EARS@theglobalfund.org.
The United Nations (UN) Global Implementation Support Team (GIST) brings together a small number of UN technical agencies, funding entities, bilateral donors and non-governmental organizations (NGOs) to review immediate and medium-term TS needs, take decisions on joint and coordinated technical support, evaluate progress and assess performance of such support. Requests for GIST's assistance are accepted from all participants in the Global Fund process. For information, refer to the UNAIDS website on GIST or contact gist@unaids.org.

- The Global Fund assists grant recipients in identifying problems in implementation and helping to find solutions. The Fund also publishes information about the performance of Principal Recipients on its website.

- The Global Fund's Technical Evaluation Reference Group (TERG) also publishes reports on performance. These reports identify common areas where capacity is likely to be weak.

- Chapter 3 of the Aidspan Guide for the Global Fund Round 7 provides a detailed analysis of what, in the Technical Review Panel's opinion, were the strengths and weaknesses of applications submitted in Round 3 through Round 6.

- The International HIV/AIDS Alliance has a Global Fund Grant Support Group, which helps in the assessment of TS needs, contact gfgsg-sec@aidsalliance.org.

Figure 2: Typical technical support needs of Global Fund grant applicants[4]

Stage of Global Fund process	Questions to ask	Typical technical support needs identified
Proposal development	Do all stakeholders have the knowledge, skills and resources to develop a successful proposal?	Proposal development skills-building for members of Country Coordinating Mechanisms (CCMs) and technical working groups. Skills-building in preparing budget plans.
Grant negotiation	Do all stakeholders have the knowledge, skills and resources to negotiate an effective grant?	Skills-building in indicator alignment, incorporation of a monitoring and evaluation plan, development of a concise procurement and supply management plan, work plan and budget alignment.
Grant management	Do all Principal Recipients (PRs) and Sub-recipients (SRs) have the capacity to manage the grant effectively?	Human resources development and management skills-building of Principal Recipients and Sub-recipients. Specific capacity building in procurement and supply.
Grant performance	Do all stakeholders have the knowledge, skills and resources to meet performance targets?	Capacity building for PRs, SRs and members of CCMs in programme monitoring and evaluation, particularly for data collection and analysis.
Phase 2 renewal	Do all stakeholders have the knowledge, skills and resources to qualify for Phase 2 renewal?	Training in reporting for staff of Principal Recipients and Sub-recipients.

Developing a technical support plan: Experts can help countries to come up with one overall national technical support plan. This plan includes TS needs for better programme implementation as well as specific technical support needs for accessing, managing and sustaining the benefits of global health investments. It also identifies specific assistance to build the capacity of all stakeholders[5]. As well, an overall TS plan can help to harmonize the assistance under the leadership of a single agency. Ideally, this should be a national agency to encourage country ownership.

The box below summarizes the steps to take in assessing TS needs and developing a TS plan for strengthening applicants and recipients throughout the Global Fund grant cycle.

Suggested steps to develop a plan for technical support throughout the Global Fund grant cycle:

1. At the pre-qualification stage, appoint a lead agency (e.g., the CCM) to manage the TS needs assessment and take responsibility for the TS plan. At this stage, the agency may wish to find technical support to build the capacity of other stakeholders to conduct the actual assessment.
2. Identify key stakeholders for achieving the objectives of global health financing and build consensus among them for TS needs assessment, stressing the benefits.
3. Review secondary sources of information and conduct a baseline participatory capacity analysis with stakeholders. This should analyse their technical, organizational and institutional capacity to meet the requirements of each stage of the grant cycle.
4. Verify the results of the capacity analysis with stakeholders and allow them to identify their own technical support needs.
5. Develop a TS plan covering all stakeholders throughout the whole grant cycle, and verify this with them. Define the objectives and indicators of success for the TS plan and include a monitoring and evaluation process within it.
6. Incorporate the TS plan into the grant proposal, i.e. TS should be in addition to, rather than drawn from, other programme budget lines.
7. Identify TS providers: first look locally, then regionally, then at the global level.
8. Monitor progress towards programme objectives, measure outcomes and analyse results in collaboration with stakeholders and adjust the TS plan accordingly.

Monitoring technical support needs: Expertise can be tapped for the design of a monitoring mechanism of a technical support plan. Such a system is crucial to regularly assess TS needs, as well as the quality of TS provided. The first TS needs assessment can be used as a baseline. From then on, stakeholders can use this baseline to monitor their TS needs and assess the quality and impact of technical support provided. This is important to allow the implementing organization to adapt and specify their requests for TS based on genuine needs.

- The International HIV/AIDS Alliance has published a list of key questions that are useful to assess the effectiveness of TS.

Generally, for all aspects above, the Technical Support Guidance Tool of the International HIV/AIDS Alliance can be obtained on request from agfg@aidsalliance.org. For further information on potential TS providers in assessing TA needs and developing TS plans, please refer to the list of TA providers in Annex I.

EXAMPLE

4. Example: international workshop provides candour and collaboration

Context

Assessing the capacity of recipients of global financing to pinpoint their TS needs can be threatening for members of staff who are under the microscope. This can lead to over-reporting of successes and strengths, and under-reporting of failures or weaknesses. One proven way to avoid these pitfalls is to enable recipients to analyse their own capacity and needs, rather than bringing in outsiders to assess organizational capacity. It should be stressed to recipients, however, that openness is the best option as the ultimate purpose of the analysis is to strengthen their capacity to successfully implement programmes.

Technical support

In 2007, the International HIV/AIDS Alliances' Global Fund Grant Support Group held a workshop that brought together four Principal Recipients of Global Fund grants: organizations from Ukraine, Senegal, South Africa and India. The participants were encouraged to share experiences and identify their own technical support needs. For each stage of the Fund's grant management cycle, they presented their experiences and highlighted challenges faced in such areas as procurement, financial management, and monitoring and evaluation.

At each stage, the Support Group highlighted strategic options available to them, allowing participants to reflect on the choices they made and what they might have done differently. Participants then identified lessons learnt. These were all documented as a checklist for Principal Recipients, with "do's and don'ts" for each stage of the grant management cycle.

EXAMPLE

Results

Principal Recipient managers were able to identify their different and shared challenges and technical support needs. They then assessed whether they could address these needs by themselves, or with the help of each other, or from external sources of TS. Finally, they included TS plans in their programmes and budgeted for them. Participants agreed that this process was successful and fostered learning and collaboration among groups from different world regions.

5. Selected reading

1 Making the money work through greater UN support for AIDS responses: The 2006-2007 Consolidated UN Technical Support Plan for AIDS. UNAIDS, 2005.

2 The Challenge of Capacity Development: Working Towards Good Practice. OECD/DAC, 2006.

3 19th Meeting of the UNAIDS Programme Coordinating Board. UNAIDS, 2006.

4 Technical Support: Sharing Experience and Good Practice. WHO, 2006.

5 Technical Support Needs Assessment: Malaria Action Coalition (MAC) Senegal Mission Report. MSH (in collaboration with WHO), 2005.

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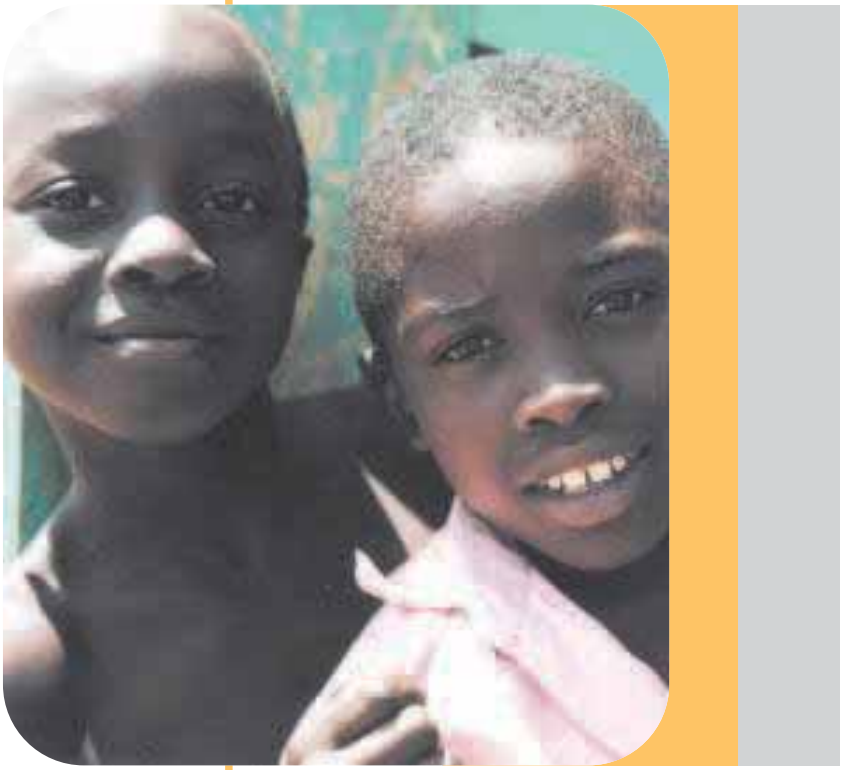

Photos
Page 1 to 14: Capacity assessment of Principal Recipients in different countries. Copyright The International HIV/AIDS Alliance.
Page 15: Two boys. Copyright Guley Ulutuncok.

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2

Strategic planning

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section looks at the link between national strategic plans and global health financing. It lists basic principles of strategic planning, identifies challenges and technical support available and offers examples of successful technical assistance. The content focuses on strategic planning as related to HIV, but much of the information about principles, challenges, technical support and tools available is applicable to other areas of strategic health planning.

Why is this topic important? In recent years, most countries have developed and implemented strategic plans. Many of these plans are yet too unrealistic and countries have shown a need for technical assistance in framing plans that generate positive results. Well-developed national plans pay major dividends, however: they align external support with national strategies, promote one agreed framework to coordinate the work of all partners (the first of the "Three Ones" Principles) and are considered as a precondition to attract funding from national and global sources.

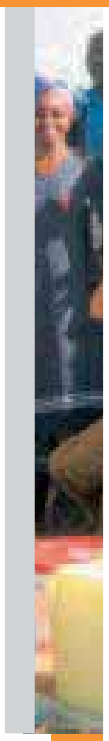
Principles guiding strategic health planning

What is meant by strategic planning?

Strategic planning defines not only the strategic framework of the national response to a disease (its fundamental principles, broad strategies and institutional framework), but also the intermediate steps towards achieving its goals: e.g., through annual action plans[1]. Well-developed strategic plans consider a variety of determinants of populations such as social class, religion and gender, for instance.

Why are annual action plans useful?

Annual action plans provide a detailed road map identifying specific activities leading towards the general goals of national strategic plans, and ensuring a timely response to changing epidemics. They are developed in a participatory manner, are carefully costed and include clear and simple monitoring and evaluation indicators. As well they detail capacity gaps and needs and delineate roles and responsibilities. Well-developed annual AIDS action plans, for example, are prioritized, drive implementation, improve oversight, emphasize results, and provide a solid basis for aligning support from national and multilateral institutions and international partners[2].



Three recent reviews assess progress made in the last years towards national strategic HIV planning in 31 countries[2]. These studies indicate that most national strategic plans follow the UNAIDS 1998 guidelines and exhibit certain characteristics of sound strategies: existing plans tend to be fairly comprehensive and underpinned by evidence. They also tend to focus on results and to promote stakeholder involvement, grassroots and community mobilization, decentralization, capacity building, empowerment and gender sensitivity. These reviews also recommend that public health decision-makers be particularly mindful of the following principles in developing national strategic plans:

- Harmonize plans with broader national development instruments: Strategic plans need to inform, and be aligned with, other national development plans or poverty reduction strategy papers, as well as health and other sectoral plans.
- Anchor plans in evidence and keep them flexible: Strategic plans should be based on the best available epidemiological, behavioural and other evidence and an accurate analysis of needs. Epidemics can evolve rapidly, so plans have to be adapted according to latest findings.
- Participatory approach: Successful plans draw on the resources and expertise of a wide range of social groups such as civil society organizations, representatives of businesses, religious authorities etc.
- Promote a multisectoral response: Particularly for HIV, strategic plans have to spell out how each key sector will contribute to the response – either directly or by addressing the causes and effects of the epidemic (see box).
- Make them operable: Strategic plans are of no use if they do not set realistic priorities based on a range of criteria and define concrete goals and interventions. They should, therefore, be broken down into realistic annual action or operational plans, aiming at the dissemination of information and decentralized implementation.
- Costing: Strategic plans need to be realistically costed, and plan for mobilizing international as well as domestic funding for implementation.
- Monitor and evaluate (M&E): Poor management of monitoring and evaluation is one of the major causes for weak reporting and accountability (see also Section 9). National strategic plans have to define indicators that can be tracked over time in one clearly defined and agreed on system of M&E (the third of the "Three Ones"). As well, strategic plans should be adapted to address the results of M&E.

Mainstreaming AIDS in all sectors, at all levels

HIV epidemics demand action across a range of social and economic sectors, owing to its exceptional characteristics: the epidemic affects people in their most productive years, it carries with it powerful stigma and it is often fuelled by gender and income inequalities. Mainstreaming is one way to achieve such a multisectoral response. The term refers to a process that enables development actors in many sectors to address HIV in an effective and sustained manner through their usual areas of activity and places of work.

Mainstreaming AIDS mobilizes individuals and agencies by helping them to

› understand the causes and effects of the epidemic on their work and workplace;
› determine their comparative advantage to address these causes and effects; and
› work with others to coordinate efforts, pool resources and broaden their interventions.

How can strategic plans help to mainstream efforts to address the epidemic?

Strategic AIDS plans need to include mainstreaming activities to achieve a multisectoral response. These activities must be clearly spelt out in the national plan to assure effective funding and implementation. If a strategic plan incorporates mainstreaming well, resources of all relevant partners can be harnessed and structural factors that heighten vulnerability to HIV and AIDS can be addressed. This also helps to strengthen the response of countries to HIV by embedding it in long-term development processes, and improving agencies' overall performance – changing HIV from a challenge to an opportunity[3].

2. Challenges: "few strategic plans are really strategic"

The principles listed inform the best national strategic plans; but the reviews of national plans mentioned above show that few plans are genuinely strategic – and ignore many of these principles:

They seldom provide careful costing or include annual action plans; many are also based on inadequate epidemiological data and are not integrated with national or sectoral programmes. Some national strategies present long "wish lists" of activities without explicit priorities or plans for targeting interventions and mobilizing resources. And most strategic plans still need to analyse the institutional and human resources required to implement activities, or provide for adequate monitoring and evaluation. For exmple, in the push to achieve universal access to HIV prevention, treatment, care and support by 2010, many countries must improve their strategic planning – and make use of technical support where needed.

Weak surveillance data undermine strategy

A World Bank report cites the example of an unnamed African country that held broad consultations to develop a plan based on the premise that it needed to address a highly generalized HIV epidemic. The plan, therefore, provided for wide-ranging social mobilization and many different interventions.

Unfortunately, the strategy was based on inadequate analysis of surveillance data. HIV prevalence in the general adult population was 1.8% and antenatal data indicated that the epidemic had been stable for a decade. The data also suggested that the peak age of HIV prevalence was relatively high for men and women, at 35-39 years. The plan failed, however, to address a salient fact – that HIV prevalence among sex workers was exceptionally high, at 78-82% percent in the two largest cities. Yet the national plan allocated just 0.8% of HIV spending for interventions among sex-workers[2].

3. Technical support: from analysis to action and evaluation

Technical support for harmonized and sound strategic planning can help countries to secure national and global funding and to scale up the response to major diseases. A variety of technical assistance in this area is available:

Analysis of epidemiological data: National planning and programme development should be supported by careful analysis and interpretation of epidemiological data. Technical support can, for example, help countries identify target groups for specific interventions, understand changing epidemics and promote better access to information. Additional useful sources of epidemiological software, tools and databases include:

- UNAIDS, which has published both epidemiological software and databases.
- Constella Futures, which offers a range of modelling and forecasting software.

Capacity assessment: Technical expertise can help in assessing the capacity of governments, organizations, the private sector and public services. This allows countries to analyse strengths and constraints of human resources and their infrastructure, to evaluate their response to diseases and to respond to specific country requests. As well, a range of tools are available to help with these assessments:

- The World Bank, on behalf of UNAIDS, has developed a self-assessment tool with guidelines designed for an AIDS Strategy and Action Plan (ASAP).
- WHO's Health Mapping Approach provides access to mapping systems and networks of technical support, among other tools.
- The Goals Model, a tool developed by Constella Futures, links programme goals and funding.

Annual action plans: Technical assistance is also available to translate national strategies into annual action plans and other frameworks, set priorities and select interventions that are most likely to pay the greatest health, social and economic dividends: processes such as knowledge-sharing via best practices can be facilitated, existing tools can be upgraded or new ones can be provided.

Budgeting: Technical experts can also help health care planners to assess how much to allocate for specific measures and interventions, tap resources from all sectors and mobilize new sources of funding. For example, national strategic plans often do not include an analysis of how to fund workplace programmes, which can undermine such important initiatives; but technical support can help in conducting such analyses. Some useful budgeting resources and links include:

- UNAIDS costing guidelines for HIV and AIDS Intervention Strategies.
- Constella Futures' Resource Needs Model, software to calculate the funding required for an expanded response to HIV at the national level.
- A step by step methodological guide for costing HIV programmes by Partners for Health Reform plus (PHRplus).

Policy reviewing and updating: Technical support in this area can help to create an enabling environment for scaling up responses to diseases. For example, in countries with concentrated epidemics of HIV among injecting drug users, laws may need to be revised to allow for needle and syringe programmes and opioid substitution treatment.

Mainstreaming: Technical assistance can help to engage multiple stakeholders and foster a participatory approach in the response to diseases. Resources for mainstreaming include also:

- A digital library of documents on DVD developed by UNAIDS/United Nations Development Programme (UNDP)/World Bank to support multisectoral responses and mainstreaming processes. This can be ordered from mainstreaming@unaids.org.
- An Implementation Guide for mainstreaming in sectors and programmes is also available from UNAIDS, UNDP and the World Bank.
- GTZ has published a comprehensive toolkit on DVD, titled Mainstreaming HIV/AIDS: How we do it; please contact your local GTZ country office for the toolkit and other support in this area.

- HIV and AIDS mainstreaming checklists and tools have been developed by the International Planned Parenthood Federation (IPPF).

- A set of tools for mainstreamed responses to the epidemic is available from the South-Africa-based Health Economics and HIV/AIDS Research Division (HEARD).

- The Swiss Agency for Development and Cooperation (SDC) has developed a toolkit titled Mainstreaming HIV/AIDS in Practice.

- The United States Agency for International Development (USAID) has also developed a toolkit to assist in implementing participatory approaches to manage HIV activities.

Monitoring and evaluation of strategic plans: Technical support is also available for monitoring and evaluation of strategic plans. Please see Section 9 of this guide for information, tools and links.

Annex I of this guide provides some details and contact information about technical support providers, including those that offer support for strategic planning.

Guinea sharpens its strategy with second-generation surveillance of HIV

Second-generation sentinel surveillance gathers data on different groups – pregnant women, men having sex with men, sex workers etc. – based on general information about the HIV epidemic. Data is collected regularly (every year, for instance) and results from HIV testing are combined with information about sexual behaviour of the groups to offer adequate prevention, treatment, care and support services. Such reliable data is crucial for improved national planning and programming. HIV second-generation surveillance systems offer the big advantage of being able to compare results from several data collections, to trace tendencies over time and to adapt responses to changes in the epidemic.

When Guinea first addressed HIV in the early 1990s, its efforts were blunted by a lack of reliable epidemiological data. In 2004 the government, therefore, sought the support of GTZ to establish a HIV second-generation surveillance system. A first survey designed according to the experiences of neighbouring countries integrated 4500 pregnant women, of whom 4.2% were found to be HIV-positive. HIV prevalence among pregnant women allows for reasonable estimates of actual HIV-prevalence in the sexually active population (aged 15–49), hence data from this sentinel surveillance could serve as a basis for taking action against the epidemic.

Sentinel surveillance was thereafter integrated into Guinea's national planning, so that health care professionals could make continued use of its data and respond quickly to changes in the epidemic. Priorities in the national strategic plan were set accordingly: the regions with the heaviest burden of HIV were identified and subsequent national plans have given priority to special interventions for these areas.

4. Examples: implementing strategic plans

EXAMPLE

Ukraine's strategic efforts to target HIV in the world of work

Context

Ukraine has the most severe HIV epidemic in Eastern Europe and Central Asia, with an adult prevalence at 1.5%. Though concentrated chiefly among injecting drug users, female sex workers and men who have sex with men, rising prevalence among pregnant women suggests that the country is fast approaching a generalized epidemic. The impact of the epidemic on the economy can already be detected, and estimates indicate that by 2014, it may reduce the gross domestic product by 6% and cut the workforce by 12%.

Despite the gravity of this epidemic, efforts to address it are hampered by widespread ignorance and stigma and discrimination. Faced with the speed at which the epidemic is spreading, observers have called for measures anchoring the response in a comprehensive national strategic plan.

Technical support

With support from GTZ, an expert team from the International Labour Organization (ILO) Ukraine, together with consultants from the Ministry of Health, have supported the government in developing a National Strategic Programme on HIV/AIDS for 2006-2010 and in amending national legislation on HIV/AIDS. The team has also conducted training sessions to promote a National Strategy of Tripartite Partnership on HIV/AIDS. This partnership brings together government officials, representatives of employers and representatives of workers to promote one national strategy to fight HIV in the workplace.

ILO Ukraine has also offered technical assistance in breaking down the national strategic plan into concrete activities. Since 2003 it has trained more than 100 trainers for the development of workplace policies and programmes for voluntary counselling and testing, and has assisted in publishing a manual to foster the implementation of such programmes.

Results

This marks the first time that HIV programming in the workplace has been made part of Ukraine's National Programme, and the first time that government officials, employers and workers are collaborating to promote such initiatives. As a result, it is expected that knowledge about HIV will fan out through Ukrainian society. The tripartite partnership now enjoys representation on the National Coordination Council on HIV/AIDS and the GTZ-ILO initiative has created opportunities for Ukraine to work with other UN agencies: for example, in promoting social dialogue and legal reforms.

EXAMPLE

Tanzania implements a multi-sectoral strategic framework to fight HIV[4]

Context

Tanzania is burdened with a serious, generalized HIV epidemic (6.5% of adults aged 15-49 were HIV-positive in 2005) that is threatening to reverse the progress towards development made in the post-colonial era. In 2001, an Act of Parliament established the Tanzania Commission for AIDS (TACAIDS) and charged it with developing a multisectoral national response to the epidemic. TACAIDS worked with a broad range of stakeholders to develop Tanzania's Multisectoral Strategic Framework (NMSF) on HIV/AIDS for the period 2003-2007. Since 2001 also, domestic funding of the AIDS response has more than doubled.

To further encourage a multisectoral response and build capacity at the decentralized level, Multisectoral AIDS Committees in councils (CMACs) and wards (WMACs) have been established. These are meant to serve as key mechanisms to increase community awareness of HIV, monitoring of programmes and bottom-up communications about the appropriateness of national policies – and ways to improve them.

Technical support

At the national level, GTZ financed a consultant to assist in the formulation of the Strategic Framework: e.g., with its situational analysis, structure, definition of strategic activities and choice of M&E indicators. Technical advisors hired by GTZ are now also helping to establish a process and committee for the review of the Framework. The findings will be used to revise the document for the next five year phase, 2007–2011.

At the local level, a TACAIDS quality assurance team, in collaboration with GTZ and two consulting agencies (evaplan/University of Heidelberg and HealthScope Tanzania), have helped to implement the multisectoral response and to provide technical assistance in building the capacity of CMAC and WMAC members. A baseline survey had shown that many of the committees faced major obstacles in their initial work: for example, members were not appointed in a timely manner and capacity to manage and monitor projects was low. Training programmes and materials were thus developed by TACAIDS and its partners, and 50 facilitators were recruited and trained to begin making use of the materials in districts and wards.

Results

Nearly all ministries have developed strategic plans to mainstream AIDS, and all local government authorities have multisectoral AIDS committees with legal status. By July 2005, the CMACs had also made progress. Most had held regular meetings, retained their members, received assistance from the Regional Administrative Secretariats and many had developed their own multisectoral plans. By the end of 2006, all local government authorities had established multisectoral AIDS committees with legal status, and civil society organizations were seen as partners and stakeholders in the national response to HIV. Development partners have signed a memorandum of understanding with the government to support the implementation of the National Multisectoral Strategic Framework. In short, Tanzania has effectively established a multisectoral response to HIV.

5. Selected reading

1 Guide to the Strategic Planning Process for a National Response to HIV/AIDS, Introduction. UNAIDS, 1998, p. 3.

2 Supporting Improved Strategic Planning for HIV/AIDS: AIDS Strategy and Action Plan (ASAP) – Business Plan, 2006-2008. Draft for Discussion. UNAIDS and World Bank, 2006, in particular, p. 12-13.

3 Mainstreaming AIDS in Development Instruments and Processes at the National Level: A review of experiences. UNAIDS, UNDP and World Bank, 2005.

Mainstreaming HIV and AIDS in sectors and programmes: An implementation guide for national responses. UNAIDS, UNDP and World Bank, 2005.

Mainstreaming HIV/AIDS Programs into development instruments: Experience of the Africa Region with HIPC-PRSP, Presentation. World Bank, 2006.

4 Bringing the AIDS Response Home: Empowering District and Local Authorities in Lesotho, Tanzania and Mpumalanga, South Africa. GTZ HIV Practice Collection, 2006.

HIV/AIDS, Tuberculosis and Malaria: Strategic Planning and Innovation. WHO, 2004.

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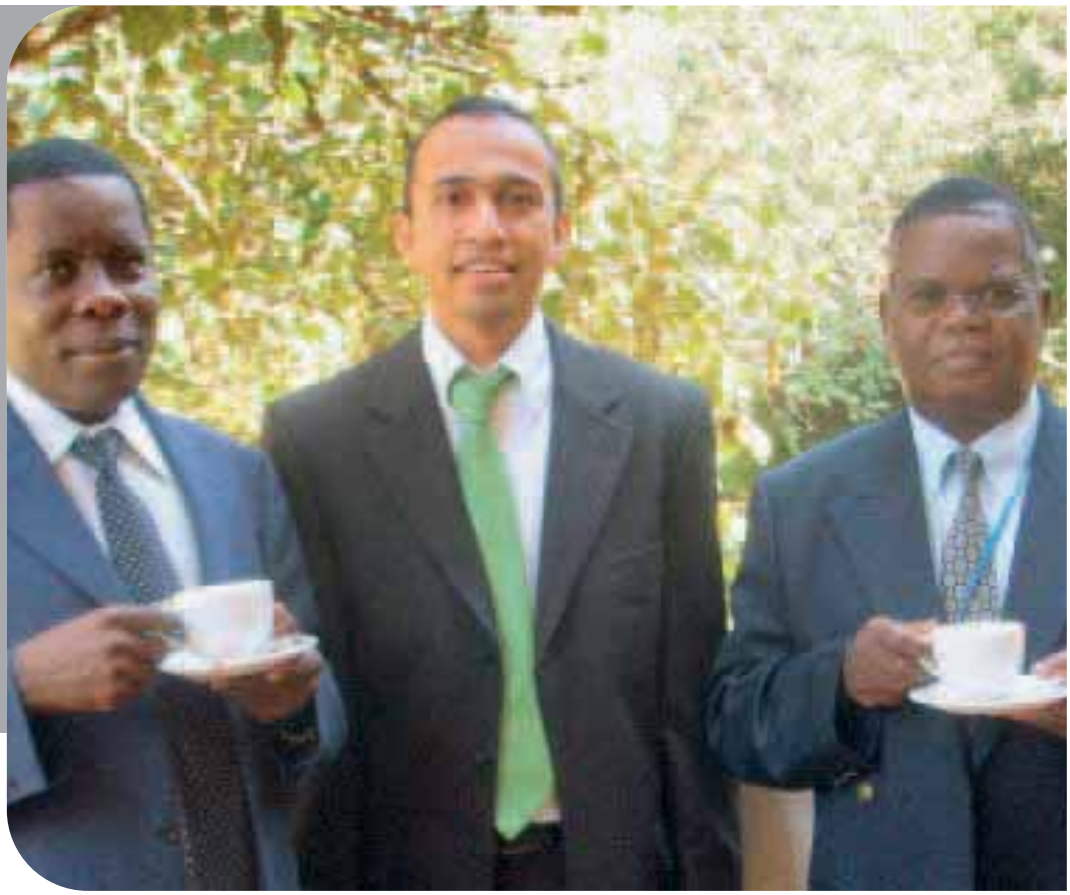


Accessing financial resources

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section looks at ways that government institutions, organizations and programmes can access international funding and mobilize national and local resources to scale up health services. It describes the roles played by recipient countries and local actors in mobilizing resources, identifies opportunities for collaboration with private enterprises and gives examples of how technical support can assist in building capacity to tap new sources of health financing.

Why is this topic important? Vastly increased and more sustainable resources are needed to provide universal access to HIV prevention, treatment and care by 2010 and to achieve the Millennium Development Goals by 2015. While global health financing has dramatically increased in recent years, the gap between available and required funds is still growing. In addition, the low capacity of health systems is preventing many countries from gaining support from the Global Fund and other international sources. These countries need help simply to prime the pump of health financing, so that they can begin to develop their capacity. Furthermore, at the regional, district and local level money and other resources are often scarce or health care managers do not know how to unblock existing resources. Technical support to tap resources can help countries to become more accountable to global health financing mechanisms.

What sources of health financing can be accessed by countries?

A broad spectrum of health financing and other support for programmes at national and decentralized levels are now available from domestic, private, bilateral and multilateral sources. The following list includes entities according to their volume of financing and accessibility, but does not claim to be comprehensive.

Domestic sources

These are growing, gradually. At the national level, UNAIDS projects, for example, that funding from domestic sources for the HIV-response in low and middle income countries will increase from US$ 2.6 billion in 2005 to US$ 3 billion in 2007. About 30% of total spending on HIV in these countries now comes from domestic sources; however, most governments of low income countries have yet to boost their investments in health significantly (see the UNAIDS 2006 report on financing the response to AIDS).

African countries, for instance, have fallen far short of their commitment to raise health financing to at least 15% of total spending as vowed in the Abuja Declaration of 2001. This demonstrates that countries still face many challenges in unblocking additional domestic sources, and should benefit from technical support to create advocacy and to overcome these challenges.

Private sector sources

These include private contributions from international and national sources such as multinational corporations, foundations, companies, nongovernmental organizations (NGOs), charities and individuals. The largest private international donor is the Bill and Melinda Gates Foundation, which has an endowment worth $31.9 billion. Since its inception in 2000, it has allocated $6 billion in health grants.

Another major donor is the William J. Clinton Foundation, which strives to make treatment for HIV more affordable and to implement large-scale integrated prevention, treatment and care programmes.

There are also private European foundations, which are estimated to have contributed US$ 93 million in 2005 to HIV programmes in the developing world – a threefold increase since 2003.

"Hidden" private sources of support at the local and national level

Private companies, NGOs and other agencies at the local and national levels are increasingly inclined to privately support health initiatives. This assistance may be financial or in-kind. Examples include cash contributions (corporations match funds raised by employees in exchange for public recognition), co-investment (companies extend services developed for their employees to the wider community) or income-generating activities (shops and restaurants in a hospital, a vegetable garden and a gas station are three recent examples). As well, organizations can contribute by offering in-kind assistance (provision of space or use of transport and distribution systems), pro-bono services (expertise in programme management or for communication processes) or advocacy and leadership of a prominent person. Even in the poorest settings, one can often find such "hidden" sources of support.

Bilateral cooperation

This refers to aid and assistance given by one country to another, for development programmes and projects. Major bilateral donors and their executing agencies provide most of the world's development assistance. The nature of the support is negotiated by the two governments.

For example, estimated disbursements of bilateral assistance for HIV from the 23 major donor countries in the Organization for Economic Cooperation and Development (OECD) amounted to $2.7 billion in 2005, or 77% of the $3.5 billion committed in that year. A Kaiser Family Foundation report gives details of this assistance. Additionally, foreign embassies in many countries provide small amounts of aid to projects or programmes in line with general agreements. Information can be accessed via country-specific presentations of the embassies. For example, small scale projects in Tanzania are financed by the German Embassy.

Together with the U.S. Centers for Disease Control and Prevention (CDC) and other federal partners, the U.S. Agency for International Development (USAID) is leading the President's Emergency Plan for AIDS Relief (PEPFAR), which will allocate $15 billion to prevention, treatment and care programmes in the five-year period ending 2008 – most of this in 15 focus countries. In 2006 about 20% of planned funding was for prevention, 50% for treatment and 28% for care (including orphans and vulnerable children).

In May 2007, the U.S. government announced to contribute an additional $ 30 billion to respond to HIV over the coming 5 years. PEPFAR's web site includes information about the cooperation of federal partners as well as details regarding eligibility and guidance under PEPFAR.

A recent report by the U.S. Government Accountability Office (GAO) criticized PEPFAR for promoting abstinence and being faithful to one's partner at the expense of promoting condom use; and it raised questions about the low priority given to reducing HIV transmission among injecting drug users and sex workers. See also the web page of AVERT for further information.

Multilateral financing

This category refers to joint financing by a large number of states. Multilateral sources of financing for HIV, tuberculosis and malaria are increasing. The largest such sources are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and the United Nations.

By December 2006, the Global Fund had approved $5.3 billion in grants to 132 countries, of which $3.24 billion had been disbursed. About 40% of its funding has been for HIV programmes, 27% for tuberculosis, 27% for malaria, and 6% for general health system strengthening. The Fund usually makes demand-driven grants only: to countries and organizations that apply for funding. Applications are submitted by representative Country Coordinating Mechanisms (CCMs, see Section 4). The highest priority is given to countries and regions with the greatest need, highest burden of disease or risk of disease and the fewest resources to address these health problems. A full list of eligibility criteria are published on the Fund's web site. The Aidspan Guide to Round 7 Applications to the Global Fund (2007) and other AIDSPAN publications also provide useful information for applicants.

As of 2006, the World Bank had committed more than US$ 1.8 billion in grants, loans and credits to HIV programmes in 29 African countries and four sub-regional programmes. Most of this flowed through its Multi-country HIV/AIDS Program for Africa (MAP). Eligibility criteria include satisfactory evidence of a strategic approach to HIV, existence of a high-level HIV coordinating body, government commitment and agreement by the government to use multiple implementation agencies. Further information about MAP is available on the internet. The World Bank's Global HIV/AIDS Program also supports efforts to expand access to antiretroviral therapy and to strengthen health systems, as well as for prevention and education. The Bank tries to emphasize support for community-level projects and to avoid bureaucracy. These programmes typically entail many small transactions and require carefully designed accounting procedures, as funds flow from the National AIDS Coordinating Authorities to intermediary bodies, and from there to community-level organizations. For details, see the World Bank HIV/AIDS Program's 2005 Guidance Note on Disbursement Procedures.

The International Finance Corporation (IFC) is the private-sector arm of the World Bank Group. It aims to engage major corporations in developing countries to play an intermediary role in capacity development of local organizations. For investments in the private sector, IFC's 179 member countries provide authorized share capital of $2.45 billion. Project support typically ranges from $1 million to $100 million and can cover up to half of the eligible costs incurred in a project for up to 18 months.

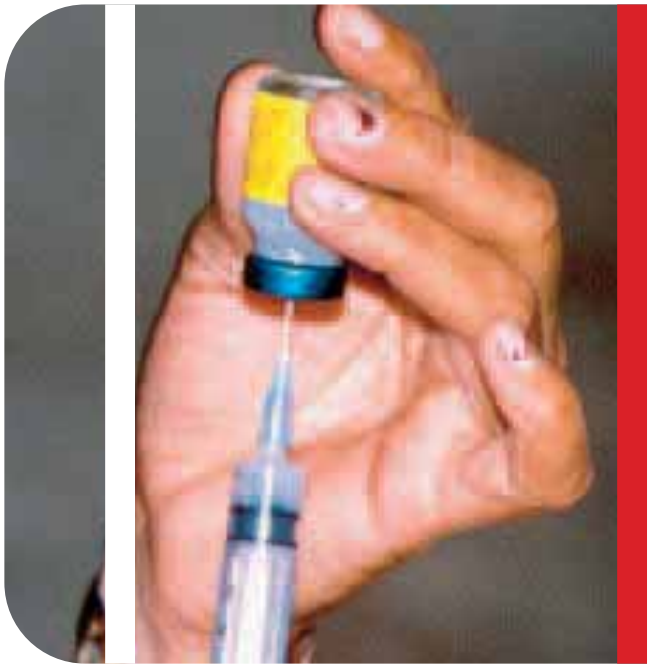
Numerous entities within the United Nations system carry out activities in support of health. Each provides varying levels of project assistance to countries and a significant amount of technical assistance. Funding used by UN entities to support HIV activities mostly comes from specific HIV-related donor contributions (e.g., funding for UNAIDS) or general contributions by member countries. The two-year budget for 2006-2007 is $2.6 billion.

For 2003-2006, the European Commission (EC) allocated about US$ 450 million (351 million euros) for innovative initiatives to improve effectiveness and efficiency in prevention, treatment and care. The EC web site provides general information about this funding and details on eligibility and disbursement criteria. Further general information is available in a report by the Kaiser Family Foundation.

The Global Alliance for Vaccines and Immunization (GAVI) was created as a financing instrument to support immunization goals. It now has over $3 billion in commitments for the next ten years from the governments of several countries. GAVI provides funding to help governments strengthen their basic immunization services and health systems.

Innovative mechanisms of sustainable health financing

With its secretariat at WHO, UNITAID, an international drug purchasing facility, will be



funded from a number of sources, including a tax on air fares. France introduced the new tax in July 2006 and hopes to raise $238 million annually. More than 43 other countries have also agreed to participate in a pilot group on innovative funding.

First proposed by the United Kingdom, the International Finance Facility aims to raise $50 billion a year in development assistance between now and 2015 through international capital (bond) markets. A smaller facility dedicated for immunizing children against diseases in low income countries (IFFIm) was launched in September 2005 by European countries. The "International development" section of the web site of Her Majesty's Treasury (UK) provides details about the Facility.

2. Challenges: barriers to accessing resources

The plethora of new resources becoming available is too often beyond the reach of many ministries of health and health service organizations owing to barriers at the global, national and local levels. Some of the most common barriers are listed below.

Weak tax systems, corruption: Governments of low and middle income countries are losing billions of dollars each year owing to leaky tax systems and corruption. A new study shows, for example, that if low income countries were to strengthen financial administration and abolish tax exemptions for transnational corporations, revenues would increase by about US$ 140 billion per year[1].

Disharmony: Respect of the UNAIDS "Three Ones" helps in the management of resources; yet disrespect tends to be the rule rather than the exception at country-level, leading to poor alignment, lack of harmonization and, as a result, fragmented and substandard programmes.

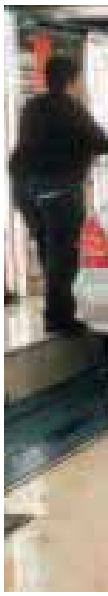
Weak coordinating bodies: Country Coordinating Mechanisms – and other national coordinating bodies – have been unable or unwilling to attract significant corporate resources. As well the bureaucracy of some CCMs is cumbersome.

Complex application procedures: Some applicants have found the processes for applying to the Global Fund, World Bank and other agencies complex and unwieldy. CCMs often lack the know-how to develop strong proposals for the Global Fund and thus fail to receive financial resources.

Antagonism, inexperience: Owing to their different organizational cultures and other factors, business people, government officials and members of the general public do not always work well together. Competition between ministries of health and nongovernmental organizations, and between different business interests has sometimes undermined partnerships for scaling up health services. As well, private corporations seldom have experience in running community-based health programmes and may be afraid of financial liabilities.

Low capacity, poor infrastructure: Organizations and health agencies working at the local level often lack staff with the skills and knowledge needed to apply successfully for funding. Also a lack of cooperation among agencies, secretive or opaque systems for distributing funds and poor local fundraising mechanisms inhibit efforts to scale up responses to diseases.

Lack of information, ignorance of best practices: Government, organizations and health care providers are often unaware of effective measures and innovative programmes implemented in neighbouring countries – for example, to learn from public-private partnerships (PPP) in other countries to expand prevention, treatment and care services.



3. Technical support: tapping new sources of health financing

Capacity development in many aspects of public health programming can help health care administrators and providers to address some of these challenges and to mobilize resources. Support can help countries to exercise greater accountability and make better use of resources – great virtues in the eyes of donors. Technical support is available in the following specific areas to develop capacity for tapping new resources:

Connecting partners, building networks: Mobilizing resources becomes easier when stakeholders from multiple sectors communicate with one another. Technical experts can help organizations and government institutions to find appropriate partners and donors, establish processes and platforms for cooperation and exchange best practices. This promotes the "Three Ones", reduces duplication and helps choosing the most appropriate modes of funding.

- The World Bank provides a tool known as Client Connection, which allows partners to access and compare country-specific information related to grants, credits, trust funds etc. through its web site.

Grant proposals: Assistance is available to governments, CCMs, civil society organizations and private corporations to help in the development of proposals for Global Fund grants, and for financing from other multilateral and bilateral donors. Support is available for drafting budgets, planning for data collection and identifying appropriate technical support. Three useful resources are:

- Aidspan guides for developing Global Fund proposals, which provide detailed practical advice.

- A guide by Physicians for Human Rights on using the Global Fund to support health system strengthening. This focuses on preparation of proposals for the Global Fund.

- A short course on consultancy skills in proposal development is offered by the University of Heidelberg.

Public-private partnerships: PPPs are partnerships of public (state) agencies and private corporations or NGOs. PPPs always involve at least one private for-profit organization and at least one not-for-profit or public organization. Corporations often need guidance about possible public-private partnerships and the processes to be followed. Technical support can help to identify promising opportunities for partnerships, help to overcome antagonism between public and

private stakeholders, use advocacy to advance projects, and promote best practices. Support and expertise in mobilizing PPPs is for example available from these bodies:

- German Technical Cooperation (GTZ) has invested heavily in an approach known as (public-private) co-investment. GTZ's multilevel involvement, with the private as well as the public sector, opens up a wide range of possible contributions to co-investment[2]. The example at the end of this section and GTZ's public-private partnerships web pages provide further information.

- Global Business Coalition (GBC) brings international companies into one network dedicated to combating the HIV epidemic using the business sector's skills and expertise. The GBC web site provides information about companies that are already engaged in, or willing to enter, PPPs.

- African Comprehensive HIV/AIDS Partnerships (ACHAP) is a country-led, public-private partnership between the Government of Botswana, the Bill & Melinda Gates Foundation, and the Merck Company Foundation/Merck & Co. It is dedicated to supporting and enhancing Botswana's national response to HIV.

- PharmAccess Foundation, established by the University of Amsterdam, establishes PPPs to link private sector facilities with public sector health care to expand HIV programmes in communities.

Developing capacity of civil society to raise funds: Technical assistance can provide organizations with tools and techniques to exploit their capacity in this critical area (see also Section 5). This may call for an assessment of an organization's mission, its strengths and weaknesses, financial status, the important features of its programmes and the unique abilities of its staff. It helps organizations to advocate for their comparative advantages and to raise funds at the local, district and national levels. Specific tools available include:

- An International HIV/AIDS Alliance toolkit for NGOs on raising funds and mobilising resources for HIV work.
- A Financial Management Assessment Tool (FIMAT) developed by Management Sciences for Health (MSH) to improve the capacity of organizations to manage their financial resources.
- The World Bank Guide to Resources for NGOs.

More generally, the Guide to Reproductive Health, HIV/AIDS and Population Assistance by the German Foundation for World Population (DSW) offers detailed information about funding in the European Union. This is complemented by tips and tricks on how to apply for the European Commission budget lines and on how to access technical support to identify funding sources. The International Labour Organization has also published a helpful guide, which offers detailed information on TA providers for resource mobilization. An overview of global and domestic funding for HIV can be found at the web sites of the international charity AVERT. For general support on accessing resources including all the above mentioned aspects, refer also to the list of TA providers in Annex I.

EXAMPLE

4. Example: accelerating co-investment in Kenya and Malawi

Context

Co-investment is a form of public-private partnership to scale up HIV prevention, treatment and care for people outside office or company gates[3]. Done properly, it benefits everyone: Companies receive public funds and other support (political leadership, quality assurance, surveillance, monitoring and evaluation, for example) to extend their programmes into the wider community and, in doing so, sustain their efforts in prevention, treatment and care. And public services expand swiftly, by building on existing programmes and infrastructure developed by private companies.

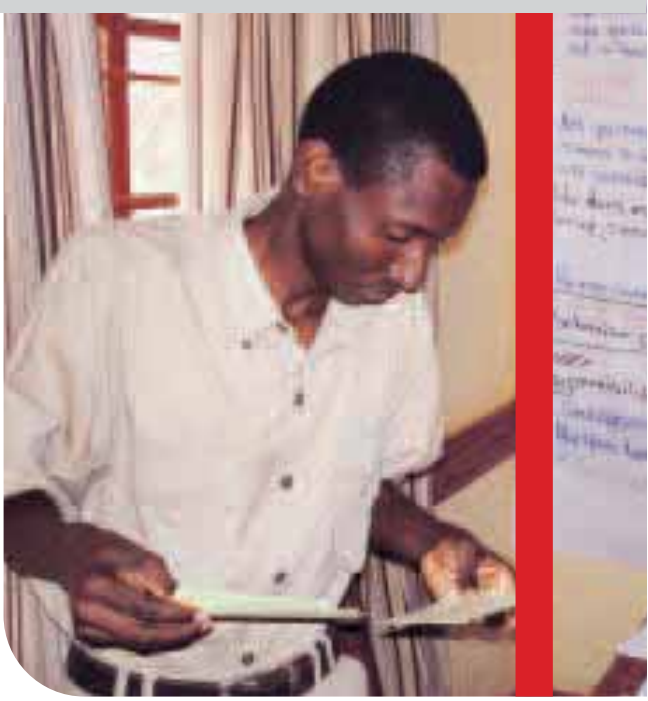
Donors and agencies at all levels are willing to support co-investment. The International Labour Organization recommends a multisectoral approach to co-investment, and advises that different partners take on the roles for which they have a comparative advantage. The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria, which represents more than 200 international companies, provides expertise in coordinating co-investments. Multinational organizations such as the Global Fund, ILO, UNAIDS, the World Bank and WHO can provide funding and technical support for co-investment, as can many bilateral agencies, such as GTZ. At the national level, many Country Coordinating Mechanisms are able to support co-investments; and at the local level, health authorities, chambers of commerce, small and medium-size enterprises and community organizations may also provide local knowledge, space, and other resources.

Technical support

In Kenya, Unilever Tea has signed a contract with GTZ to receive technical and financial assistance for a two-year project that will extend the company's successful programmes for HIV – which already benefit 18000 employees and their families – to a neighbouring community[2]. The project focuses on prevention services for young people and outreach to more than 300 small tea farms, Unilever's out-growers. It also engages the Kenya Tea Growers Association in the promotion of similar HIV workplace interventions throughout the sector. This Association has 57 companies employing up to 100 000 workers. The financial commitment from the private sector (Unilever) and the public sector (GTZ) is close to 50-50. As well, GTZ has provided technical assistance on how to extend existing HIV services.

In Malawi, the government has mandated the Malawi Business Coalition against HIV/AIDS[4] to coordinate the private sector's participation in the national programme to scale up antiretroviral therapy (ART). The coalition provides technical assistance for capacity building, quality assurance and

EXAMPLE



resource mobilization for private companies that participate. It also meets regularly with the Ministry of Health and companies and their clinicians to monitor the programme and address any problems.

Results

Kenya's Unilever co-investment scheme could soon extend health services to hundreds of thousands of people and is setting an example for the wider Kenyan business community in modes of expanding workplace programmes for HIV and demonstrates how bilateral partners can support such co-investment.

Under Malawi's co-investment initiative, no fewer than 28 private sector health clinics (18 of which are for-profit; 10 run by companies for their employees) have been accredited to provide antiretroviral therapy. The company clinics now treat dependents as well as their employees, and two of the clinics are open to the general public. The other health facilities serve a broader range of private sector employees than previously. In a six-month period, the private clinics were able to provide ART to nearly 1600 patients, contributing to Malawi's swift progress in scaling up.

5. Selected reading

1 What If Developing Countries Could Finance Poverty Eradication from Their Own Public Resources? Global Policy Forum, 2006.

2 Making Co-investment a Reality: Strategies and Experiences. GTZ et al., 2005.

3 HIV/AIDS workplace programmes and Public-Private Partnerships (PPP) through co-investment – extension of treatment and care into the community. ILO et al., 2005.

4 Malawi Business Coalition Against HIV/AIDS (MBCA) Profile. World Economic Forum, 2006.

Mobilizing Additional Resources for the Global Fund: A Planning Guide for the Private Sector. Global Fund to Fight AIDS, Tuberculosis and Malaria, 2005.

Mobilizing Local Resources to Support Health Programs. Management Sciences for Health, 2006.

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4

National coordination and management

gtz BACKUP Initiative

commissioned by:
Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section describes the national bodies in place which coordinate and manage responses to HIV, tuberculosis, malaria and other diseases. It highlights some of the challenges these bodies face and shows how they can use technical support to overcome these challenges. The section ends with three examples of how technical expertise can support coordinating bodies and make them benefit from global health financing.

Why is this topic important? Coordinating and managing structures need to be strengthened to enable countries to attract and make best use of global health financing. Major donors often require strengthened and more representative coordinating bodies, and release money only incrementally, as national coordinating and managing bodies demonstrate that they are accountable and effective. Strengthened coordinating structures are also more likely to encourage harmonization and ownership – another asset in attracting funds.

Coordinating and managing bodies: who's who?

Countries attempting to scale up their responses to epidemics need to sustain national bodies to manage programmes for prevention, treatment and care. These bodies should include different stakeholders, allow for transparent decision-making and be able to attract and manage global financing. Governments can increase the effectiveness and credibility of these structures by investing more in them and providing them with sufficient human resources.

The national bodies may include Country Coordinating Mechanisms (CCMs), as required for applications to the Global Fund; National AIDS Coordinating Authorities (NACs), which cooperate with the World Bank Multi-Country AIDS Program (MAP); UN Theme Groups, which coordinate the work of UN agencies on HIV at country-level; and Principal Recipients (PR), those responsible for implementing Global Fund grants.

Country Coordinating Mechanisms (CCMs)

Country Coordinating Mechanisms[1] are required to be broadly representative, with members from the ministry of health and other relevant ministries, the private sector, faith-based organizations, community organizations, self-help groups, people living with HIV, multilateral/bilateral organizations and educational and research institutions. It is also recommended that they include representatives from districts or establish sub-national CCMs. For sake of efficiency and effectiveness, however, the Global Fund encourages these mechanisms to balance

the need for broad representation with the need to remain at a manageable size. Many CCMs have also established one or more committees, to share the burden of work and make best use of expertise.

Country Coordinating Mechanisms: roles and tasks

- Prepare and submit national proposals for Global Fund grant(s).
- Select Principal Recipients of grant(s).
- Monitor implementation of grant(s), approve necessary changes in implementation plans.
- Oversee the performance of funded programmes and of PRs.
- Submit requests for continued (i.e., Phase 2) funding to the Global Fund.
- Ensure linkages and consistency between programmes financed by Global Fund, etc..

National AIDS Coordinating Authorities (NACs)

National AIDS Coordinating Authorities[2] are usually made up of a council (or committee) and a secretariat, as required for access to World Bank financing. The council should include senior officials from the Office of the President or Prime Minister and Office of the Cabinet, and representatives from the ministry of health, the national assembly or parliament and from major donors, the private sector, civil society organizations (CSOs) and organizations representing people living with HIV. The secretariat provides administrative and technical support to the council and coordinates multisectoral HIV programmes funded by the government and development partners. Usually, NACs have decentralized structures with representatives from public and private sectors at all levels, to remain as close as possible to the actual beneficiaries of financing.

National AIDS Coordinating Authorities: roles and tasks

- Take a leading role in national advocacy for HIV, pushing for coordinated responses.
- Oversee development of HIV policies and legislation, for approval by government.
- Guide the formulation, review and revision of a national HIV strategy and annual priority action plans with budgets.
- Review and approve annual action plans and budgets developed by all departments.
- Review and make decisions on proposed national projects and programmes.
- Monitor and evaluate HIV programmes.
- Manage and channel approved grants to lower levels (MAP grants).

UN Theme Groups

UN Theme Groups[3] act as coordinating bodies for UN agencies to bring together international donors and local groups. Each Theme Group is meant to serve as a forum to plan, manage and monitor a coordinated UN-system response. A major role of the Theme Groups is to promote and provide space for multisectoral partnerships on HIV, led by government and including CCMs, NACs, CSOs, the private sector and other key stakeholders.

Principal Recipients (PRs) and Sub-recipients (SRs)

Principal Recipients are country-based agencies or organizations that are legally responsible and financially accountable for the dispersal of Global Fund grants. They are also charged with programme implementation consistent with the original proposal. The nomination of PRs and additional Sub-recipients must be confirmed by the Global Fund[4]. To ensure that funding is effective, the Global Fund recommends that, from Round 8 on, all country proposals nominate two PRs: one governmental body (for example, the ministry of health) and one nongovernmental organization. If a proposal does not include both types of PR, the reason for this must be explained[5]. Sub-recipients that implement grants on the decentralized level can stem from various areas e.g. NGOs, FBOs, private sector companies etc..

Down with duplication; respect the Second One!

In June 2006, UNAIDS asked the Global Fund and other partners to accelerate the harmonization of country-level activities by paying particular attention to the second of the Three Ones Principles – one agreed national coordinating authority. The national coordinating authority should thus take the lead in reducing duplication between the CCM and any other national coordinating authority, retaining the best features of both (i.e., the inclusive nature of CCMs), and consider eventual mergers where appropriate[6].

Can coordinating bodies serve a variety of donors?

Yes. The Global Task Team recommendations of 2005 and the UN Three Ones Principles encourage donors to align their coordinating and management structures with national structures to avoid duplication. National bodies are encouraged to serve a variety of donors. For example, a National AIDS Coordinating Authority can serve as a CCM at the same time cooperating with different donors. Eligibility for financing is not compromised by this sort of fusion, as long as the coordinating bodies respect specific rules – about conflicts of interest, for example. These coordinating bodies can provide fora for partners also participating in UN Theme Groups, National Steering Committees for Tuberculosis Control or joint inter-agency committees for Sector-Wide Approaches (SWAps). To promote coherent health policies, these bodies should ensure that proposals and approved grants contribute to – or are embedded in – national health strategies, Poverty Reduction Strategies and SWAps*.

* A Sector-Wide Approach (SWAp) to international development brings together governments, donors and other stakeholders within one sector. They aim to support a set of operating principles that allow for the broadening of policy dialogue, development of a single sector policy and a common realistic expenditure programme. Countries that have implemented Poverty Reduction Strategy Papers (PRSP) often agree to SWAps in exchange for debt relief.

2. Challenges: problem areas in coordination and management

Experience has shown that coordinating and managing bodies – CCMs, NACs, PRs and SRs, in particular – face challenges in several areas. These areas include:

Low participation and secrecy: Coordinating bodies often have difficulties in adhering to the guidelines and principles established by partners such as the Global Fund. These guidelines and principles ask for participatory processes and transparency in grant application and implementation. Coordinating bodies, however, often include only a few partners and do not work transparently. CCMs may, for example, not be transparent about the process for selecting the Principal Recipient of a grant.

Disharmony: Harmonization among coordinating and implementing bodies is required under the Three Ones, but countries seldom achieve this. Also, where there is disharmony there is often limited communication and information-sharing between different national bodies.

Weak management: The managerial skills of coordinating bodies are often underdeveloped, resulting in weak applications for grants, slow or inadequate dispersal of grant money and ineffective implementation of activities. Poorly managed coordinating bodies may not contribute effectively to the design and implementation of plans, and are hence not accountable to stakeholders and donors. For example, negotiation and managerial skills of Principal Recipients and Sub-recipients are frequently weak and may not meet requirements at the national and local levels.

Inadequate leadership of mainstreaming: NACs often lack capacity to lead the AIDS mainstreaming process. As a result, Poverty Reduction Strategies, national AIDS frameworks and sectoral plans may be badly aligned and ministries may not receive the support they need from NACs to develop realistic annual plans.

Monitoring and oversight: Coordinating bodies may also lack the skills to monitor and provide effective oversight of the implementation of grants. Too often they have insufficient knowledge to review approaches, track outcomes, report adequately and harmonize the monitoring and evaluation (M&E) required of all stakeholders.

3. Technical support: developing capacity to coordinate

Technical support can help countries tackling these problems and provide them with appropriate solutions to increase accountability and the continued flow of health care financing. TS includes expertise and tools as follows:

Participatory and transparent processes: Expertise can help coordinating and managing bodies to establish transparent and participatory processes that address the principles and requirements of all stakeholders. This includes processes for choosing members of national bodies, especially CCMs and PRs, for developing grant applications and for implementing approved grants. There are also tools available supporting national authorities in their efforts to improve transparency and develop more structured processes:

- Global Fund guidelines on the purpose, structure and composition of CCMs.
- Global Fund documentation clarifying CCM minimum requirements.
- A synthesis of lessons learnt about NACs, published by the United Kingdom's Department for International Development (DFID).
- An Aidspan guide to building and running an effective CCM.

Harmonization: Technical experts and tools can help coordinating and implementing bodies to align their activities, improve their communications and share knowledge. For example, HIV activities of different coordinating entities can be aligned and monitored jointly; as well, technical assistance can help in the translation of documents into local languages. A useful resource is the

- UNAIDS country harmonization and alignment tool (CHAT).

Management: Technical support is also available to develop the managerial skills of coordinating and managing bodies, which helps them to better perform their roles and tasks, implement grants and disperse money. For example, negotiation and managerial skills of Principal Recipients and Subrecipients can be strengthened. As well, these tools are available:

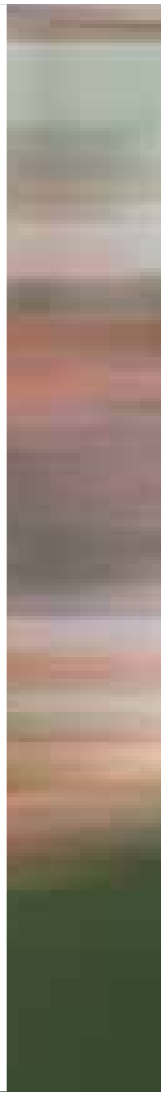
- A Global Fund CCM Performance Checklist and the User's Guide to this checklist.
- Aidspan's guide to building and running an effective CCM.
- The Global Fund's guidelines for the Principal Recipient assessment.

NAC leadership in mainstreaming AIDS: TS in this area could include making the case in ministries of finance and planning for an appropriate level of inclusion of HIV in the PRSP and other instruments, such as the national budget (see Section 2). Refer also to:

- A synthesis of lessons learnt on NACs by DFID.

Monitoring and evaluation: All coordinating and managing bodies can benefit from expertise in developing appropriate monitoring and evaluation systems (see also Section 9) and harmonizing them with national systems. Support is available for training in M&E at all levels; review and development of reporting formats and tools; performance of outcome and impact studies and the development of disease surveillance systems. Helpful tools and resources include:

- Tools on the assessment of CCMs published by the Global Fund Technical Evaluation Reference Group Report (TERG).
- The CCM Performance Checklist by the Global Fund.
- A monitoring and evaluation operations manual by UNAIDS and the World Bank.



- A monitoring and evaluation systems strengthening tool developed by the Global Fund, U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and others.

Additional information on coordinating and managing bodies, on tools available and on access to technical support can be found in the World Bank's Generic Operations Manual (GOM) for Multi-Country HIV/AIDS Programs in Africa and in the Aidspan Guide to Obtaining Global Fund-Related Technical Assistance. For a detailed list of technical support providers see Annex I.

EXAMPLE

4. Examples: stronger mechanisms, better managers

Support for CCMs in Southeast Asia

Context

Cambodia, the Lao People's Democratic Republic and the Philippines are addressing HIV epidemics of varying magnitude. Cambodia is burdened with one of the worst HIV epidemics in Asia, with about 1.6% of adults aged 15-49 living with HIV. Laos and the Philippines have, by contrast, experienced very limited epidemics, with national adult prevalence of under 0.1%.

Technical support

All three countries have received Global Fund grants to respond to AIDS, tuberculosis and malaria, and have been keen to benefit from technical support to make best use of this funding. In consultation with the countries, BACKUP supported a training initiative that aimed to strengthen the capacity of their Country Coordinating Mechanisms, Principal Recipients and other implementing organizations.

This training initiative which took place in 2004-2005 aimed to achieve three goals:

- Strengthen the coordination, management and grant proposal-writing of CCMs, their secretariats and other stakeholders.
- Better understanding of policies related to migration and mobile populations in the region.
- Strengthening of monitoring and evaluation of HIV and other disease programmes.

Representatives of the CCMs and grant holders (PR and/or Sub-recipients) from the three countries collaborated with independent consultants and the Southeast Asia Ministers of Education Organization (SEAMEO) Tropical Medicine and Public Health Network in planning the initiative, participated in regional and national workshops and, when appropriate, brought in counterparts from other countries in the region and other disease areas such as tuberculosis and malaria, to learn more and coordinate their work.

Activities included a workshop on leadership, coordination, Global Fund work and planning of national workshops, which led to the restructuring of PR and CCM secretariat and training in financial management and improvement of reporting systems. The initiative also allowed for regional and national workshops on proposal writing. The Philippines workshop, for example, generated three revised proposals, and a revised proposal development process that ensured input from experts working on malaria and tuberculosis as well as HIV.

Results

Overall, participants agree that the SEAMEO/GTZ regional initiative allowed CCMs and grant recipients to improve the effectiveness and efficiency of their work, while contributing generally to stronger health systems. It also generated new links for the sharing of information and stimulated healthy competition among groups in the three countries.

EXAMPLE

El Salvador: clear rules strengthen country's response to HIV and tuberculosis

Context

In El Salvador, the work of the CCM established in 2002 was hampered by low participation, poor control of funds and confusion about the roles of members of the CCM and the PR. There was a general need for El Salvador's CCM to strengthen its structure, and a specific need to design a methodology for the development of a participatory approach to prevention strategies as part of the Global Fund-financed project.

Technical support

The BACKUP Initiative paid for a consultant to provide technical assistance to strengthen the strategic management of El Salvador's CCM and implementation of the country's Global Fund grant proposal. This consultant helped to develop two critical documents:

- Statutes and regulations that define the role of the CCM, its objectives, composition, electoral procedures and other functions. The document also defines the relations that the CCM will have with strategic partners, including the Principal Recipient.
- An operational plan that is guiding the technical management of the CCM, and clarifying the steps by which it will monitor and evaluate the implementation of its grant.

Results

In 2005, an external evaluation, conducted by the DFID Health System Resource Centre, concluded that the technical support strengthened the CCM and built the capacity that it needs to implement the Global Fund grant. The evaluators also found that it provided a mechanism to promote broader participation in the CCM. As a result, representatives of civil society and government are for the first time discussing the implementation of HIV and tuberculosis treatment programmes. Finally, the technical support helped the CCM harmonize its work with other agencies: for example, by forging links with the technical working groups of El Salvador's HIV and the tuberculosis programme.

EXAMPLE

Niger and Chad: strengthening the capacity of Principal Recipients

Context

Niger and Chad have both received Global Fund grants to address serious disease epidemics, and had trouble implementing them owing to the weak capacity of their coordinating bodies.

One year after Niger had gained funding for its HIV programmes from the Global Fund, little had been achieved with the money. The Principal Recipient, Coordination Intersectorielle de Lutte contre les IST/VIH/SIDA (CISLS), the NAC of Niger, was overburdened, as it was also in charge of major financing from the World Bank MAP. It, therefore, asked for technical support from the World Bank and the BACKUP Initiative.

Chad gained funding for its tuberculosis and HIV programmes in Rounds 2 and 3 of the Global Fund, and began implementation of the grants in May and August of 2004. The country sought technical support from the BACKUP Initiative to develop the managerial capacity of the Principal and Sub-recipients of the grants.

Technical Support

A needs assessment was conducted in Niger by the UN Global Implementation Support Team (GIST) and a GTZ consultant. This discovered that national guidelines for testing were not being followed and a severe shortage of trained health workers was hurting implementation. The joint mission also found that the implementation of funds was being slowed by shortcomings, such as poor understanding of Global Fund principles and of the roles of coordinating and managing bodies, inadequate human resources and weak management in the Principal Recipient, poor decision-making and leadership in the Ministry of Health, and frustration among civil society groups. Based on this assessment, a technical assistance plan was developed and realized with support from a technical advisor funded by GTZ.

In Chad, BACKUP financed a technical advisor to work with Principal and Sub-recipients for a one-year period. Under the supervision of the grants administrator, this consultant supports the recipients' programming, implementation, decentralization and monitoring of tuberculosis- and HIV-related activities. The advisor is also to help with prompt evaluations of the execution of annual action plans, reporting and assisting the CCM and PR in the coordination of interventions funded by the Global Fund. The emphasis in all this work is to build capacity among Chad's health care managers to ensure that they are able to maintain the systems.

EXAMPLE

Results

By mid-2006, one year after the start of BACKUP's support, Niger's national bodies are coordinating their activities more effectively. The National Health Development Plan to address significant gaps in Niger's health system had been improved. The country has also set priorities for its national response to HIV and begun focusing its resources on these. Staff of the PR and Sub-recipients are trained on leadership and management capacity to sustain interventions after the departure of the external technical advisor.

Chad's BACKUP support began only in September 2006, so it is too early to report on its results, however, early indications are that the technical support is developing new capacity for the managing bodies to make best use of the global health financing.

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5

Empowering civil society

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section looks at the role of civil society organizations (CSOs) in global health financing processes. It describes the strengths of these organizations as well as the challenges they are facing at the national and local level. The section also identifies technical support available to help civil society organizations act and participate effectively in the structures and processes of global financing.

Why is this topic important? Civil society organizations play an important role in implementing HIV, tuberculosis and malaria programmes, but sometimes lack the capacity and skills for implementation and are, hence, not always able to fulfill their responsibilities. Furthermore, in many countries, there is still no true participation of civil society organizations in the dispersal and implementation of global financing. The greater involvement of CSOs, however, in policy-making and national programmes to fight diseases would help countries to meet international standards, and allow governments and the organizations themselves to better benefit from global financing.

The role of civil society organizations

Civil society refers to all voluntary civic and social organizations and institutions that occupy a position between the household, the state and the private sector. These often form the basis of a functioning society and include, for example, self-help groups of people living with HIV, men having sex with men, and faith-based organizations engaged in prevention and care[1] [2]. These organizations are critical actors in policy development and programme design, delivery and measurement of health interventions.

Strong partnerships with civil society organizations are essential in building equitable health systems, as they promote social mobilization, activate political will, contribute to policy design and hold governments and health care providers accountable[3]. In many countries, CSOs have also been the first to recognize and respond to HIV epidemics.

Through their work, CSOs help to bring diseases into the open and to reduce stigma and discrimination (see box). Often civil society groups are also effective managers of health financing and services. The Global Fund has stated, for instance, that many nongovernmental organizations (NGOs) and community organizations have proven themselves to be successful programme implementers. However, it is worth noting that civil society and government health programmes are not easy to compare since those run by government tend to be larger and more complex[4].

Guarding human rights, rolling back epidemics

Stigma and discrimination related to disease create barriers to preventing further infection and providing care and support. Civil society organizations represent those most vulnerable to discrimination; so, it is essential to engage civil society in efforts to fight disease. This was formally adopted as a principle at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV/AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic[5]. A 2005 UNAIDS Best Practices study shows that empowering people living with HIV to take the lead in support and advocacy activities is among the best measures for uprooting stigma, normalizing attitudes towards disease and guarding human rights[6]. This is one of the reasons why countries are advised to engage representatives of civil society in their coordinating and managing bodies.

2. Challenges: coordination, management and communication

A growing number of civil society organizations are finding ways to fund their activities through grants from the Global Fund and other major sources of health financing. Too often, however, CSOs' efforts to attract funding are hampered by external challenges and organizational shortcomings.

Exclusion: International agencies have failed to develop a coordinated, well-funded approach to capacity development for civil society, and governments often compete, rather than partner, with civil society organizations. Many governments, for example, do not adhere to the Global Fund guidelines about the composition and conduct of Country Coordinating Mechanisms (CCMs), which call for the strong participation of civil society. These governments often refuse to allow CSOs to exercise a measure of ownership or to participate fully in coordinating bodies.

Weak management: Furthermore, many civil society groups suffer from weak internal management and strategic deficits. They lack human resources and methods of recruitment and training to retain skilled employees. Often, they are unaccountable, fail to forge strong linkages with national coordinating bodies and grant recipients and fail to access the resources needed to address these weaknesses: the assistance now available for technical support to manage Global Fund grants, for example. This makes it difficult for CSOs to attract funds, adapt quickly to new opportunities of funding, and to develop their capacity. As well, CSOs often compete with other organizations for resources instead of building strong networks and learning from best practices.

Poor communication: Civil society organizations often do not communicate or share information consistently and effectively with the people that they represent and with partner organizations. This prevents them from developing their authority and expertise. For example, research by the International Planned Parenthood Federation (IPPF) indicates that a lack of accurate information has prevented many of its member associations from joining Country Coordinating Mechanisms[7].

Despite these weaknesses, donors count on civil society organizations

As noted above, insecure governments often resist working with civil society or feel threatened by the activism of civil society groups – one of the reasons why CSOs remain less engaged than they could be in the fight against major disease.

Since the establishment of the Global Fund in 2002, however, donors have demonstrated greater openness to listen to and include representatives of civil society in their decision-making, implementation and oversight. As a result, many governments now recognize that partnerships with CSOs attract additional resources and produce even better national plans for addressing diseases. The Global Fund has given an unprecedented role to civil society at all levels and recommends 40% civil society membership in CCMs. Still, many countries have yet to achieve this multisectoral ideal: for example, just 18% of Benin's CCM members are from civil society[8].

Other financing mechanisms do not require that CSOs be directly engaged in decision-making, but doors are opening to this sector. The World Bank Multi-country HIV/AIDS Program for Africa (MAP) for example, aims to fund projects that empower stakeholders including government, communities, civil society, faith-based organizations, and the private sector.

3. Technical support: expanding capacity and influence

To strengthen networks of civil society organizations and develop the capacity and accountability of CSOs, a wide range of technical support is available:

Capacity analysis and building: Support can be tapped, for example, for capacity analysis and capacity building of organizations and their members. Technical experts can assist CSOs in analysing existing structures and identifying areas of strength and weakness. CSO members can also be trained and gain, for example, access to other organizations to learn from best practices, draw on the expertise of other organizations or support partners and build networks for further collaboration. Useful tools and organizations include:

- The International HIV/AIDS Alliance has developed toolkits for assessing and building capacity of CSOs so that they are able to respond effectively to HIV.

- The Egyptian NGO Support Center provides links to hundreds of organizations.

Structures and management: Experts can assist organizations in establishing or improving their organizational structures and management. Such support allows for more effective governance, better strategic planning, transparent reporting and greater involvement of key constituents of health-oriented CSOs – people living with diseases. Materials available include:

- A manual on setting up self-help groups, published by the Global Network of People Living with HIV/AIDS (GNP+).

- A World Bank Guide to Resources for NGOs (introduction, in particular).

- Management tools developed by NGO Manager.

- Tools for managing NGOs, developed by eldis.

Grant management: Technical assistance is also available for handling financial resources, including grant-making and financial administration. TS can help, for example, to attract and make best use of funds, to select accountable NGOs as partners and to support these groups with the implementation of programmes. Organizations can also get help in developing their financial administration, enabling them to be accountable and sustainable over the long term. Furthermore, CSOs can be provided with support to adopt business-like approaches, sell their "products" and market their expertise.

- Here again, civil society organizations may find useful the World Bank Guide to Resources for NGOs (part II, chapter 2, in particular).

Gaining influence: Organizations can also use technical assistance to gain influence in national and local institutions. TS providers can help CSOs, for instance, to advocate more effectively, to raise awareness of their issues and to collaborate with the government, partners and other organizations to reach their goals. Two useful resources in this area are:

- An Advocacy in Action toolkit by the International HIV/AIDS Alliance.
- Building Organizational Networks for Good Governance and Advocacy (BONGA), a promising new approach in Tanzania.

Resources helping to implement all the above mentioned aspects are for example a NGO toolkit prepared by the International HIV/AIDS Alliance including a section on technical support. A guide on consultancy work by Oxfam focuses on NGOs. The World Bank Guide to Resources for NGOs, mentioned above, provides a wealth of information on a range of topics. See also the Code of Good Practice for NGOs Responding to HIV/AIDS, published by a consortium of NGOs, including ActionAID, CARE USA and Global Health Council. The Central and Eastern European Harm Reduction Network (CEEHRN) Knowledge Hub provides access to a database of trainers and other technical support providers who work with civil society organizations (see also example below). A list of TS providers, with contact information, can be found in Annex I.

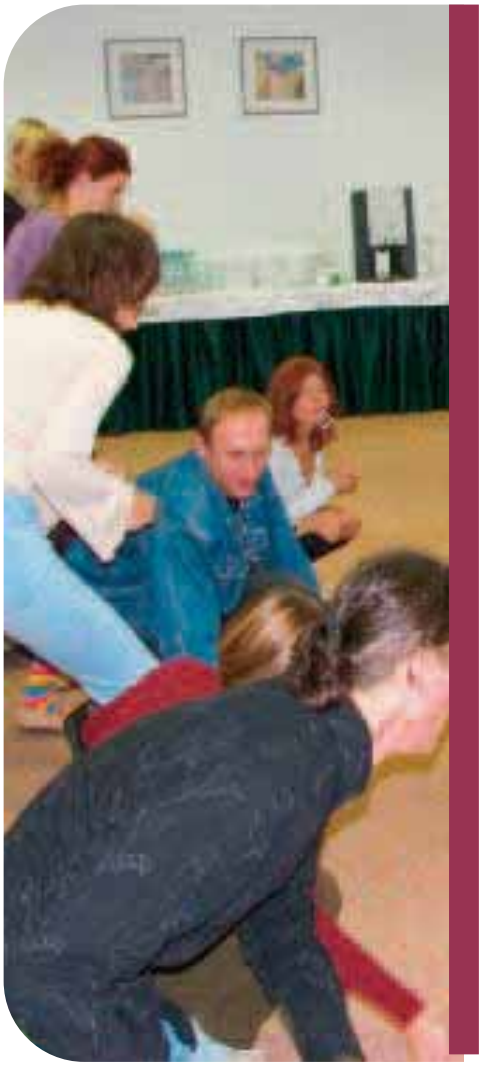
4. Examples: building Hubs, empowering the vulnerable

EXAMPLE

Central and Eastern Europe: Knowledge Hub trains hundreds in harm reduction

Context

HIV came later to Central and Eastern Europe than to elsewhere, but with explosive infection rates driven mainly by injecting drug use – 63% of all registered HIV cases here are among injecting drug users. Promoting measures to reduce the harms associated with injecting drug use have been hampered by an undue emphasis in many countries on law enforcement and repression. Services for drug users are, therefore, scarce (coverage was under 10% at the end of 2005) and, without strong government support, evidence-informed programmes for needle exchange, peer-outreach and opioid substitution therapy have had to depend on international support. The Global Fund is addressing this need, but more resources are required to provide adequate technical support to train new staff, boost advocacy for harm-reduction measures and scale up services.



EXAMPLE

Technical support

In 2004, GTZ and WHO's European Regional Office supported the establishment of the Central and Eastern European Harm Reduction Network (CEEHRN Knowledge Hub) to address this critical gap. Based in Vilnius, Lithuania, it focuses expertise on developing the capacity of CSOs in this region. Three activities are key to this: developing tools for state-of-the-art training, providing training, and developing a pool of regional and national trainers.

The Hub has developed and presented training modules and manuals. Training and services are largely demand-driven and adapted with attention given to lessons learnt and case studies from countries in the region. The training aims, for example, to build knowledge about harm reduction among police and prison officers and to raise awareness about treatment among mothers of drug users. As well, the Hub has developed an extensive database of trainers and other technical support providers, and offers its expertise in helping governments to revise laws and policies governing harm-reduction. Details about more than 120 national and regional experts are included in this database, along with a list of training centres and host organizations.

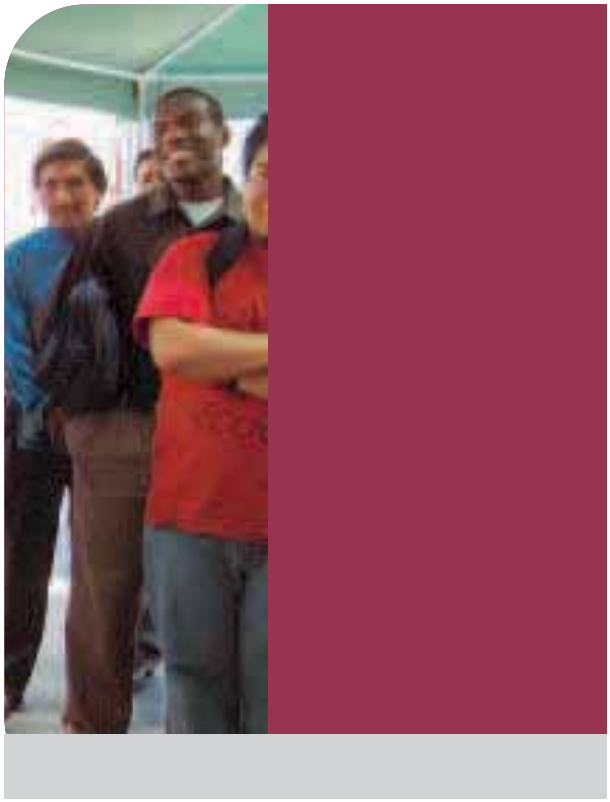
Results

The demand for training has been strong. In a 12-month period, the Hub held no fewer than 24 training sessions for 404 participants, mostly from countries that had received Global Fund grants. Trainees have joined national commissions addressing drug issues, and report that they play more active roles in their CCMs. The work of the Hub has also strengthened advocacy and partnerships in the region: for example, for opioid substitution therapy in Ukraine and other countries where the introduction of this service is being supported by the Global Fund. In the last two years, access to services for injecting drug users has begun to increase in Albania, Estonia, Kyrgyzstan, Macedonia and Ukraine.

Latin America and the Caribbean: empowering vulnerable groups

Context

In Latin America and the Caribbean, HIV prevention programmes often do not target groups that are most at risk. For example, levels of HIV infection between 2% and 28% are being found among men who have sex with men (MSM) in Latin American countries, but few governments have engaged this community to shape responses to HIV and lower infection rates, even though unprotected sexual intercourse remains the main mode of transmission.



Technical support

Addressing such weaknesses is the priority of a programme established by the International HIV/AIDS Alliance and the Asociación para la Salud Integral y Ciudadanía en el Caribe y América Latina (ASICAL), which is funded by the BACKUP Initiative. Launched in December 2004, the programme aims to strengthen the participation of gay people and MSM in Global Fund processes through capacity building in organizational development, focused interventions and advocacy.

With support from experts based in the region, training on project development and capacity building to implement interventions has been done at three regional centres – for Central America and the Caribbean, the Andean zone and the southern cone of South America. As a result, several CSOs have learned to develop strategic plans and to monitor and evaluate their activities. Advocacy training has also helped to provide skills for awareness-raising with decision-makers and the media about the specific needs of gay, MSM and transgendered populations.

EXAMPLE

Results

As of November 2006, the two-year programme had trained 63 representatives of 52 organizations of MSM in the three regions. It has fostered a plethora of new partnerships (for example, with the ICTC in Brazil, see Section 6) and is improving the participation of MSM groups in the coordination of Global Fund grants. HMNP, a gay organization in Paraguay that participated in the training, went on to contribute to the development of the HIV proposal submitted to Round 6 of the Global Fund in July 2006. This proposal was successful and HMNP is expected to be receiving funds soon. In Ecuador, meanwhile, there is now a seat on the CCM reserved for a representative of gay people, and this current representative has recently been elected vice-president of the national body – a major step towards strengthening the participation of MSM in Global Fund activities in the region. The project has also fostered the creation of two sub-regional networks of MSM: the Andean Alliance to Promote the Citizenship Rights of Gay and Other MSM (ALANPROC), and the Central America and the Spanish-speaking Caribbean's Coalition of Gay and Other MSM groups (CONGA). These networks further disseminate the lessons learnt and enable CSOs to share experiences and advocate for their constituents through exchange visits.

Guinea: timely support renews key civil society organization

Context

Despite a fast growing HIV epidemic, Guinea had until recently limited managerial capacity and resources to fight the disease. Civil society is weak, with few nongovernmental organizations and low professionalism within most existing ones; furthermore, it is still difficult to work openly on some issues considered taboo in the Guinean context – being HIV-seropositive, for example.

Technical support

Known as "Breaking the Silence", a project supported by the BACKUP Initiative began in September 2003 and ran for 18 months. The purpose was to strengthen the Association Guinéenne de Personnes vivant avec le VIH (AGUIP+) so that it could become a key actor in the fight against HIV.

Instead of hiring external consultants, AGUIP+ benefited from direct funding by BACKUP to cover the cost of antiretroviral therapy for the core membership of the organization, many of whom would have otherwise died or been unable to do their work. Core members were hence able to actively support the organization and to build their capacity through participation in training sessions for HIV advocacy, information and counselling and through participation in HIV conferences in France, Gambia and Mali. They also increased the membership from 8 to more than 100 and imparted their knowledge to the new members.

Results

According to an independent evaluation by the United Kingdom's Department for International Development (DFID), BACKUP's support paid major dividends for AGUIP+ and civil society in Guinea. Its timely, flexible funding enabled them to work for the development of their association. AGUIP+ could then tap its own human resources to provide assistance to new members and other organizations. This included, for example:

- Advocacy, information and communication in Conakry and the regions;
- New links with health facilities and other supportive networks;
- Home visits and psychosocial support for people living with HIV and families; and
- Development of income-generating activities.

As a result, AGUIP+ is now known as the first effective actor in the response to HIV in Guinea, with representation in national forums including the CCM. It is also becoming more independent and, by setting an example for organizations throughout the country, helping to undermine the stigmatization of people living with HIV. Partnerships with agencies such as UNAIDS, UNDP (United Nations Development Programme), USAID and FHI (Family Health International) were forged, and – drawing on the experience of AGUIP+ – Médecins sans Frontières has started to support a centre for voluntary testing and treatment of people living with HIV.

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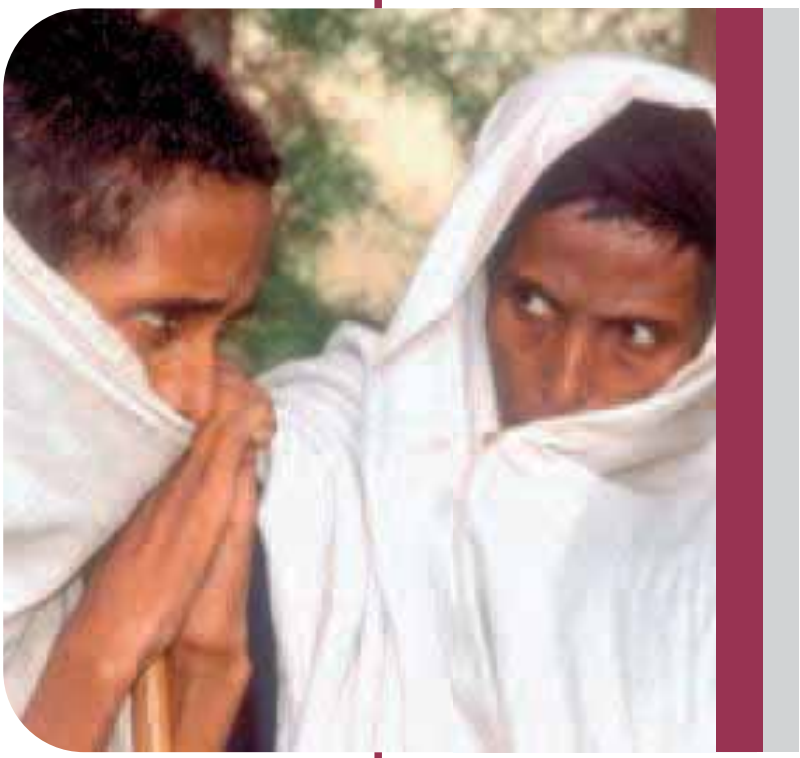

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6

Developing human resources for health

gtz BACKUP Initiative

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Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section describes the dire shortage of human resources (HR) in the health systems of low and middle income countries and the special challenges posed by this crisis. It touches on ways of addressing shortages of qualified staff and gives several examples of how countries can use technical support to build stronger a health workforce.

Why is this topic important? Human resources are crucial in providing the specialized services needed to fight HIV, tuberculosis, malaria and other diseases. Countries, however, often poorly manage the provision and retention of health workforces and this weakens their implementation of critical programmes. It also slows the process of scaling up health systems to fight major diseases and prevents countries from fulfilling requirements of international financing sources.

A global crisis: shortage of health workers demands unified action

WHO's 2006 World Health Report defines health workers as "all people primarily engaged in actions with the primary intent of enhancing health"[1]. The report estimates that there are about 59.2 million full-time paid workers engaged in the health sector worldwide. Countries face, however, a very serious shortage of health workers hampering their ability to scale up services in response to diseases. Fifty-seven countries, mainly in Africa and Asia, face the most acute crisis, with health workers facing economic hardship, insecurity, crumbling infrastructures and deteriorating health, chiefly because of HIV. Worldwide, the report estimates that more than 4 million doctors, nurses, managers and other public health workers are needed to fill the gap. Without prompt action, the shortage will intensify.

Rural areas, in general, face more serious shortages of health workers than cities. About one half of the world's population resides in rural areas, but 75% of physicians and 60% of nurses live in urban areas. Poor distribution of the health workforce can be exacerbated by inadequate human resource planning and coordination. A lack of appropriate training and the migration of health workers to developed countries further aggravate the problem. The pull of higher salaries in industrialized countries and the push of poor working conditions at home drive thousands of health workers to jobs abroad each year[1].

2. Challenges: planning, financing and training

While countries try to ensure that their health care staff are properly qualified and to deploy them where most needed at the right time, they face a number of difficult challenges.

Insufficient planning for human resources in the health sector: Planning for human resources is complex and calls for the engagement of a wide range of stakeholders – something that is often overlooked. The capacity of existing human resources and health systems may also not be assessed comprehensively, leading to inaccurate projections of human-resources needs. Poor communication and exchange of information among health authorities also undermines efforts to improve HR, and health care managers often do not have effective strategies to recruit and retain health workers.

Financing of human resources: Developing a health workforce is a costly, long-term undertaking. In a service sector based on many one-to-one interactions, it comes as no surprise that the expenditures for health workers in the government and non-government sector can constitute up to 50 percent of all health spending. This high-level of spending is also linked to the scale up of services for HIV, which adds greatly to the workloads of health care providers and requires extra funding for the extra hands needed. A 2006 WHO analysis of Global Fund grants in five countries found that countries have yet to fully exploit the opportunities now provided by this major source for human resource development[2]. The study suggests also that the financial commitments made to short-term health projects may not contribute to sustained improvements in human resources for health systems, over the long term.

Low and middle income countries also face serious problems with the high turnover of qualified staff due to inadequate financing of human resources. Inadequate pay and poor work conditions prompt many staff members to abandon public sector posts for better jobs with international health agencies or nongovernmental organizations (NGOs), to leave rural clinics for urban hospitals, or to emigrate to the health systems of more affluent countries. Governments of low income countries, therefore, often fail to retain health workers where they are needed most – for example, in rural areas – placing an even heavier burden on the staff who remain.

Lack of training: As health services for chronic conditions have evolved, so too has their complexity. Although much has improved, the volume of information and the high number of medications and providers poses an ever increasing challenge to health workers[1]. Health care staff are often insufficiently trained to deal with the growing complexity of health care. In addition, communication, information-sharing and teamwork are often inadequate. Studies show that errors in health care are not only frequent, but are also leading causes of sickness and death.

Poor training institutions and training materials: Many countries have a range of institutions with significant experience related to training. Such institutions, however, often lack teachers and the technical and financial support to train large numbers of health workers, build up certification structures and renovate buildings, etc. Furthermore, simple in-service training materials – critical to the rapid expansion of training of health workers – are often not widely available at all system levels, or they are outdated.

3. Technical support: coordinating, retaining and optimizing HR

Countries frequently need support to develop human resources systematically and overcome the challenges described above. At the global level, there is a growing awareness of this pressing need, as evidenced by the subject chosen for the 2006 World Health Report: human resources for health[1]. The launch in 2006 of a global "Treat, Train, Retain" initiative (see box) also reflects this awareness that urgent, and sustained, action is needed to address shortages of health workers. Technical support can help countries to develop their health workforce and overcome challenges in a manner that is consistent with best practices and initiatives such as Treat, Train and Retain. It can also help governments to be more accountable on HR issues and, thus, attract greater global health financing.

National human resource planning and coordination: This is key to developing comprehensive human-resource strategies that reflect the guidance of global organizations. Governments need to ensure that their plans are operationalized by local authorities that understand and support them. Figure 1 outlines the steps that governments should take, as recommended by international guidelines, for planning and coordinating TS to develop human resources for health[4]. Health care professionals may also find useful the following tools and resources for national planning and coordination of HR:

Treat, Train and Retain health workers – a global initiative[3]

In August 2006, WHO and multisectoral partners launched a coordinated global effort known as Treat, Train, Retain, as part of WHO's overall plan to strengthen human resources for health and to promote comprehensive national strategies for human resource development. A strategic approach, rather than formal programme, the three-pronged initiative aims to:

Treat: provide a package of HIV prevention, treatment, care and support services for health workers who may be infected or affected by HIV disease.

Train: empower health workers to deliver universal access to HIV services, with both pre-service and in-service training for a public health approach.

Retain: promote strategies to enable public health systems to retain workers, including financial and other incentives, occupational health and safety and other measures to improve the workplace, as well as initiatives to reduce the migration of health workers.

- WHO's Global Atlas of the Health Workforce.
- WHO's tools for HR-situational analysis, policies, planning and management systems.
- Tools for planning and developing human resources developed by Management Sciences for Health (MSH) and WHO.
- Documents and reports published by the Global Health Workforce Alliance (GHWA).

Figure 1: Technical support for national human resource planning and coordination

Gathering data about the state and capacity of human resources and current human resource gaps in health services, as well as assessing migration processes. This requires analysing the types of health workers in the system, and rates of retention and loss.

Comparing the data to the requirements of services: how many health workers are needed to do what and where?

Identifying constraints to addressing gaps in the health workforce and examining the root causes of these constraints so that appropriate actions may be taken.

Setting priorities: e.g., plans with timelines and clear recommendations as to what needs to be done at each level.

Seeking leadership and support of multiple stakeholders to implement and monitor the results of action plans.

Developing an advocacy strategy for mobilizing opinion at different levels and in different sectors, including civil society, universities, donors, providers of technical support and professional associations, as well as from ministries of health to promote plans for developing the health workforce.

Developing strategies to recruit and retain sufficient numbers of health workers.

Optimal use of human resources: Technical assistance is also available to optimize the use of human resources for scaling up access to health services and to adopt a public health approach to develop HR. One such approach, which has been pioneered by WHO, is known as the Integrated Management of Adolescent and Adult Illness (IMAI, see box next page).

● For details about IMAI, and TS to optimize the use of HR, see WHO's IMAI Toolkit.

Retaining workers: TS can help to create conditions that retain health workers where needed most: in particular, in rural areas and in the public health system. This is done with measures to improve work conditions: for example, policies to minimize migration and the provision of appropriate salaries and financial and non-financial incentives (in-service training, for instance). Health workers are also more likely to stay when governments provide better housing, loan schemes, child-care and subsidies for travel and school fees and respectful and supportive supervision. Other critical incentives include support for HIV-positive health workers, safe working conditions, job security, career development and jobs that allow workers to apply their particular knowledge and skills.

● For research, policies and links on this topic, see WHO's web pages on health workforce migration and retention.

Task-shifting mobilizes more health workers

In view of the small number of doctors and the time it takes to train them (at least six years), most clinical teams in countries with high prevalence of HIV must rely on nurses or clinical officers. WHO's IMAI approach encourages this "task-shifting", as it can greatly aid decentralization of services and promote sharing of clinical management responsibilities to the lowest relevant cadre and into the community – a vital step for chronic disease management and the shift to long-term treatment and care. With this approach, simplified operational guidelines, tools, and training materials enable clinical teams and community-based workers to deliver HIV services and to use a standardized patient-tracking system. Sharing and shifting case-management tasks from doctors, to nurses or clinical officers, to lay providers (trained and paid to join the clinical team), to community workers, and to patients themselves is an innovative way of optimizing the use of human resources. It helps overstretched clinical teams to cope with an expanding workload, to better manage patient illness and side effects, to increase adherence to treatment and to prevent disease transmission.

Financing human resources: As noted, financial incentives can help to retain health care staff, and technical expertise is available to help countries develop effective policies for financing HR. There is, also, a growing amount of international financing to support HR and institutional development, and countries can make use of TS in the development of Global Fund proposals that integrate human-resource planning and development from beginning to end.

Strengthening training institutions: Countries need to develop their own pre-service training institutions (for students) and in-service training programmes (for qualified doctors, nurses, clinical officers and others) to prepare the health workers needed to expand access to prevention, treatment and care over the long term. Institutional development is challenging, however, and often depends on long-term technical and financial support in five areas: working with ministries of education and health care managers to assess existing gaps in supply of health care cadres; assessing the migration of health workers and revising pre-service training curricula to produce more health workers for national service, rather than for export; assessing if HIV and other diseases undermine the quality of teaching; drawing up plans to train qualified and effective lecturers and tutors, and for providing institutions with needed laboratory equipment, information technology and other infrastructure; and developing appropriate training curricula, materials and certification procedures.

Further information on institutional development is available from these organizations:

- Regional Knowledge Hubs for Europe (based in Croatia), Eastern Europe (Ukraine and Lithuania) and Africa (Uganda).
- Brazil's International Center for Technical Cooperation (ICTC) on HIV/AIDS.
- Uganda's AIDS Support Organization (TASO).

Training and developing human resources: Technical support can also help countries to train and develop the capacity of human resources. Assistance is available to assess exact requirements for vocational training, to plan for financing and organization of education, to choose the right approach, to secure continued learning and sharing of knowledge with other team members and to evaluate and recognize acquired knowledge. Useful sources, here, include Hubs, tools and organizations mentioned previously, and a knowledge network:

- Regional Knowledge Hubs for Europe (based in Croatia), Eastern Europe (Ukraine and Lithuania) and Africa (Uganda).
- Tools for planning and developing human resources by MSH/WHO.
- Global Health Workforce Alliance (GHWA).
- EurasiaHealth Knowledge Network.

General information about how technical support can best be accessed is available from the UNAIDS Technical Support Facilities (TSFs) for East Africa, West and Central Africa, Southern Africa and South-East Asia and the Pacific. WHO has a web page devoted to health workers, with useful information and links. See also the innovative global initiative funded by USAID, the Rockefeller Foundation's Joint Learning Initiative and the web site of Brazil's International Center for Technical Cooperation (ICTC) on HIV/AIDS. Technical assistance is also offered by the ESTHER programme (Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau), established by the French government to focus resources on capacity building to facilitate access to care for people living with HIV (PLHIV). For further details and contact information for providers of technical support, please see Annex I.

EXAMPLE

4. Examples: increasing regional capacity

Integrated management of disease optimizes use of health workers

Context

Sub-Saharan Africa is home to almost 64% of all people living with HIV – 24.5 million. One of the greatest obstacles to scaling up prevention, treatment and care is the weakness of health systems in many low income African countries – their lack of human resources, in particular. Some countries, however, are addressing such problems by adopting the public health approach of IMAI, which allows for the rapid decentralization of integrated primary health care services.

Technical Support

Since 2003, on expression of interest by the ministry of health, a small team from WHO in partnership with other agencies will visit a country to describe to officials, policy-makers and stakeholders the aims of the IMAI approach. The IMAI guideline modules, training materials and other tools are then adapted in accordance with national needs and policies. A district management team is established, and training of trainers and expert patient-trainers (e.g. PLHIV) then begins. These trainers later fan out across the countries to train frontline health workers and to establish a simple, strong HIV care/antiretroviral therapy (ART) patient monitoring system. Countries are also encouraged to invest further in sustaining the growing capacity of their health workforces by follow-up, clinical mentoring, supportive supervision, and pre-service training. For example, every day in each of Senegal's 11 regions, a physician-mentor is on call (by phone or e-mail) to address urgent questions from nurses in district clinics and health posts.

Results

More than 35 countries are now mobilizing greater human resources for health care and scaling up services using the IMAI approach. In Uganda, at least 1600 health workers have been trained in IMAI since 2003, in association with the regional Knowledge Hub. In some parts of the country, "expert-patients" are now helping in the triage of patients, adherence support, records management and counselling. Such innovations allowed the country within two years to increase the number of sites providing ART from 35 to 175, and to expand access to HIV treatment from 17000 to 75000 Ugandans.

BACKUP fosters Brazilian export of training in antiretroviral therapy

Context

Brazil has mounted a vigorous response to HIV since the early days of the epidemic. By purchasing from domestic producers of less expensive generic copies of branded antiretroviral drugs, the country was able to provide antiretroviral therapy free of charge, which resulted in a 50% decline in HIV morbidity and mortality rates. The Ministry of Health estimates that this led to 358 000 fewer hospital admissions at a saving of about US$ 1 billion. Specialized outpatient services provide a full range of counselling/HIV-testing and support, and NGOs and other community organizations are contracted to contribute to home-based care.

The response of Brazil's health system to HIV has been held up as a model internationally. The country has played a leading role in south-south cooperation since 1996: i.e. cooperation between different countries of the southern hemisphere. In 2002, the Brazilian government allocated US$ 1 million for its newly minted International Cooperation Programme for Other Developing Countries (PCI), focusing on support to Latin America and Africa. The BACKUP Initiative started to support the PCI in 2003 and helped to finance the extension of technical cooperation to Paraguay, Colombia, El Salvador and the Dominican Republic.

Technical Support

The BACKUP supported project had four goals: to train clinical teams (usually a physician, nurses, pharmacologist and psychologist) in providing ART treatment to AIDS patients, and in establishing logistics systems; to provide treatment to at least 100 patients in each of the four countries; to train representatives of civil society in providing support for adherence to antiretroviral therapy; and to promote the exchange of experiences down to the local level. Its two years of funding provided for specialized training programmes, fellowships and seminars.

EXAMPLE

Results

An independent evaluation by the United Kingdom's Department for International Development (DFID) concluded that BACKUP contributed to the launch of Brazil's PCI in the four countries. The El Salvadoran clinical team, trained in Brazil, reported that they improved their capacity to enter into price negotiations with manufacturers. In Paraguay, additional short-term training programmes were offered and exchanges between the team trained on the national level and local clinical teams were initiated. The undertaking was less successful in the Dominican Republic and Colombia, owing to bureaucratic delays. Above all, BACKUP's support was seen as influential in helping the PCI programme to get started. The support also aided in securing further funding for the next phase of PCI. This includes the ambitious HIV initiatives of Brazil's International Center for Technical Cooperation (ICTC), established in 2004.

Regional Knowledge Hubs harness expertise to develop workforce

Context

The lack of training institutions for health workers, which undermines many public health systems, is addressed by a partnership between WHO and the BACKUP Initiative that provides for technical support and seed money to create centres of excellence. Such "Knowledge Hubs" offer systematic technical support to countries in their region to develop their own institutional training capacity: e.g. training of core cadres of health care professionals, establishment of networks, tools and guidelines (see also example in Section 5).

To date, Knowledge Hubs have built the capacity of expert trainers in 36 countries in Africa, and 24 countries in Eastern Europe and Central Asia. Knowledge Hubs now operate two sub-regional networks, covering East and Southern Africa, and West and Central Africa respectively. In Eastern Europe and Central Asia, three Knowledge Hubs are each focusing on the core aspects of HIV programmes: second generation surveillance (Zagreb, Croatia), harm reduction (Vilnius, Lithuania) and ART (Kiev, Ukraine).

Technical support

The Regional Knowledge Hub for the Care and Treatment of HIV/AIDS based in Ukraine, is a partnership of WHO, the American International Health Alliance (AIHA), the Ministry of Health, Kiev Medical Academy of Postgraduate Education, the Ukrainian National AIDS Centre and NGO partners such as AIDS Foundation East West and Médecins sans Frontières. It aims to develop regional frameworks and affiliated national training and technical assistance capacity to expand access over the long-term to HIV treatment and care programmes throughout Eastern Europe and Central Asia. The Hub has been able to draw on the extensive expertise of its implementing partner AIHA, which developed training sessions and supported the Hub in planning for and financing of human resources.

Results

Since 2004, the Ukraine Hub has developed or adapted 21 distinct curricula on aspects of HIV treatment and care, with related training materials, and conducted 74 courses reaching a total of 1744 participants from 8 countries. In Ukraine, alone, the Hub has helped to provide training to 888 professionals and expert-patients: adult and pediatric ART physicians, nurses, social workers, administrators and laboratory specialists from AIDS centres, infectious disease hospitals, prisons and nongovernmental organizations representing people living with HIV.

Knowledge Hubs are not yet self-sustaining, but are moving in that direction. Since 2004, after seed-funding from the BACKUP Initiative, the Ukraine Hub has attracted financing from countries with Global Fund grants, and from USAID, United Nations Children's Fund (UNICEF) and other sources worth more than US$ 1 million. Knowledge Hubs are now directly involved in Global Fund grant implementation in Uganda, Ukraine, Russian Federation, Kazakhstan, Tajikistan, Uzbekistan and Azerbaijan.

5. Selected reading

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7

Improving health financing systems

gtz BACKUP Initiative

commissioned by:
Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section outlines some of the core issues in health financing in low and middle income countries. The central question discussed is "How can sources of global health financing contribute to the development of fair and sustainable health financing systems". The section points out typical challenges in financing health and explains how technical support can help to overcome some of these challenges. It ends with recent examples of technical support in this area.

Why is this topic important? Health systems in low and middle income countries are often financed in a way that prevents the majority of the population from accessing essential health services. Enhanced transparency and fair financing, however, have the potential to improve services, empower the poor to demand better protection and increase the accountability of decision-makers – as required by major donors and financing mechanisms. Technical support in this area can, therefore, help to promote a cycle that attracts greater international support for long-term improvements to national and local systems of financing health services.

Core issues in health financing

Health financing is a broad issue and encompasses three main functions: the raising of revenue for the health system, the pooling of risks and funds and the purchasing of services. **Social health protection** refers to forms of insurance or a national health system that protects the poor against illness and the risk of not being able to afford expensive health services. Effective systems of social health protection deal with all three functions of health financing.

Building equitable health financing and social protection systems is not an exact science, but it is possible to identify core issues and constraints. Above all, one has to distinguish between payment by the individual at the point of service, and systems that allow people to pay in advance for health services. The former does not allow for spreading the cost of health protection among a large number of individuals, whereas the latter, prepayment for the possible occurrence of a health risk, allows for this so-called risk- or fund-pooling.

Out-of-pocket payment at the point of service is still common in many low and middle income countries, either for the full cost of treatment (cost-recovery principle) or as partial payments (also known as user fees). This is the most inequitable form of health

financing as it further marginalizes the poorest and neediest people, many of whom are living with chronic diseases such as HIV. Systems based on out-of-pocket payments prevent people from seeking adequate health care, since they often cannot afford services when they most need them.

Instead of paying at time of use, people can pool their risks and recur to forms of **pre-payment**. Basically, this can be done either through general taxation or through some kind of insurance. Whether a tax-based system or an insurance system can provide adequate social protection more effectively does not depend on the source of financing as such but rather on the concrete implementation of the specific system. If policy-makers wish to ensure a measure of competition in the system, on the side of provider or purchaser (e.g., to give consumers an opportunity to choose from a number of health service providers or health insurance policies), market principles can be introduced to strengthen the demand-side and foster fair financing of social health protection. Social protection in health is not effective, however, unless it provides adequate coverage against financial risks, provides health services according to people's needs and shares the costs of the system equitably among those who use it.

Options for prepayment

Social health insurance (SHI), or national health insurance as it is often called, is typically mandatory for the entire population or for certain occupational groups. Specific contributions earmarked for health are collected from workers, enterprises, self-employed people and, in many cases, also from governments.

In many low and middle income countries, SHI is limited to relatively well-off workers in the formal sector. Recently, efforts have been made to extend social health insurance to the informal sector: for example, in the Philippines and Kenya, where GTZ is providing technical support to establish national health insurance schemes (see example at the end of this section). Another example is Ghana, where linkages to community-based health insurance have been forged.

Community-based health insurance (CBHI): While social health insurances are insurances on the national level, community-based health insurances are based on prepayment schemes at the local level. Simple community-based health insurance schemes are useful when people have difficulty

paying for health services during certain periods of the year, as it is normal in communities of agricultural or seasonal workers. In the last decade, international cooperation has increasingly focused on health insurance schemes for the informal sector and rural populations. However, experience shows that without strong state support, CBHIs often fail to provide coverage to a substantial part of the population. Moreover, the poorest members of society are not able to contribute to community-based insurance, so these schemes usually depend on subsidies from national or international sources.

Private health insurance (PHI), which are for-profit insurance schemes, require individuals to pay premiums that are calculated according to their risk profile (and not according to their ability to pay). They are commonly used in developing countries, therefore, by only a narrow segment of the population – the better off. As a result, their application should be considered as restricted to the topping up of health services only.

It would be helpful to have a blueprint for the construction of social health protection systems worldwide. Of course, this does not exist as different societies require different blueprints; so each country has to design its own system, according to its resources and needs changing also over time. To function well and provide social health protection, however, health financing systems must meet these basic criteria:

- Be sustainable.
- Cover the population, especially the needy.
- Allow for some degree of risk-pooling among various population groups.
- Provide added-value in its benefit package.
- Use resources efficiently.
- Be transparent in its financing.
- Be equitable in its financing.

Equitable financing means that the costs of the system must be shared fairly throughout society, and not favour the rich. The fairness of a health financing system can be assessed by looking at the division of wealth within a country and evaluating sources of revenue and the relative utilization of resources by each segment of society.

2. Challenges: advocacy, transparency and management

WHO estimates that every year more than 100 million individuals are pushed into poverty by the need to pay for health services out-of-pocket, at time of use[1]. The introduction and development of better health financing and social protection systems is crucial, therefore, to leave out-of-pocket payments behind and assure better protection to all. This task is complex and fraught with challenges at both the macro- and micro-levels:

Weak advocacy for fair health financing: National policy-makers are often neither aware of the importance of the subject nor of the needs of the poorest. As a result, there is little public discussion about the risks of out-of-pocket payments, the inequity of existing health financing mechanisms, inadequate health spending for populations at the periphery and limitations of access to basic health services at the moment of need.

Weak tracking of finances: Governments of low and middle income countries often have little knowledge about the revenue and expenditures in their health systems: particularly, where and for whom money is spent. This confusion, and subsequent waste, becomes all the more serious when these poorly understood health systems receive major injections of revenue from the Global Fund, World Bank and other international sources.

Neglect of demand side in the health system: Often, the management of health delivery systems focuses too much on suppliers – health care providers and decision-makers, for example – and not enough on the concerns and purchasing power of consumers. Such supply-side systems react only to the interests of providers and are often weakened by arbitrary budget decisions at country and international levels.

Poorly adjusted benefit packages: National health insurance schemes sometimes lack the technical capacity to provide comprehensive and appropriate coverage that can be sustained by public contributions, taking at the same the contributory capacity of people into account.

Lack of social health protection of the poor: In most low and middle income countries, protection against the financial risks when falling ill is typically restricted to the formal sector and those with higher incomes. This is especially true in countries with official national health insurance schemes. This policy of "free health care for all" often leads in practice to substandard services for the poor coupled with the proliferation of under-the-table payments or quasi-institutionalized co-payments.

Badly managed community-based health insurance: Well-managed community-based health insurance programmes have the potential to protect the poor, alleviate poverty and give effective coverage to many others. Frequently, however, they are badly managed and lacking the technical capacity to address the complex issues associated with insurance. Bankruptcy is often the result, disappointing those who contributed to the failed insurance programme and weakening negotiating power with providers.

3. Technical support: from national dialogue to local development

Investing global and domestic resources in the development of health financing systems provides a double-benefit. First, countries benefit directly by investing in their health systems and this leads to strengthening whole health systems – not just to fighting a particular disease. Second, if the investments lead to improvements in the functioning of health systems all health resources are liable to be managed in a more effective way. Progress in this area is indispensable to achieve accountability and helps to attract financing from international sources. Below, are some areas in which technical support for health financing systems is available, together with some tools, resources and links.

Encouraging dialogue at national and local levels: Politics and social preferences often determine whether countries have an open dialogue about health financing options, but technical experts can help make the case for fair health financing and trigger discussion. This can raise public awareness of the topic and put it on the political agenda if not into national planning processes. Open dialogue can also help the poorest to advocate for their needs and rights. Two initiatives launched in recent years to raise awareness at national level are:

- The Health Financing Task Force (HFTF) was created to raise awareness about the need for systemic health financing and the role this plays in advancing the right to health in low and middle income countries. The success of the Task Force owes much to its high-profile and independent voice, mix of expertise (financial matters, human rights and health), and its strong focus on results that respond to country needs.

- The GTZ-ILO-WHO Consortium on Social Protection in Health was established in 2004 to foster cooperation in the field of social protection in health, sustainable health financing systems and efficient contracting. It can help promote national dialogue on health financing, and provides a range of technical assistance at all levels for feasibility studies, legislation, policy advice, actuarial studies, etc..

Improving the flow of health financing: Technical support can help to analyse "where the money comes from" (revenues available for financing health systems) and "where the money goes" (how and where revenues are spent, and which services are paid for by the government). Technical experts can also help to analyse financing flows and gaps, better modes of investment and how to avoid corruption by introducing proper accounting mechanisms, selecting appropriate indicators and monitoring data. National Health Accounts (NHA) provide for the systematic, comprehensive and consistent monitoring of health resource flows and foster transparency. Such NHAs are poorly developed in many countries and stand to benefit from strong external professional assistance. Resources include:

- The web site of WHO for guidance, further tools and a link to an expert group on how to produce NHAs.

- The Kaiser Family Foundation web site for information on health expenditure in all countries.

- Short courses on sustainable financing offered by Harvard University's International Health Systems Program.

Responding to needs and capacity to pay: Countries can also make use of expertise to develop benefit packages that match the needs of the population with its capacity to pay for services. This includes, for example, the development of a comprehensive approach based on available data, support for the implementation of benefit packages and monitoring and evaluation of established benefit schemes. A tool in this area is:

- WHO and GTZ's SimIns simulation model for analysing the basic mechanisms of health insurance. The tool illustrates the implications of initial policies with respect to key health insurance variables, contributions, utilization patterns and/or health care costs ensuring financial equilibrium, and the impact of health insurance on the overall structure of health financing. For further information, write to simins@gtz.de.

Protecting the poor against financial catastrophe: TA is available to help countries and poor and marginalized groups assess what sort of health financing is likely to serve them best while being equitable, sustainable, based on the pooling of risk and responsive to consumers. This will make it easier to guarantee access to adequate care for even the poorest of the poor (see examples at the end of this section).

Strengthening health insurance at the micro-level: Technical support can help managers of community-based health insurance programmes to develop their skills: for example, in technical, commercial and policy matters and in continuous improvement of products and services. This may include help to develop insurance products and quality standards or support for conducting seminars and training programmes. In addition, a number of training materials, manuals and tools have been created to assist in the development of community-based health insurance:

- GTZ's Centre of Health Insurance Competence (CHIC) draws on five years of experience with community-based health insurance, to respond to the financial, organizational and managerial weaknesses of private health benefit schemes. Since 2003, GTZ has held CHIC workshops in a number of countries.

- InfoSure is an internet-based, multilingual database developed by GTZ, which offers a wide range of opportunities for evaluating, monitoring and comparing health insurance schemes. Its detailed questionnaires raise issues relevant to health insurance and offer a guideline for technical assistance.

- Micro-Assurance Santé (MAS) Gestion software developed by the ILO/STEP programme supports the main activities for the management of health care insurance schemes at micro-level. MAS Gestion, which includes a concise accounting module, facilitates simple and fast operations related to registration, follow-up and control of membership, contributions and benefits.

- Global Information on Micro-insurance (GIMI), initiated by the ILO/STEP programme, is a tool that brings together actors in the field of health insurance from all over the world, and is designed to evolve constantly through the contributions of users.

Cambodia: paying for the poor out of health equity funds

In Cambodia, WHO, UNICEF and other organizations have helped to introduce funds for financing health services at the micro-level with a demand-side approach called Health Equity Funds (HEFs). Health Equity Funds operate as a third-party payer for patients who cannot pay user fees and set up criteria for waiving the user fees of needy patients. Usually, health care providers are responsible for determining whether a patient qualifies to have his or her user fees waived and since the income of health workers often depends largely on the collection of user fees, even the poorest patients may end up paying. An independent HEF implementer, however, identifies the poor in areas where no pre-identification of the poorest exists and pays on their behalf, thus providing an alternative to generally ineffective fee exemption policies.

HEFs in Cambodia are financed partly through the Ministry of Health and by external funding sources (international and local organizations). They have a double objective: improved access to preventive and hospital care for the poor; and decreased catastrophic health expenditure among the poor. The benefit package comprises payment of user fees charged by the public health facilities, other access-related costs, such as the cost of transportation to the health facility, food during hospitalization and other social support (funerals, for example). In future, these Health Equity Funds will be closely linked to the introduction of a national health insurance scheme to enable a fading-out of this structure and to create a coherent system of social protection in Cambodia.

For general information and support related to all areas above, please refer to the GTZ-ILO-WHO Consortium website with training, courses and study programmes on social health insurance and similar topics. The GTZ Department of Social Protection also offers information on TS providers in this area, such as AOK consult. Readers may write to the Department at social-protection@gtz.de. MSH has developed a toolkit on social insurance assessment and there is a useful (French-language) forum on social health insurance, run by La Concertation. Short courses, seminars and summer school courses on all aspects of health financing can be accessed via the web sites of the University of Heidelberg and the University of Maastricht. For a list of TA providers, with contact information, see Annex I.

4. Examples: strengthening health insurance schemes

EXAMPLE

Kenya: channelling international funding to extend social health insurance coverage

Context

In Kenya, there is a compulsory, income-related and potentially universal health insurance system in place: the Kenyan National Hospital Insurance Fund (NHIF). This scheme also aims to cover the health care of 2.2 million people living with HIV. However, the country's weak economy and high levels of poverty put narrow limits on the contribution-borne revenue of the insurance programme. As a result, covering ongoing therapy for tuberculosis, malaria and other infectious diseases **plus** antiretroviral treatment is likely to threaten the financial sustainability of the health system. Therefore, NHIF plans to bundle all international health funding for specific health problems so that it can avoid the cost of supporting parallel external structures and strengthen existing national health system structures. Under this arrangement, the Fund will become responsible for channelling international financial support into specific disease programmes and will ensure that money reaches the target group. This will also help to sustain a comprehensive benefit package including chronic diseases, promote transparency, reliability and efficiency in the management of resources and build trust with international donors.

Technical support

To achieve these ambitious results, managers of NHIF applied for support from the BACKUP Initiative at the end of 2004, and gained the assistance of a technical advisor, who has since then been working for them. This consultant is helping in the transition of the Fund and advises mainly on the expansion of the benefit package and the improvement of contracting service providers. He is also responsible for helping to extend the NHIF into the informal sector and in increasing the efficiency of the Fund.

Results

In January 2006, NHIF expanded the benefit package from partial payment of inpatient bills to full payment of admission costs in most hospitals in Kenya, especially rural hospitals. In June 2006, NHIF launched a national campaign to include the informal sector in the fund. At the same time, the Fund began to cover the treatment of people with cancer and HIV and those over the age of 60. Efforts are now being made to further strengthen the reform process of NHIF and the improvement of access to health care for all.

EXAMPLE

Rwanda: covering the cost of health insurance for the poorest

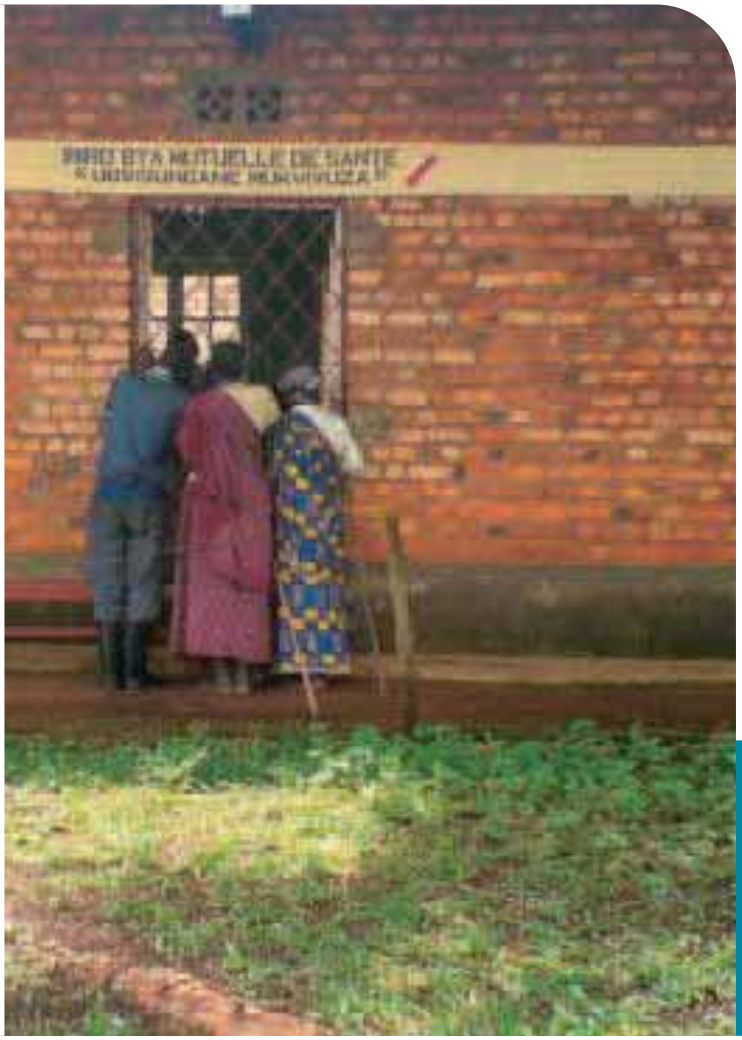
Context

Community-based health insurances, known as Mutuelles de Santé, were introduced in Rwanda in 1999. They have since spread rapidly and now cover 73% of the population. However, as 60% Rwandans are living in poverty, even a minimal contribution to insurance schemes constitutes a major barrier for most people to access health care services. Extensive external subsidies are necessary, as a result, to guarantee the financial sustainability of the insurance system. Over time, different development partners have supported the extension of insurance to the poorest part of the population by paying their fees. The communities themselves determine eligibility for support on a regular basis by identifying five different levels of poverty and assessing new members according to this scale. With limited government resources but substantial external financing flows for different vertical health programmes, it was deemed necessary to channel external funds into existing national programmes to improve the viability of the insurance system over the long term.

Technical Support

GTZ was among the first development partners in Rwanda to provide technical and financial support to insurance of the poorest members of society. Activities included preparing a proposal for Global Fund support, coordinating and aligning efforts of different stakeholders and consulting with the CCM, as well as partial payment of insurance membership fees. In addition, GTZ supported

EXAMPLE



Results

The success of the health insurance membership provision approach has enabled the CCM to submit a successful proposal for Health System Strengthening to the Global Fund in Round 5. The Global Fund now covers the cost of the annual health insurance for the poorest population strata in Rwanda for a five-year period ending in 2010. Funds are channelled through the CCM directly to the districts, which further disburse them. With this support it is now possible to provide a comprehensive benefit package to a wider population including the poorest. This increases equity of access and improves the overall quality of health care.

studies of the ability of Rwandans to pay health insurance fees and on the different financial flows within the health system and helped to call for reassurance mechanisms between the Mutuelles and further external financial support.

5. Selected reading

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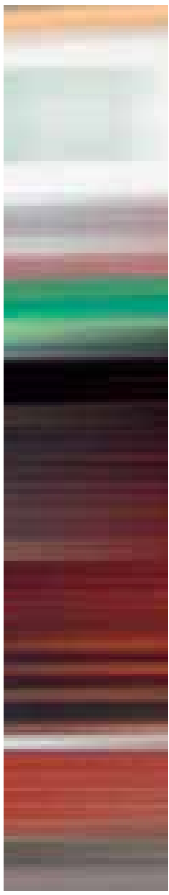


Procurement and supply management

gtz BACKUP Initiative

commissioned by:
Federal Ministry
for Economic Cooperation
and Development

1. Content and context

This section defines the major stages of procurement and supply management (PSM) and looks at the challenges faced in managing the procurement and supply of diagnostic equipment, medicines and other medical products to prevent, diagnose and treat disease. It focuses on national and decentralized levels in low and middle income countries and describes the technical support available to strengthen PSM systems.

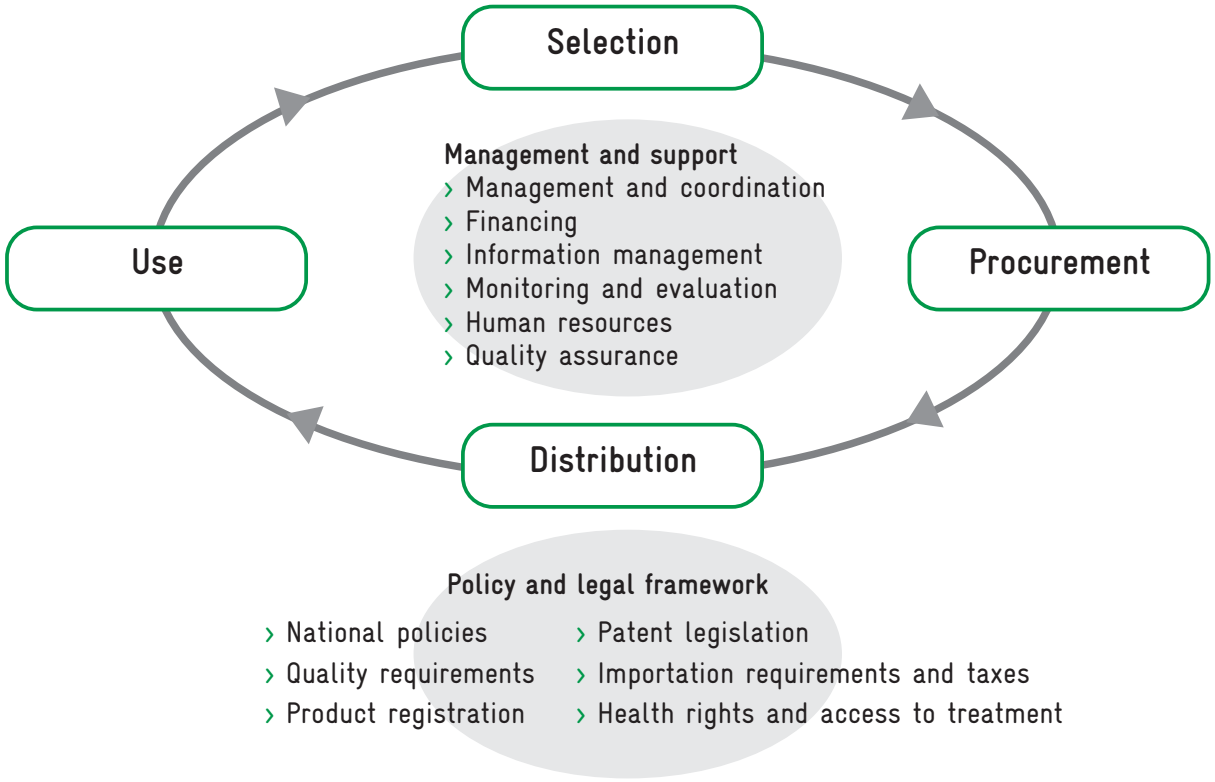
Why is this topic important? Roughly half of all grants approved by the Global Fund go towards the purchase of essential medicines. Effective PSM provides a steady and adequate supply of essential health commodities, reduces the waste of medicines, and builds the capacity of health care providers. In these, and other ways, it can do much to overcome the numerous challenges that health workers face in scaling up responses to major epidemics. Appropriate technical support can strengthen the capacity of national and district level PSM systems, and promote more equitable access to services and medicines. This also helps health programmes and agencies to be more accountable to international and domestic funding authorities.

Defining procurement and supply management

Competition and pricing in the international context

Many countries have recognized the need for sound PSM systems, as evidenced by the Johannesburg Declaration of December 2004, which brought together recipient and donor countries, nongovernmental organizations and international agencies to agree on priorities for strengthening national systems for public procurement[1]. Increasing competition among pharmaceutical manufacturers and developing stronger markets for medicines and health commodities are vitally important to effective procurement and supply management – and equitable access to life-saving treatments and services. Clearly, high prices of medicines and other health requirements are a major factor in inhibiting access. Prices depend on factors such as import duties, in-country taxes and monopolistic producers and suppliers. These topics fall outside the focus of this section, however. To learn more about competition, pricing and the role of patents and trade laws in this area, see the final report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health, April 2006.

Figure 1: Four stages of procurement and supply management



Procurement and supply management refers to the activities that health care providers must perform to get sufficient quantities of health products – of assured quality, at a competitive price and in accordance with national and international laws – to the patients who need them, in a reliable and timely fashion.

Usually, PSM is depicted as a cycle with four stages[2] (see Figure 1):

- Selection: the careful choice of medicines, diagnostics and other items according to need and to national or international guidelines e.g., of the World Health Organization.
- Procurement: purchasing the necessary items, of proven quality, in appropriate quantities and at the best possible price.
- Distribution: bringing the goods through continuous and secure systems to the point of use.
- Rational use: prescribing and using the items to obtain the best health outcomes.

The four stages of the cycle are, of course, not isolated. Decisions and actions taken in each stage interact and depend on each other. As shown in the figure, the cycle is also facilitated by a range of activities in management and support as well as by enabling policies and legislation.

2. Challenges: providing medicines where and when needed

The main objective of effective PSM is to ensure that the necessary products are available where and when they are needed, in the correct quantities and that they are used properly. Barriers to achieving these objectives can occur at any of the four stages of the PSM cycle:

Restricted selection: Outdated national guidelines for testing, diagnosis and treatment that are inconsistent with recent international (e.g. WHO) guidelines and best practices often cause health care managers to make unwise choices. A dearth of accurate data and information about the quantity and quality of the products required also undermines their work. Selection may be restricted by long in-country delays in approving medicines and diagnostics that have already been approved by stringent regulatory authorities (WHO Selected Medicine Information Systems or the U.S. Food and Drug Administration, for example). Furthermore, few governments have chosen to exercise the flexibilities that allow for the domestic production of generic medicines in public health emergencies such as HIV epidemics. A further challenge is the widespread availability of counterfeit and substandard medicines.

Poor procurement: Three main challenges to rational procurement are poor quantification, opaque or corrupt procurement and tender practices and procedures, and poor financial management and payment methods: Inaccurate quantification is common in the absence of reliable data on illness and usage. It leads to shortages of essential medicines and other supplies and wastage; for example, owing to the purchase of stocks of medicines not used before their expiry dates. The challenges posed by corrupt practices are obvious, as they result in shortages of goods owing to the diversion of financial resources from their intended purpose. Poor payment systems and methods can lead to manufacturers refusing to fill subsequent orders and stock-outs – which can put the lives of thousands of people at risk.

In addition, health care managers in many countries lack the training and knowledge needed to develop sound procurement and supply plans – a critical part of Global Fund applications for financial support, as well as of good housekeeping. They may also be unaware of the numerous tools and methods available for quantification and procurement, be unaware of best practices and may choose uncertified suppliers. The result: poor quality medicines and other products are more likely to be purchased, causing patients and the general public to distrust health care providers and whole health systems.

Undermined distribution: Distribution includes storage and inventory management, physical distribution and tracking of products nationwide. The distribution of goods is frequently handicapped by inadequate infrastructure, excessive centralization and the lack of effective management information systems. It is also undermined by a shortage of warehouses and transport vehicles, poor roads and broken bridges, missing links in and poor management of the cold chain (a fatal flaw for heat-sensitive antiretrovirals), and clinics without secure storage space.

The information systems for tracking stock and associated documentation may also be poorly managed, leading to gaps in the control of orders at all levels. Front-line health care providers lack the knowledge, or may not be legally authorized, to place orders. Mismanagement of distribution is therefore common, leading to both the oversupply of unnecessary products and the undersupply or stock-outs of essential items, including life-saving and other essential medicines.

Irrational use: The correct medicine for the correct patient, taken at the correct time, in the correct quantity and correct way, for the correct period and with the correct precautions is crucial. This calls for accurate prescribing, wise dispensing and good advice. Unfortunately, rational use is often undermined by economic factors, inaccurate information (sometimes deliberately provided by the supplier to increase consumption and sales), system weaknesses and a lack of public knowledge about usage.

System weaknesses include, for instance, outdated national guidelines that do not recommend the use of paediatric formulations of HIV medicines and diagnostics for children. Many children in low-income countries, therefore, rely on adult formulations of HIV medicines that are cut by hand – and receive inexact doses. The widespread shortage of skilled health workers (in rural clinics in sub-Saharan African countries, for example) is a critical factor that contributes to the irrational use of health care products, as does widespread corruption, theft and fraud. Furthermore, extreme poverty among patients and their families often results in the misuse of drugs provided free of charge: for example, poor people often sell their medications to pay for food for other family members.

In many countries as well, lack of education and widespread ignorance about disease, treatment and human rights prevent at-risk populations from asserting their needs, demanding quality services and ensuring rational use. The failure of countries to empower at-risk populations contributes to this malaise.

What managerial and policy supports are needed at each stage in the PSM cycle?

Good management is at the centre of this cycle. Critical to success are sound planning and coordination, integrated efforts, adequate financing, effective management information systems, the development of and strict adherence to standard operating procedures and the development of human capacity to assure the quality of services at each stage. Efficient communication between stakeholders is also crucial.

The work of health care staff in PSM is greatly supported by enabling government policies and laws. This includes national policies requiring the use of quality products; patent legislation that allows for the procurement of the best available commodities, including generic products; the elimination of taxes, duties and other obstacles to the importation of essential medicines and commodities; and the promotion of human rights, such as the right to treatment.

Good procurement and supply management also relies on staff with special or technical skills. In the early stages of PSM, they are needed to set up systems and build capacity among local staff. To maintain PSM systems, adequate numbers of pharmacists are also needed. Many countries do not recruit, train or retain enough of these staff, and need technical support to address this particular shortage of human resources.

3. Technical support: for planning, integration, quality and financing

The improvement of PSM is a long-term, multifaceted and multidisciplinary undertaking, which calls for high-level political commitment and coordinated efforts within countries. Decision-makers should plan for the use of technical support, rather than seek it on an ad hoc basis, and integrate its contributions to allow for sustainable improvements. In recognition of the complexity of this work, the Global Fund has developed guidelines to strengthen procurement and supply management[3]. Below is a list of areas in which TS is available, together with useful tools, resources and links.

Strategic planning and management: Technical support can help to assess already existing structures and processes in PSM and to develop long-term PSM plans on national and decentralized levels. It can then be used to build the capacity of staff to plan for, and manage, the strengthening of procurement and supply systems: i.e., develop information systems, improve quantification, budgeting and financial management and promote transparency.

Implementation, down to the district- and facility-level, with appropriate training and supervision are critical to success. These steps help health care managers to react quickly to the changing needs of populations, to ensure the rational selection and use of medicines and to enable even unspecialized staff to manage parts of the procurement and supply chain. TS in this area is crucial as, for example, the Global Fund asks for detailed PSM plans from applicants and a major bottleneck impeding the flow of grant money has been countries' inability to plan for these activities. Helpful organizations, tools and support include:

- The AIDS Medicines and Diagnostics Service (AMDS), a network of international agencies including UNICEF, WHO and the World Bank, which gathers global data on HIV-drug procurement and assists medicine supply-chain managers in planning[4].
- WHO, which offers a range of tools and expertise to help managers in the selection and rational use of medicines.
- Drug and supply management tools developed by Management Sciences for Health (MSH).
- Courses for capacity building in supply chain management offered by IDA Solutions.
- Courses on promoting rational drug use provided by the International Network for the Rational Use of Drugs (INRUD)/Boston School of Public Health/WHO.

Integration: Technical experts can also help to integrate the procurement and supply of commodities for prevention and treatment, a measure that will reinforce both activities. Help is available to coordinate the activities of multiple agencies that are engaged in PSM in a single country (ministries of health, district clinics, private charities, faith-based organizations and United Nations agencies, for example), to plan for and create one national pharmacy laboratory acting independently on a regular basis, as well as one national storage system.

Quality assurance (QA): Counterfeit and sub-standard products lead to treatment failures as well as other harm and the waste of scarce funds. TS can help health care managers procure products of high quality, promote tendering procedures and prevent black-market supply. Among the resources available to strengthen QA are:

- A list of prequalified pharmaceutical manufacturers and products from WHO.
- A MINI Lab for spot checks of active pharmaceutical ingredients (APIs), WHO-designated, regional quality assurance laboratories and efforts to bring Good Manufacturing Practices (GMP) for medicines to a uniform acceptable standard.

Pooled resources: Where possible, financing from global and national sources is best channelled through a single procurement agency, as this facilitates larger orders (bulk procurement) and lower prices (e.g. for female condoms). TS can help managers to pool resources, to harmonize activities with those of countries with similar needs, and to use benchmarking to promote the procurement of quality products at the best available prices.

- Procurement agencies providing also technical assistance to pool resources include UNICEF groups of countries at the regional level, and semi-autonomous facilities at the national level. Burkina Faso's Centrale d'Achat des Médicaments Essentiels Génériques et des Consommables Médicaux (CAMEG) is one example[4].
- WHO has developed an HIV test kit bulk procurement scheme.
- WHO, MSH and Health Action International (HAI) publish a range of drug-price indicators.

As well, many tools and programmes have been developed recently to assist at all steps in procurement and supply chain management. These include the Prequalification Project, the medicine library and further tools by WHO. A range of resources and expert support offered by UNICEF and a toolkit for programme managers by WHO/UNAIDS/GTZ/The International HIV/AIDS Alliance are available. MSH's training series for managing drug supply may be helpful to the reader, as well as the MSH software for quantification (contact Quantimed@msh.org for more information on this).

There is also an integrated and focused project known as the Supply Chain Management System available; write to scmsinfo@pfscm.org for more information. The Pharmaceutical Inspection Cooperation (PIC) Scheme can be of help, as well as the International Network for the Rational Use of Drugs.

Short courses on PSM by ARV Access for Africa, MSH and the Swiss Tropical Institute (STI) and longer courses on PSM provided by the Medunsa University in South Africa and Inwent (Germany) and the University of Leeds are also accessible to learn about procurement and supply management. For further information on technical support providers, see the list in Annex I.

4. Example: helping pharmacists dispense good drugs in Tanzania

Context

Duka la dawa baridi (DLDB) are retail outlets authorized by the Tanzania Food and Drugs Authority (TFDA) to provide non-prescription medicines in the private sector. With an estimated 4600 stores, DLDB is the largest network of licensed retail outlets for medicines in Tanzania. However, dispensing staff at these stores often lack basic qualifications and training, and the quality of medicines varies.

Technical support

Management Sciences for Health's (MSH) Strategies for Enhancing Access to Medicines Program has helped to address this problem. It provided technical support to the Ministry of Health in Tanzania to develop an accredited drug dispensing outlet (ADDO) program to improve access to affordable, quality pharmaceuticals and services at retail outlets in rural or periurban areas, where few registered pharmacies exist. The programme aimed to combine training, supervision, and monitoring of ADDO owners and dispensers, as well as financial incentives to ensure adherence to national standards.

The TS provided by MSH has included:

- Developing food and drug accreditation based on government-instituted standards and regulations.
- Training and supervising dispensing staff.
- Measures to raise consumer awareness of drug-quality and the importance of treatment compliance.
- Improving legal access to a limited list of basic, high-quality essential medicines.
- Improving local regulatory capacity.

EXAMPLE

Results

The first shops received accreditation by the TFDA in August 2003 and within three years, 279 shops had been accredited across the pilot region of Ruvuma. Results of an evaluation comparing ADDOs with a control group of DLDBs in the Singida region showed significant improvements:

The proportion of unregistered medicines in Ruvuma was reduced by a factor of 13, from 26 percent to 2 percent. As a result of this improvement, people in Ruvuma now have a 1 in 50 chance of buying an unapproved medicine, compared to a 1 in 10 chance for the people of Singida. Just 14% of ADDO attendants in Ruvuma recommended antibiotics for upper respiratory tract infections, compared to 39% of DLDB attendants nationwide in 2001 (antibiotics are not the recommended treatment for upper respiratory track infections). ADDOs in Ruvuma now have a legal right to sell selected antibiotics and are selling them more responsibly than in 2001, while DLDBs are still forbidden from selling prescription medicines. The Tanzania Food and Drug Administration implemented regulations in which the local government, acting on behalf of the TFDA, is responsible for regulating (licensing and inspecting) ADDOs.

EXAMPLE

The lesson learnt is that pharmaceutical services in developing countries can be substantially improved through technical support: i.e. training, accreditation, and regulation of private-sector drug sellers. Even prescription medicines can be rationally dispensed through local outlets, but monitoring is necessary to support improvements in rational use.

5. Selected reading

1 A Framework for Developing Effective Procurement Systems in Developing Countries: The Johannesburg Declaration. OECD/DAC, 2004.

2 Managing Drug Supply: The Selection, Procurement, Distribution and Use of Pharmaceuticals. Kumarian Press Inc., 1997.

3 Guide to the Global Fund's Policies on Procurement and Supply Management. Global Fund to Fight AIDS, Tuberculosis and Malaria, 2006.

4 Progress on Global Access to HIV Antiretroviral Therapy: A Report on "3 by 5" and Beyond. WHO and UNAIDS, 2006, especially p. 27, 29.

Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and Related Services. World Bank, 2004.

Harmonising Donor Practices for Effective Aid Delivery: Volume 3, Strengthening Procurement Capacities in Developing Countries. OECD and World Bank, 2005.

Procurement Strategies for Health Commodities. USAID, 2006.

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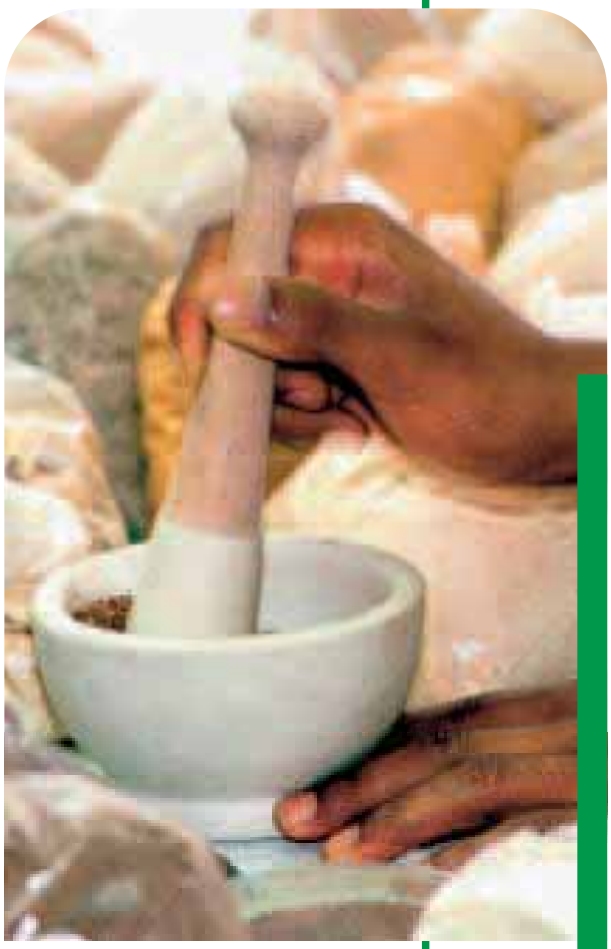

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Monitoring and evaluation

gtz BACKUP Initiative

commissioned by:

Federal Ministry
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1. Content and context

This section looks at capacity development to strengthen monitoring and evaluation (M&E) of health services at the national and decentralized levels. It defines basic terms and principles, outlines features of strong monitoring and evaluation systems and describes common challenges in developing these systems. The section also touches on the technical support available to develop capacity in this area and provides some examples from the field.

Why is this topic important? At the global level, M&E is seen as a key to scaling up health services and strengthening health systems. At country-level, it is indispensable for tracking the progress of programmes and projects and identifying how well these are following plans and achieving their goals. M&E allows health care managers and staff to make well-informed decisions, track the speed and drivers of epidemics, adapt programmes to changing epidemics and conditions and ensure that people are getting the services they need, when and where they need them. In short, developing capacity for M&E allows for accountability, a critical attribute to sustain health funding from national and international sources.

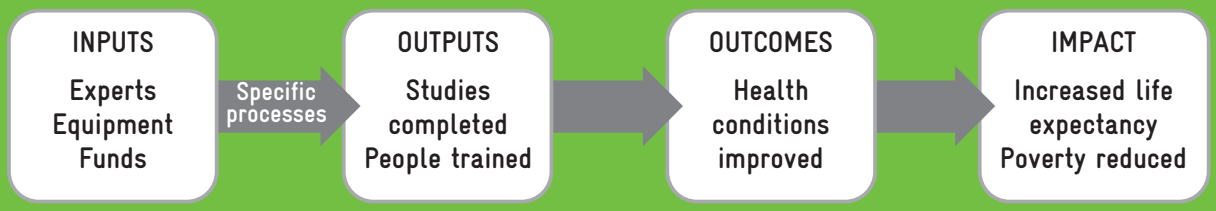
Monitoring and evaluation, from input to impact

Monitoring is the routine tracking of aspects of programme or project performance, through record-keeping, reporting and surveillance, health facility observation and client surveys. It helps to determine which areas require greater effort for an improved response. In a well-designed system, monitoring contributes greatly to evaluation. **Evaluation** is an episodic assessment of overall achievements; it attempts to link a particular output or outcome directly to an intervention after a period of time (see box next page). Evaluation helps stakeholders determine the value of a specific programme or project.

Monitoring and evaluation can strengthen all aspects of programmes, if well-designed and integrated from the outset. M&E systems call for clear standards and well-chosen indicators. A standard is a statement of what is to be provided (the goal), e.g., paediatric formulations of HIV medicines for all children in need in a specific region. Standards guide health workers to review their performance. An indicator is a quantitative or qualitative measure of change. Common quantitative indicators of overall health in a community, for example, would include infant and maternal mortality rates and birth weights.

From input to impact: the scope of monitoring and evaluation in national systems[1]

Monitoring and evaluation allows one to assess many aspects of a programme or project, and indicators can be chosen to measure everything from input to impact. For a programme to achieve its goals, inputs, such as money, staff and policies are needed to produce outputs, such as pamphlets about HIV prevention or nurses trained in managing antiretroviral therapy. These outputs are often the result of specific processes, such as training sessions for staff. If these outputs are well designed and reach the populations for which they are intended, the programme is likely to have positive short-term outcomes: increased use of condoms with casual partners or increased access to antiretroviral therapy, for instance. Positive outcomes should also lead to changes in the long-term impact of programmes: for example, lower rates of HIV infection and, among those living with HIV, improved health and lower death rates.



One size does not fit all: health initiatives in different countries, for different diseases and at different levels need M&E tailored to their particular needs. Most robust national systems, however, share a number of common features[2]:

› Central coordination, decentralized resources: An M&E unit in the ministry of health coordinates the national system, with designated managers and a budget of at least 5–10% of national health spending. The unit has formal links to line ministries, nongovernmental organizations (NGOs), donors and research institutions and access to expertise in areas such as epidemiology, data handling, and the tracking of financial and commodity resources. At national, regional and district levels, human resources for M&E are available and training is offered regularly. Stakeholders harmonize their activities and indicators to feed into the national system. A technical working group with wide representation and partnerships fosters collaboration and communication among M&E officers at all levels.

- Clear goals, costed work plans: Goals are defined by a national M&E framework or programme plan with integrated, costed work plans (see also Section 2). These are revised regularly, based on evaluation. Guidelines inform the M&E done by districts and regions, link health with education, labour and military and harmonize the M&E of donors and government.
- Well chosen indicators: These underpin all good M&E systems. Indicators need to be objective, reliable and SMART (specific, measurable, achievable, relevant and time-constrained). The results of M&E need to be comparable, so the best national systems include a core set of internationally recognized indicators that are updated regularly. The national set of HIV indicators, for example, should include those chosen by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)[3], and indicators such as those set by the UNAIDS Monitoring and Evaluation Reference Group (MERG) to roll back malaria[4].
- Rich data: A national plan for data collection and analysis and an evaluation agenda provide for periodic analyses of indicators and data sets from different areas, partners and sources (surveys, health information systems, etc.). Data are drawn mainly from existing structures, and are available without long delays. Tools such as second generation surveillance may be used to link behavioural data with surveillance data about HIV and other sexually transmitted infections (see Section 2, box on second-generation surveillance).
- Good reporting and use of data: To produce a regular flow of strategic information, countries need a national plan for the dissemination of data, which includes well-developed annual reports from the central M&E unit, regular meetings to discuss findings, a clearinghouse for findings and the coordination of national and donor data reporting. Good M&E systems produce data that are used in decision-making. For example, data that identify new drivers of an HIV epidemic are used to revise programming.

2. Challenges: weak systems, overburdened staff

M&E systems that include the above features strengthen health programmes, making them more efficient, effective and accountable: qualities that attract sustained financing. Developing such systems, however, can be a complex undertaking; so it is best to begin early, learn by doing and make use of technical support. This approach helps to get around common challenges that countries face in implementing sound M&E systems.

What challenges are M&E systems facing?

M&E systems are often implemented in a vertical manner for a single disease or donor, and need to be harmonized and integrated into health programmes and projects from the outset. A lack of human and financial resources often makes this difficult. Many African governments, for example, give inadequate political and financial support to M&E at the national, district and community levels.

M&E systems are often weak and unsustainable, as key stakeholders do not contribute to them and communicate inadequately. The specific conditions set by donor agencies for the development of information systems and M&E are sometimes impractical or unrealistic. Often, M&E systems do not incorporate best practices, hence indicators and methods are poorly suited to national needs.

As well, staff members may resist the introduction of M&E for a number of reasons. Some may not understand the benefits and fear that it will only add to their workload. Others may fear that they lack the required skills. Others still, may resist the scrutiny that M&E affords of their decision-making – or simply object to change, showing no interest in a continuous capacity building process.

3. Technical support: addressing disharmony, handling data

Technical support is increasingly available to help partner countries meet these challenges and begin to integrate M&E activities into working routines. Technical support is accessible in the following areas:

Advocacy: Sustained advocacy and communications support can encourage stakeholders in health systems to identify priorities of M&E. It can also bring all relevant partners into the process and overcome resistance to change. Technical experts can help staff to understand the tangible benefits of M&E and to knit M&E into daily routines.

Harmonization: The Global Fund, World Bank and other agencies are among those that fund or provide direct technical support to assist countries in adhering to the third of the Three Ones: the development of one agreed national system of monitoring and evaluation. As well, experts can help different bodies collaborate and communicate better in their M&E activities: for example, Country Coordinating Mechanisms and Principal Recipients. Partnerships that provide technical support for harmonized M&E activities are for example:

- The Roll Back Malaria Partnership Monitoring and Evaluation Reference Group (MERG), which includes WHO, UNICEF, United Nations Development Programme (UNDP) and the World Bank.

- WHO's Health Metrics Network, a global partnership aligning health information systems around the world.

Data management: Specific procedures and standards for the collection, registration, transfer and analysis of data are needed – from community groups and health clinics to district, regional and national authorities. Technical experts can assist in introducing these by conveying best practices and implementing tools for data management.

As well, TS can develop capacity to ensure that M&E activities are of high quality and help to balance the demands of data handling, programme implementation and reporting. There is a growing need, for example, for assistance in the collection and use of data to track the progress of people receiving antiretroviral therapy. Ministries of health need support to manage data about stock orders, and the distribution and use of essential medicines – thus strengthening their procurement and supply systems (see Section 8). There is also a variety of tools for data management available such as

- Epi Info™ by the Centers for Disease Control and Prevention (CDC) to develop questionnaires, enter and analyse data.

- Software developed by UNAIDS.

- Software designed by Constella Futures.

- A Global Health Atlas with standardized data and statistics for diseases, published by WHO.

Integrated disease surveillance: By improving data-sharing among surveillance systems for related diseases – HIV, tuberculosis and malaria, for example – health care managers are better able to track changes in epidemics and adjust prevention and care services accordingly.

- The United States CDC (Division of epidemiology and surveillance capacity development available for integrated surveillance) has also developed training programmes in this area.

Financing: Technical experts can help governments and other agencies to identify new sources of funding for the development of M&E systems, or assist them in drafting grant proposals that include funding for M&E activities. A useful tool here is

- The World Bank Monitoring and Evaluation Operations Manual, which provides information on, among other topics, the cost of building participatory M&E programmes.

Technical support can also help to plan for and implement overall M&E systems, including all these specific aspects, and assist partners with the design and use of methods and tools such as surveys, assessment tools, peer-reviews or e-learning workplaces. The World Bank has established a Global AIDS Monitoring and Evaluation Team (GAMET), a network of consultants that works with countries to operationalize national M&E systems. The Country Response Information System (CRIS) developed by UNAIDS brings together a wealth of useful information; readers can write to this address for information CRIS@UNAIDS.ORG. A tool developed by UNGASS can help partners to choose and apply M&E indicators.

Other resources include a facilitator's guide by Family Health International (FHI), the Synergy Project APDIME toolkit and a comprehensive monitoring and evaluation toolkit produced by WHO/UNAIDS. A monitoring and evaluation toolkit developed by the International HIV/AIDS Alliance and the Monitoring and Evaluation Systems Strengthening Tool by the Global Fund are also helpful. The Regional Knowledge Hub on Second Generation HIV/AIDS Surveillance in Zagreb, together with WHO/EURO and the BACKUP Initiative, provides a number of training courses on all aspects of M&E. For a list of providers of technical support for M&E, among other areas covered by this guide, see Annex I.

EXAMPLE

4. Examples: support boosts M&E in health systems

Providing tools to implement El Salvador's Global Fund grant

Context

El Salvador is facing a fast growing HIV epidemic, with infection rates rising most notably among men who have sex with men and commercial sex workers. In July 2003, the Global Fund awarded El Salvador a grant worth $27 million over five years to address HIV and tuberculosis. UNDP is the Principal Recipient and its work is overseen by the Salvador Global Fund Coordinating Committee (CCE). At the outset, however, members of the CCE were concerned that they lacked the means to do this oversight. They therefore, asked the BACKUP Initiative to provide TS to develop their capacity and, in particular, to develop an integrated M&E system to improve the quality of HIV and tuberculosis services.

Technical support

The support from BACKUP began with a three-phase plan to design and implement an integrated M&E system (IMES). First, in 2003, technical experts held a series of meetings with stakeholders to agree on a harmonized design for the system. Second, a consultant helped in the choice and validation of indicators. Third, consultants helped to finalize the system design, which was then pilot-tested. Implementation began soon after in early 2005.

Throughout, the project made sure that the process included all key stakeholders and that IMES integrated the M&E activities of all relevant agencies: the CCE and the Principal

Recipient, the National HIV/AIDS and Tuberculosis Programmes, NGOs and self-help organizations serving as Sub-recipients of the grant. It also supported the development of a manual about IMES. As well, the BACKUP Initiative provided experts to help design data and to verify that the indicators were comparable with those of the UNAIDS Country Response Information System (CRIS).

Results

The rapid response of the BACKUP Initiative to the request of the CCE resulted in "activities undertaken with efficiency, producing clear and useful results", according to an evaluation by the Health Systems Resource Centre of the United Kingdom's Department for International Development (DFID). The participatory approach used in the M&E system, and other related interventions, boosted transparency and strengthened the CCE. This, in turn, facilitated the smooth implementation of the Global Fund grant. The promising results of IMES in El Salvador encouraged the governments of Honduras, Guatemala, Nicaragua, Paraguay and Ecuador to adopt the same approach. Paraguay, for example, is now using IMES to monitor and evaluate all national health programmes.

EXAMPLE

Developing Guinea's capacity to monitor, evaluate and coordinate HIV programmes

Context

Guinea's efforts to address rising rates of HIV have been undermined by extremely low technical and managerial capacity, and a lack of transparency in public administration. In addition, the country did not have a CCM during the early rounds of the Global Fund, making it ineligible for grants to address these weaknesses and scale up health services for HIV, tuberculosis and malaria.

Technical support

After consulting with the BACKUP Initiative and its partners, the Ministry of Health asked for support from GTZ for several projects. The one described here aimed to strengthen the capacity of the Comité National de Lutte Contre Le SIDA (CNLS) to coordinate, monitor and evaluate HIV programmes. This filled a gap in the support provided to the CNLS by the World Bank and the UNAIDS Global Monitoring and Evaluation Team (GAMET): the need to develop and install shared M&E software for organizations working on HIV.

Known as SIDAPES (the French acronym for Development and implementation of an effective monitoring and coordination system), the project began in April 2004 and lasted 12 months. Its objectives were to improve the collaboration and harmonization of strategies and action plans developed by key health service partners all over the country, and to ensure that all aspects of the national HIV plan were properly addressed. Under SIDAPES, the Ministry of Health hired a German consulting firm, Health Focus, to provide technical support in five areas:

- Analysis of the needs of the different actors involved;
- Identification and assessment of the existing systems;
- Development of monitoring and evaluation software, including a database known as PESCH (Planning Evaluation Suiting Collaboration Harmonization) and an internet forum for HIV agencies to communicate among themselves;
- Training of the future users of this system; and
- Installation of the system.

Results

SIDAPES has yet to be completed, partly owing to the slowness of public administration and CNLS and poor communication among partners. An evaluation by DFID in 2005, however, found that SIDAPES was effective in providing the national committee and its partners with a common tool – PESCH – to better coordinate M&E of HIV interventions. The internet forum also allows for the exchange of data and good practices. The activities supported, coupled with flexible, short-term financial aid, helped the Ministry of Health fill logistical and technical gaps at a crucial time and secure US$ 22 million in new global health financing. Improved coordination and M&E also contributed indirectly to the scale-up of voluntary counselling and testing, as well as psychosocial and medical treatment for people living with HIV.

EXAMPLE

GTZ helps Philippines to track progress of health programmes

Context

In the Philippines, the Tropical Disease Foundation is the Principal Recipient of five Global Fund project grants worth more than US$ 83 million. These grants aim to reduce the burden of tuberculosis, malaria and HIV in this country of 85 million people. The Foundation's management of the grants has been made difficult, however, by a weak monitoring and evaluation system, which is based on spreadsheets and separate from the system that tracks the financial status of Global Fund programmes.

Technical support

In July 2006, at the request of the Foundation, GTZ provided funding for a team of four to visit New Caledonia, for meetings with the Secretariat of the Pacific Community (the Principal Recipient of a Global Fund grant). Here the team received training in the use of the Secretariat's Project Information Management System (PIMS) and began to customize the web-based software, so that Filipino agencies and the Secretariat of the Pacific Community could share it. The software is a powerful tool for monitoring and reporting on Global Fund grant programmes. It allows managers to record programme and financial plans and to archive and generate reports; and, since it is web-based, it is easily accessible to stakeholders: Sub-recipients and other implementing partners, as well as members of CCMs, technical working groups and Local Fund Agents. It is hoped, therefore, that PIMS will aid in the country's grant decision-making, coordination and oversight.

After funding the initial training, GTZ financed the work of a technical consultant who, over several months, helped to develop and implement the system in the Philippines. Meanwhile, at meetings, managers of programmes addressing HIV, tuberculosis and malaria agreed on ways of customizing the new system, and hammered out a five-phase plan to introduce PIMS across a network of ministries, agencies and programmes by early 2007. The plan also allows for an external evaluation of the new system after one year.

Results

It is too early to assess results, but it is expected that PIMS will tighten the links in a network of organizations implementing Global Fund grants and improve the management of HIV, tuberculosis and malaria programmes throughout the Philippines and Pacific Community.

5. Selected reading

1 Handbook on monitoring and evaluating for results. UNDP, 2002.

2 From Concept to Ingredient List to Recipe: Eleven components of a fully functional HIV M&E system. World Bank Global HIV Program GAMET, 2006.

3 Guidelines on Construction of Core Indicators. UNGASS, 2005.

4 Guidelines for Core Population Coverage Indicators for Roll Back Malaria. RBM et al., 2006.

HIV/AIDS M&E – Getting Results: New Approaches to the "Third One" in a Changing M&E Landscape. World Bank Global HIV Program GAMET, 2006.

Monitoring & Evaluation: Some Tools, Methods & Approaches. World Bank. 2006.

Roll Back Malaria: Framework for Monitoring Progress & Evaluating Outcomes and Impact. WHO, 2000.

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Social Protection
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E backup-initiative@gtz.de
I www.gtz.de/backup-initiative

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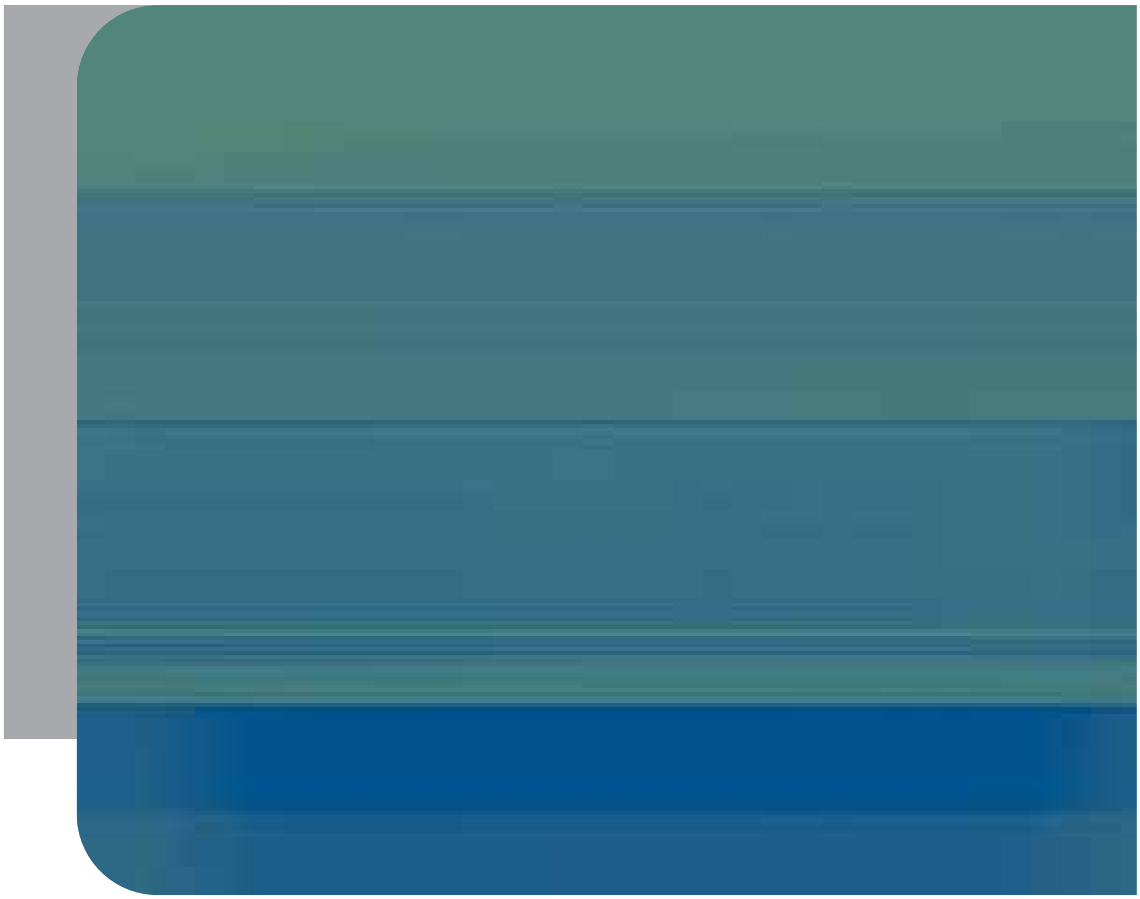

Annex

I Technical support providers

II New foundations for health and development

gtz BACKUP Initiative

commissioned by:

Federal Ministry
for Economic Cooperation
and Development

Annex I – Technical support providers

This table lists technical support providers in alphabetical order. The organizations listed all took part in a survey conducted by the BACKUP Initiative of members of the OECD Development Assistance Committee (DAC), all other member states of the European Union and selected international NGOs. All providers can be contacted for further information.

No.	Contact details of TS provider	Type of organization	Human resources available: TS can be provided in: English	French	Spanish	Portuguese	Russian	TS is provided via: Own personnel	External experts	TS Service fee
1	**ActionAid International** Johannesburg, South Africa T +27117314500 I www.actionaid.org E christine.sadia@actionaid.org	NGO, Educational	●	●		●		●	●	In some cases
2	**African Medical and Research Foundation (AMREF)** Nairobi, Kenya T +254206993000 I www.amref.org E cathyb@amrefhq.org	NGO	●	●				●	●	Yes
3	**AIDS Foundation East-West (AFEW)** Moscow, Russia T +74952506377 I www.afew.org E robin_montgomery@afew.org	NGO	●				●	●		In some cases
4	**Aidspan** New York, USA T +12125314717 I www.aidspan.org E rivers@aidspan.org	NGO	●					●		No

	Regional focus						Expertise available																				
							Area of expertise													Disease			Expertise with financing mechanisms				
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
5	**AIDS Strategy and Action Plan (ASAP)** Hosted by the World Bank on behalf of UNAIDS Washington, USA T +12024732469 I www.worldbank.org/asap E jbrown3@worldbank.org	Multilateral	●	●	●	●	●	●	●	No
6	**American International Health Alliance (AIHA)** Washington, USA T +12027891136 I www.aiha.com E jim@aiha.com	NGO	●				●	●	●	Yes
7	**Asia Pacific Council of AIDS Service Organizations (APCASO)** Kuala Lumpur, Malaysia T +60340439178 I www.apcaso.org E mae@apcaso.org	NGO	●					●	●	In some cases
8	**Australian Agency for International Development (AusAID)** Canberra, Australia T +61262064257 I www.ausaid.gov.au E infoausaid@ausaid.gov.au.	Govern-mental	●					●		No

	Regional focus						Expertise available																				
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
9	**Belgian Technical Cooperation (BTC)** Brussels, Belgium T +3225053782 I www.btcctb.org E gitt.smans@btcctb.org	Bilateral	●	●	●			●	●	No
10	**Central and Eastern European Harm Reduction Network (CEEHRN)** Vilnius, Lithuania T +37052601600 I www.ceehrn.org E training@ceehrn.org	Network	●				●	●	●	In some cases
11	**Constella Futures International, LLC** Washington, USA T +12027759680 I www.constellafutures.com E wmcgreevey@constellagroup.com		●	●	●	●	●	●		Yes
12	**CREAThE O.N.L.U.S.** Milan, Italy T +393474409892 I www.creathe.org E lital@esman.it	NGO, Educational	●	●	●			●		In some cases

	Regional focus						Expertise available																				
							Area of expertise													Disease			Expertise with financing mechanisms				
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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	●	●	●										●				●	●	●	●					●	●

			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
13	**Department for International Development (DFID)** London, UK T +442070230801 I www.dfid.gov.uk E p-cockerill@dfid.gov.uk	Bilateral	●					●	●	
14	**Deutsche Stiftung Weltbevoelkerung (DSW), German Foundation for World Population** Hannover, Germany T +49511943730 I www.dsw-online.de E joerg.maas@dsw-hannover.de	Foundation	●					●	●	No
15	**Deutsche Stiftung Weltbevölkerung (DSW), German Foundation for World Population** Kampala, Uganda T +256412200801 I www.dsw-online.de E pam.foster@dsw-hannover.de	Foundation	●	●				●	●	Yes
16	**Family Health International (FHI)** Washington, USA T +17035169779 I www.fhi.org E mbharti@fhi.org	NGO	●	●	●	●		●	●	Yes

	Regional focus						Expertise available																					
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●			
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
17	**Global Business Coalition on HIV/AIDS, TB and Malaria** New York, USA T +12126982152 I www.businessfightsaids.org E nmistry@businessfightsaids.org	NGO	●	●			●	●	●	No
18	**Institute of Tropical Medicine, Charité University Medicine Berlin** Berlin, Germany T +493030116700 I www.charite.de/tropenmedizin E gundel.harms@charite.de	Educational	●	●		●		●		In some cases
19	**International Center for Technical Cooperation on HIV/AIDS (ICTC)** Brasilia, Brazil T +556134488004 I www.cict-aids.org E carlos.passarelli@aids.gov.br	Governmental	●	●	●	●			●	No

	Regional focus						Expertise available																					
							Area of expertise																Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance				HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
	●		●	●		●	●		●	●	●	●	●		●	●		●					●	●	●	●		●	●
							●		●	●	●		●		●		●	●					●		●				
	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●			●			

			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
20	**International Council of AIDS Service Organizations (ICASO)** Ontario, Canada T +14169210018 I www.icaso.org E icaso@icaso.org	NGO	●	●	●		●	●		No
21	**International HIV/AIDS Alliance** Brighton, UK T +441273718900 I www.aidsalliance.org E pmccarrick@aidsalliance.org	NGO	●	●	●	●	●	●	●	Yes
22	**International Planned Parenthood Federation (IPPF)** London, UK T +442079398270 I www.ippf.org E nsimelela@ippf.org	NGO	●	●	●			●		Yes

	Regional focus						Expertise available																					
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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							●		●	●			●	●				●		●			●			

No.	Contact details of TS provider	Type of organization	Human resources available: TS can be provided in: English	French	Spanish	Portuguese	Russian	TS is provided via: Own personnel	External experts	TS Service fee
23	**International Planned Parenthood Federation, East & South East Asia and Oceania Region (IPPF ESEAOR)** Kuala Lumpur, Malaysia T +60342566122 I www.ippfeseaor.org E rkarim@ippfeseaor.org	NGO	●					●	●	Yes
24	**Irish Aid** Dublin, Ireland T +35314082889 I www.irishaid.gov.ie E david.weakliam@dfa.ie	Bilateral	●					●	●	No
25	**The Jerusalem AIDS Project** Jerusalem, Israel T +972547275059 I www.israaid.org.il/member_page.asp?id=11 E jaipolam@yahoo.com	Multilateral, NGO, Educational	●	●	●		●	●		Yes
26	**London School of Economics (LSEAIDS)** London, UK T +441263587136 I www.lse.ac.uk/collections/LSEAIDS/ E lseaids@lse.ac.uk	Educational	●	●				●		Yes

	Regional focus						Expertise available																					
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
					●	●	●	●	●	●	●	●	●	●	●			●	●	●			●			
	●		●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●		●	
	●	●	●	●	●	●		●	●	●	●	●		●	●		●	●		●			●		●	
	●						●	●	●		●				●			●		●			●	●		●

No.	Contact details of TS provider	Type of organization	Human resources available: TS can be provided in: English	French	Spanish	Portuguese	Russian	TS is provided via: Own personnel	External experts	TS Service fee
27	**Ministère des Affaires Étrangères** Paris, France T +33153694107 I www.diplomatie.gouv.fr/fr/	Governmental	●	●			●	●		No
28	**Norwegian Agency for Development Coperation (Norad)** Oslo, Norway T +4722242030 I www.norad.no E paul.fife@norad.no	Bilateral	●						●	Yes
29	**Office of the U.S. Global AIDS Coordinator (OGAC), U.S. Department of State** Washington, USA T +1 202 663 3848 I www.pepfar.gov E lionak@state.gov	Multilateral	●	●	●	●	●		●	No
30	**Royal Tropical Institute** Amsterdam, The Netherlands T +31205688223 I www.kit.nl E e.bussink@kit.nl	Educational	●	●	●	●		●		Yes

	Regional focus						Expertise available																				
							Area of expertise													Disease			Expertise with financing mechanisms				
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
	●	●	●	●	●	●					●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
31	**Swiss Centre for International Health, Swiss Tropical Institute (STI)** Basel, Switzerland T +41612848140 I www.sti.ch E kaspar.wyss@unibas.ch	Educational	●	●	●	●		●	●	Yes
32	**TBTEAM: technical assistance mechanism of the STB Partnership** Hosted by WHO Stop TB Department Geneva, Switzerland T +41 22 791 34 63 I www.who.int/tb/dots/planningframeworks/gf_proposals/en/index.html E tbteam@who.int	Multilateral	●	●	●	●	●	●	●	In some cases
33	**Technical Support Facility (TSF) Eastern Africa, hosted by African Medical and Research Foundation (AMREF)** Nairobi, Kenya T +254206993000 I www.amref.org E cathyb@amrefhq.org	NGO	●	●				●	●	Yes

	Regional focus						Expertise available																					
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●		
	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●		●	●	●		
	●						●	●	●	●	●	●	●			●	●	●	●	●								

			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
34	**Technical Support Facility (TSF) Southeast Asia & the Pacific** Kuala Lumpur, Malaysia T +60342576180 I www.tsfseap.org E jrock@tsfseap.org	UNAIDS-supported project	●			●			●	Yes
35	**Technical Support Facility (TSF) Southern Africa** Johannesburg, South Africa T +27832734276 I www.tsfsouthernafrica.com E rdunn@tsfsouthernafrica.com	UNAIDS-supported project	●	●		●		●	●	Yes
36	**Technical Support Facility for West & Central Africa (TSF WCA)** Ouagadougou, Burkina Faso T +22670335807 I www.tsfwca.org E raymond.onana@tsfwca.org	UNAIDS-supported project	●	●					●	Yes

	Regional focus						Expertise available																				
							Area of expertise														Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
					●	●	●	●	●	●		●	●	●	●	●	●	●	●	●			●	●	●	●
	●						●	●	●	●	●	●	●	●	●			●	●	●			●			
	●						●	●	●	●	●	●	●				●	●		●						

			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
37	**Joint United Nations Programme on HIV/AIDS (UNAIDS) Secretariat** Geneva, Switzerland T +41227911694 I www.unaids.org E mainstreaming@unaids.org	Multilateral	●	●	●	●	●	●	●	In some cases
38	**United Nations Educational Scientific and Cultural Organization (UNESCO)** Paris, France T +33145681695 I www.unesco.org E j.sass@unesco.org	Multilateral	●	●	●	●	●	●	●	No
39	**United Nations Office on Drugs and Crime (UNODC)** Vienne, Austria T +43 1260604442 I www.unodc.org E fariba.soltani@unodc.org	Multilateral	●	●	●	●	●	●	●	No

	Regional focus						Expertise available																					
							Area of expertise														Disease			Expertise with financing mechanisms					
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance		HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR		
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
40	**Department of HIV/AIDS** **World Health Organization (WHO)** Geneva, Switzerland T +41227914556 I www.who.int/hiv E chankamc@who.int	Multilateral	●	●	●	●	●	●	●	In some cases
41	**World Health Organization (WHO)** **East and Southern Regional Knowledge Hub for HIV care and treatment** Kampala, Uganda T +256772497223 I www.jcrc.co.ug E mutebim@jcrc.co.ug	Educational	●					●	●	Yes
42	**World Health Organization (WHO)** **Roll Back Malaria Partnership Secretariat** Geneva, Switzerland T +41 22 791 2847 I www.rollbackmalaria.org E bandaj@who.int	Multilateral	●	●	●	●	●	●	●	In some cases

	Regional focus						Expertise available																					
							Area of expertise														Disease			Expertise with financing mechanisms					
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance		HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR		
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
43	**World Health Organization (WHO)** **Regional Office for Africa (AFRO)** **Inter-Country Support Team (ICST)** Harare, Zimbabwe T +263 4 253724/30 I www.afro.who.int E lesikelt@zw.afro.who.int	Multilateral	●			●		●	●	In some cases
44	**World Health Organization (WHO)** **Regional Office for the Americas (AMRO)** **Panamerican Health Organization (PAHO)** Washington, USA T +1 202 974 3524 I www.paho.org E pradohug@paho.org	Multilateral	●	●	●	●		●	●	In some cases
45	**World Health Organization (WHO)** **Regional Office for South-East Asia (SEARO)** New Delhi, India T +91 11 2337 0804 I www.searo.who.int E hanums@searo.who.int	Multilateral	●					●	●	In some cases

	Regional focus						Expertise available																				
							Area of expertise														Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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			Human resources available							
			TS can be provided in					TS is provided via		
No.	Contact details of TS provider	Type of organization	English	French	Spanish	Portuguese	Russian	Own personnel	External experts	TS Service fee
46	**World Health Organization (WHO) Regional Office for Europe (EURO)** Copenhagen, Denmark T +45 3917 1606 I www.euro.who.int/aids E SMA@euro.who.int	Multilateral	●				●	●	●	In some cases
47	**World Health Organization (WHO) Regional Office of the Eastern Mediterranean (EMRO), AIDS & Sexually Transmitted Diseases (ASD)** Cairo, Egypt T +20 2 2276 5557 I www.emro.who.int E riednerg@emro.who.int	Multilateral	●	●				●	●	In some cases
48	**World Health Organization (WHO) Regional Office for the Western Pacific (WPRO)** Manila, Philippines T +63 2 528 8001 I www.wpro.who.int E manuelm@wpro.who.int	Multilateral	●	●				●	●	In some cases

	Regional focus						Expertise available																				
							Area of expertise															Disease			Expertise with financing mechanisms			
	Africa	The Americas	Europe	Eastern Mediterranean	South-East Asia	Western Pacific	Needs assessment	Strategic planning	Proposal development	Programme development	Equitable access	National coordination	Programme management	Civil society	Capacity development	Procurement and supply	Surveillance of disease	Monitoring and evaluation	Quality Assurance	HIV/AIDS	Tuberculosis	Malaria	Global Fund	World Bank MAP	Foundations	PEPFAR
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Annex II – New foundations for health and development

This annex briefly describes in alphabetical order global agreements, structures and initiatives that define the current context of technical support for health and development programming.

Abuja Special Summit

At the Abuja Special Summit in April 2001, 44 African leaders set a target of allocating at least 15% of their annual national budgets to health and committed themselves strongly to this ambitious target for the next years[1]. These African countries, however, have until now fallen far short of their commitment to raise health financing in keeping with the Abuja Declaration. Only one African country has managed to allocate 15% of its national budget to health.

Declaration of Commitment on HIV/AIDS

In June 2001, the UN General Assembly's Declaration of Commitment on HIV/AIDS recognized that, in sub-Saharan Africa, "HIV/AIDS is considered a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action" [2]. It called for increases in international financing for the AIDS response and the establishment of a Global Fund, asked for urgent action and improved co-ordination, monitoring and evaluation at all levels and called for national governments to integrate HIV prevention, treatment and care into the mainstream of all activities.

The Global Fund to Fight AIDS, Tuberculosis and Malaria[3]

The Global Fund was established in January 2002. As a partnership between governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing. It was created to increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. The Fund is a financing mechanism – the largest source to fight diseases – and works closely with other organizations involved in health and development issues to ensure that newly funded programmes are coordinated with existing ones.

The Global Implementation Support Team[4]

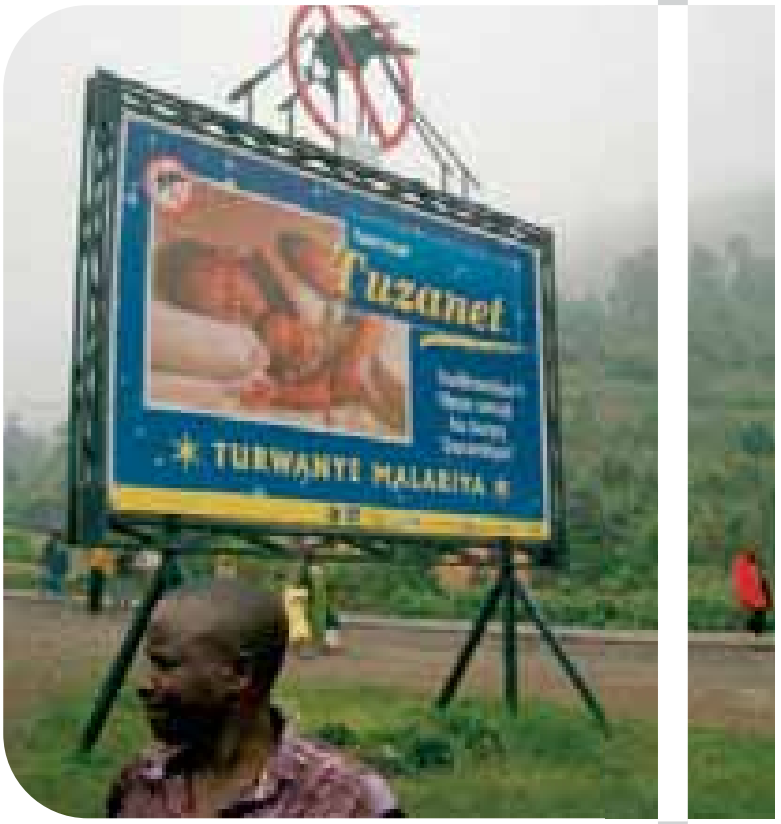
In July 2005, the United Nations (UN) organizations together with World Health Organization (WHO), World Bank and Global Fund established a Global Implementation Support Team (GIST) to function as a forum for UN technical agencies and major funding entities, and to mobilize and harmonize a rapid response for the effective use of resources to "make the money work". GIST was established to help the many countries

that face tremendous difficulties in absorbing large-scale grants from funding bodies. GIST member organizations meet on a monthly basis to review technical support needs, take decisions on joint and coordinated technical support and evaluate progress. They also look at ways to improve interaction between GIST member countries and to better align and coordinate financial and technical support to address implementation bottlenecks at country level. It has, for example, helped to strengthen pharmaceutical services and manage problems related to Country Coordinating Mechanisms and Principal Recipients.

Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors

In March 2005, a follow-up to the "Three Ones" (see below) was conducted and, as a result, a Global Task Team on Improving AIDS Coordination was established among multilateral institutions and donors. Issued in June 2005, the Task Team's final report[5] recommended that

- Countries engage all key stakeholders in the development of "annual priority action plans"; and
- Bilateral and multilateral organizations assist with the development of such plans, in strengthening national AIDS coordinating authorities as well as monitoring and evaluation systems and in establishing teams for problem solving and action in specific areas.



In response to the Global Task Team's recommendations, the ten UN organizations that cosponsor UNAIDS agreed on a Division of Labour[6] and a Consolidated UN Technical Support Plan for AIDS[7]. They also

- Established the Global Implementation Support Team (GIST) to assist countries in dealing with bottlenecks;
- Made operational the UNAIDS Technical Support Facilities in four regions and strengthened the International Center for Technical Cooperation (Brazil) and the WHO Knowledge Hubs, as well as other mechanisms for provision of technical support; and
- Established Joint UN Teams on AIDS in countries (through which AIDS-related activities are now coordinated).

Millennium Declaration

In September 2000, the UN General Assembly issued the Millennium Declaration[8] and began setting the 21st century agenda for international cooperation on health and other development issues. Donor and developing countries pledged themselves to the following three strategies:

- Substantially increasing financial support for socio-economic development;
- Supporting country-led development processes; and
- Asking all potential partners to find ways in which they can contribute.

The Assembly also established eight Millennium Development Goals, each with benchmarks for measuring progress[8]. These eight goals are so closely related that progress on one requires progress on all the others, but three focus specifically on health:

- Goal 4 is to reduce child mortality, with the target of reducing the under 5 mortality rate until, in 2015, it will be two-thirds lower than it was in 1990.
- Goal 5 is to improve maternal health, with the target of reducing the maternal mortality ratio until, in 2015, it will be three-quarters lower than it was in 1990.
- Goal 6 is to combat AIDS, malaria and other diseases, with targets of halting and beginning to reverse the spread of HIV and the incidence of malaria and other diseases by 2015.

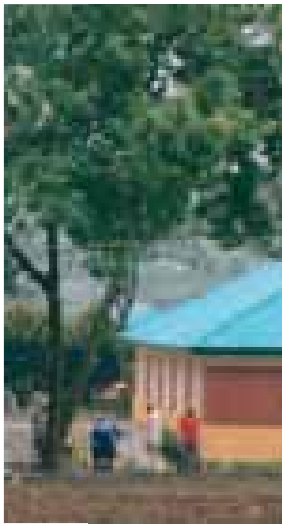
Monterrey Consensus

In March 2002, the UN Conference on Financing Development in Monterrey, Mexico, concluded with the Monterrey Consensus[9]. It lays the foundations for what is sometimes called "the new framework for development cooperation". Key elements include:

- Mobilizing the domestic resources of developing countries through improved governance;
- Increasing international financial and technical support for country-led processes, with enhanced coherence and consistency of the policies and procedures;
- Improving coordination, monitoring and evaluation; and
- Mainstreaming of HIV/AIDS prevention, treatment and care by national governments.

The Multi-Country HIV/AIDS Program for Africa by the World Bank[10]

The World Bank launched the Multi-Country HIV/AIDS Program for Africa (MAP) in September 2000. Through MAP, the World Bank is the second largest source of financing for the AIDS response and the largest source of financing for development of capacity in the whole health sector. The World Bank supports efforts to expand access to antiretroviral therapy and to strengthen health systems, as well as for prevention and education. The Bank tries to emphasize financing for community-level projects and aims at avoiding bureaucracy.



Official Development Assistance

In October 1970, the UN General Assembly resolved that donor countries would increase their contributions to Official Development Assistance (ODA) until it reached 0.7% of their Gross National Income (GNI) by 1975[11]. Donors are the 22 high-income countries represented on the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD). The DAC defines ODA as grants, low-interest loans and credits given to an official list of low and middle income countries, as well as multilateral institutions, and used to support official socio-economic development.

Since 1970, donor countries have repeatedly confirmed their commitment to the 0.7% goal but only five have ever reached the goal. A number of donor countries, however, pledged to increase their contributions[12]. In fact, ODA reached US$ 79.5 billion in 2004 and then jumped sharply to reach US$ 106.5 billion in 2005[13]. There is nevertheless still a huge gap between money raised and money needed and sources are often spent inefficiently and ineffectively[14].

Paris Declaration on Aid Effectiveness

Three years after the Monterrey Consensus, in March 2005, countries reviewed the implementation progress. They agreed on the Paris Declaration on Aid Effectiveness[15] which defines the new framework for co-operation in detail. It called on countries to:

- Develop and implement results-driven national development strategies;
- Define performance standards for national financial management systems;
- Provide more predictable long-term aid flows;
- Integrate global initiatives into broad national development agendas;
- Reform and align bilateral, multilateral and national policies and procedures, making them more cost-effective and reducing the bureaucratic burden; and
- Increase the transparency of all activities to enhance the accountability of donors and developing country governments.

Political Declaration on HIV/AIDS[16]

The UN 2006 High Level Meeting on AIDS adopted a forward-looking Political Declaration on HIV/AIDS which provided a strong mandate to advance the AIDS response, particularly with regards to scaling up towards universal access to HIV prevention, treatment, care and support. The declaration acknowledged that not all targets of the

2001 Declaration of Commitment on HIV/AIDS had been met and reaffirmed the 2001 Declaration and the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of AIDS by 2015.

The "Three Ones" Principles[17]

Representatives from donor countries, low and middle income countries and international NGOs met in April 2004 to discuss ways of making more effective use of the financial resources available for the response to AIDS[18]. They concluded by establishing the "Three Ones" principles which now guide the response to the epidemic:

- One agreed action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority with a broad-based multisectoral mandate; and
- One agreed country-level monitoring and evaluation system.

Universal Access[19 20]

Universal access is, in some ways, a successor to the "3 by 5" initiative (see below). It was launched at the World Summit 2005, when UN member states agreed on "Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it." Civil society first put this topic on the agenda, by pushing the members of the World Summit to commit to universal access. It was again confirmed in the 2006 Political Declaration on HIV/AIDS (see above) to pursue "all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of Universal Access to comprehensive prevention programmes, treatment, care and support by 2010"[16].

3 by 5 [21]

The "3 by 5" initiative was launched by UNAIDS and WHO in 2003, with the global target of providing three million people living with HIV in low and middle income countries with life-prolonging antiretroviral treatment by the end of 2005. While the strategy fell short of its target – at the end of 2005, an estimated 1.6 million people were receiving HIV treatment – it created momentum and encouraged the international community to commit to the more ambitious goal of providing universal access to HIV prevention and treatment services by 2010.

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2 Declaration of Commitment on HIV/AIDS. UN General Assembly, 26th special session on HIV/AIDS. United Nations, 2001.
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