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ASSESSING THE IMPACT OF GLOBAL HEALTH PARTNERSHIPS

COUNTRY CASE STUDY REPORT

(India, Sierra Leone, Uganda)

This paper forms part of the 2004 DFID Study: *Global Health Partnerships: Assessing the Impact.*

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PARTNERSHIP ACRONYM LIST

AAI	Accelerating Access Initiative to HIV Care
ACHAP	African Comprehensive HIV/AIDS Partnerships
AMD	Alliance for Microbicide Development
AMP	African Malaria Partnership (GSK)
APOC	African Program for Onchocerciasis Control
CF	Concept Foundation
CICCR	Consortium for Industrial Collaboration in Contraceptive Research
CVP	Children's Vaccine Program at PATH
DPP	Diflucan Partnership Program
DNDi	Drugs for Neglected Diseases Initiative
DVP	Dengue Vaccine Project
EL-MDRTBP	Eli Lilly Multi-Drug Resistance Tuberculosis Partnership
GAEL	Global Alliance to Eliminate Leprosy
GAELF	Global Alliance for the Elimination of Lymphatic Filariasis
GAIN	Global Alliance for Improved Nutrition
GATBDD	Global Alliance for TB Drug Development
GAVI	Global Alliance for Vaccines and Immunization
GBC	Global Business Coalition on HIV/AIDS
GCM	Global Campaign for Microbicides
GDF	Global TB Drug Facility
GET 2020	WHO Alliance for the Global Elimination of Trachoma
GFATM	Global Fund to Fight AIDS, TB and Malaria
GPEI	Global Polio Eradication Initiative
GPHW	Global Public-Private Partnership for Hand Washing with Soap
GSK	GlaxoSmithKline
GWEP	Guinea Worm Eradication Program
HACI	Hope for African Children Initiative
HATC	HIV/AIDS Treatment Consortium (Clinton Foundation AIDS Initiative)
HHVI	Human Hookworm Vaccine Initiative
HTVN	HIV Vaccine Trials Network
IAVI	International AIDS Vaccine Initiative
IDRI	Infectious Disease Research Institute
ILEP	International Federation of Anti-Leprosy Associations
IPAAA	International Partnership Against AIDS in Africa
IPM	International Partnership for Microbicides
IPPPH	Initiative on Public-Private Partnerships for Health
ITI	International Trachoma Initiative
IUATLD	International Union Against Tuberculosis and Lung Disease (UNION)
LEPRA	British Leprosy Relief Association
LFI	Lassa Fever Initiative
MAP	World Bank Multi-sectoral AIDS Programme
MDP 1	Mectizan Donation Program
MDP 2	Microbicides Development Programme
MDP 3	Malarone Donation Program
MEC	Mectizan Expert Committee
MI	Micronutrient Initiative
MIM	Multilateral Initiative on Malaria
MMV	Medicines for Malaria Venture
MTCT-Plus	Maternal to Child Transmission

MVI	Malaria Vaccine Initiative
MVP	Meningitis Vaccine Programme
NetMark Plus	<i>(insecticide treated net social marketing programme)</i>
PARTNERS	Partnership Against Resistant Tuberculosis: A Network for Equity and Resource Strengthening
PEPFAR	US President's Emergency Plan for HIV/AIDS Relief
RBM	Roll Back Malaria
SCI	Schistosomiasis Control Initiative
Step Forward	<i>(international pharmaceutical company initiative to support AIDS orphans)</i>
TEC	Trachoma Expert Committee
TDR	UNICEF-UNDP-WorldBank-WHO Special Programme for Training and Research in Tropical Diseases
TROPIVAL	<i>(French based R&D partnership for neglected diseases)</i>
VDP	Viramune Donation Program
VF	Vaccine Fund
Vision 2020	<i>(global initiative to eliminate unnecessary blindness)</i>
WHA	World Health Assembly
WHO	World Health Organisation
WPESS	WHO Programme to Eliminate Sleeping Sickness

ABBREVIATIONS

ART	Anti Retroviral Therapy
DALYs	Disability Adjusted Life Years
CCM	Country Coordinating Mechanism
CCPP	Child Care Partnership Project
CEO	Chief Executive Officer
DAC	Development Assistance Committee
DOTS	Directly Observed Therapy, Short Course
EPI	Expanded Programme of Immunisation
GDP	Gross Domestic Product
GHP	Global Health Partnership
GOI	Government of India
GPG	Global Public Good
HATS	Human African Trypanosomiasis
HIPC	Heavily Indebted Poor Countries Initiative
LF	Lymphatic Filariasis
IDA	International Development Association
ICC	Inter-agency Coordinating Committee
IDA	International development association
IFF	International Financing Facility
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
LMIC	Low- and Middle-Income Countries
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDT	Multidrug therapy (for leprosy)
M&E	Monitoring and evaluation
MIP	Meeting of Interested Parties
MoF/(F)MoH	(Federal) Ministry of Finance/Health
MOHS	Ministry of Health and Sanitation
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NID	National immunisation day
NGO	Non-governmental organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSA	Public Service Agreement
RPRG	Regional Programme Review Groups
R&D	Research and Development
SAC	Strategic Advisory Council
SAB	Strategic Advisory Board
STD/STI	Sexually Transmitted Diseases/Infections
SWAp	Sector Wide Approach
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TOR	Terms of Reference
TP	Technical Panel

1 PURPOSE OF COUNTRY STUDIES

The purpose of the country case studies, as indicated in the larger project Terms of Reference, was to demonstrate evidence of impact (both positive and negative) of Global Health Partnerships at country level. The TORs also ask for good practice examples to be drawn from the case studies.

2 QUESTIONS TO BE ANSWERED BY THE COUNTRY STUDIES

The TORs for the wider study ask a number of questions for the project team to try and answer, some of which were particularly pertinent to the country studies. After discussion within the wider study team, six core questions were composed, reflecting a range of the TOR questions. These were:

- Have GHPs genuinely delivered additional funds for development within the case study countries?
- Have GHPs addressed diseases that have been neglected by other forms of development assistance?
- How are governance arrangements working at country level?
- Have GHPs reduced commodity prices and improved commodity availability in countries?
- To what extent do GHPs address the needs of the poor and are gender sensitive?
- How well do GHP programmes fit with national priorities and programmes?

3 METHODOLOGY

3.1 Selection of countries for case studies

The DFID GHP team indicated that they would like case studies from three countries. The choice of country needed to ensure the widest possible coverage of the range of GHPs plus a number of other characteristics, including selection of countries from both Africa and Asia, at least one 'difficult environment' country and a range of health systems.

An initial exercise was undertaken to map the nineteen GHPs of interest to DFID and the study team on to the countries where they provide some type of intervention. The mapping exercise also included country characteristics such as demographic, disease burden, socio-economic, political and health system information.

As a result of the mapping exercise, which identified those countries that had the largest amount of GHP activity, and taking into account the desired characteristics outlined above, the study team proposed a number of options to DFID. India, Sierra Leone and Uganda were finally chosen as the case study countries.

3.2 Data collection

Each country was visited by two members of the study team. Before arriving in country and while visiting, documents and reports were collected and reviewed to help inform the studies. An interview guide was also developed, with members of the wider study team contributing questions to be asked in country. An initial list of potential interviewees was also drawn up to be used by each of the country study teams, and included National Disease Programme Managers, MOH Directors of Planning (or equivalents), UN agencies, NACs, NGOs as well as district/state level health managers. DFID staff, where available, were also interviewed.

3.3 Analysis

As each of the country studies attempted to answer the six core questions, these questions formed the main unit of analysis, with similarities and differences highlighted. The analysis also considered the interaction and effect of different health systems, as represented by these countries, on the functioning of GHPs, and vice versa. Finally, good practice stories were highlighted.

3.4 Limitations and constraints

The study teams were limited in the time they had in each country to go as much in depth into understanding how GHPs were working. The maximum amount of time spent in any one country was 13 days. This meant that the picture of what is happening below national level is necessarily constrained by the teams having only visited a few states or districts. However, at national level, sufficient numbers of different organisations and people were interviewed that a certain degree of data saturation was attained (the same stories were told by a wide range of different sources), making the study teams confident they were receiving a reasonably 'true' picture of the situation.

As with any case study methodology, it is difficult to extrapolate the lessons learned from individual cases to other countries. The full country study reports can be found in Appendix B (India), Appendix C (Sierra Leone) and Appendix D (Uganda).

4 RESULTS

4.1 Health and Health system information

The three countries studies have very different health systems, with very different proportions of funding through state and private means, as well as different degrees of dependency on external funding for running health services. Table 1 briefly outlines the health system in each country, health factors and factors affecting health system functioning.

Table 1: National health and health system characteristics

	India	Sierra Leone	Uganda
Political stability	Stable multi-party democracy	Post-conflict, limited stability	Stable, one-party movement
GDP per capita	\$462	\$146	\$249
Level of dependence on external aid	Low	High	High
Level of decentralisation	High	Low (starting process late 2004)	Medium
Predominant aid instruments used in health sector	Loans and grants to central government; project aid to NGOs	Project aid to MoHS and direct to NGOs	SWAP with budget support as preferred aid instrument, but also includes projects and earmarked sector support
Life expectancy	65	37	47
Infant Mortality Rate	66/1000 live births	170/1000 live births	88/1000 live births
HIV prevalence	0.5%	0.9%*	6-7%**
Malaria prevalence	7/100,000	44,695/100,000***	46/100,000
TB prevalence	199/100,000	258/100,000	187/100,000

All information, unless otherwise stated, from Country Mapping Exercise and Country Studies.

* HIV prevalence rates in Sierra Leone are fairly contested, due to widely differing results of various sentinel surveys, with findings ranging from 0.9% to 4%.

** HIV prevalence rates in Uganda have also been contested recently, with some observers saying prevalence is as high as 17%. Most organisations agree that it is probably higher than 6-7%, but not as high as 17%.

***2002 figures from <http://www.statistics-sierra-leone.org/ASD%202004/CHAPTER%20%2019.htm>

4.2 Have GHPs delivered additional funds for development within the case study countries?

GHPs have undoubtedly brought in additional funds for health within in all the three case study countries. Documents and respondents in Sierra Leone and India indicated that GHP funding received was additional and reasonably complementary to other sources of health financing, especially for HIV/AIDS, TB, malaria and immunisation, as well as for neglected diseases. In Uganda managers of Disease Control programmes indicated that their budgets had been reduced as a result of the sector ceiling and the first disbursements of GFATM funds especially as project funds. The graph below demonstrates the effect the Global Fund has had on health sector budgets:

Graph 1: Indicative view of total budget for the health sector (with fixed ceiling)

Health Budget 2003 – 2004	Health Budget 2004 - 2005
Off Budget Projects	Off Budget Projects (including GFATM funds)
MOH Budget (includes donor funding as Direct Budget, Sector Support, and earmarked sector support)	MOH Budget (includes donor funding as Direct Budget, Sector Support, and earmarked sector support)

Although the Uganda MOFPED claims that the sector ceiling was raised to include GFATM funds, various MoH officials reported 20 – 23% reduction in budgets. This cannot be proved through documents as on paper the budgets look fine. There is a difference, however, between budgeting for what the department will get and what it actually receives. National Health Accounts will probably demonstrate this but none has been reviewed recently.

While no one questioned that financing GHPs had provided additional funds, their financing mechanisms were more problematic. GHPs that are solely or partially financing GHPs (e.g. GFATM or GAVI) are highly reliant on government financial and service delivery systems for ensuring that GHP goals are translated to national and sub-national level. Where those systems are weak and accountability poor, as in Sierra Leone, GHP objectives have less chance of being met.

The country studies also indicated that in-country absorptive capacity was relatively weak, especially in Sierra Leone and Uganda. This was due in part to the poor delivery systems in both countries (especially at district level and below). In Sierra Leone, as a country emerging from conflict, GHP support is particularly welcome as the government's external assistance makes the transition from humanitarian relief to more developmental activities. These transitions often leave gaps in funding for health services. However, the transition also negatively effects service management and delivery capacity and therefore limits the effectiveness of extra resources at this early stage.

Financial capping in Uganda and India also means that GHPs are either limited in how much they can contribute, or they by-pass national systems, and opt for a vertical programme approach. In Uganda GFATM has set up a separate project unit in the Ministry of Health in order to not have funding limited by national financial capping. In India the Gates Foundation is channelling HIV prevention funds equivalent to one-third of government AIDS budget directly to NGOs in order to circumvent the fiscal limits imposed by the government budget. It can be argued that these efforts to by pass or circumvent government efforts at fiscal discipline undermine SWAPs and government accountability systems. However, some of those interviewed indicated that increased resources coming in through GFATM and GAVI also put pressure on government to revise its health budget ceiling upwards, which falls in line with Government of India commitments to increase social sector budgets in general.

4.3 Have GHPs addressed neglected diseases?

Neglected diseases, for the purposes of this study, included guinea worm, leprosy, lymphatic filariasis and onchocerciasis, as the neglected diseases covered in the 19 GHPs reviewed, plus sleeping sickness and schistosomiasis in Uganda. Informants were in no doubt that the GHPs specific to guinea worm, lymphatic filariasis and onchocerciasis had helped to raise the profile of these diseases in country, provided much needed support to national eradication programmes as well as access to preventive measures and drug treatment. APOC's role in rebuilding onchocerciasis control efforts in Sierra Leone is seen as highly pertinent, as the oncho-affected geographic zone has expanded because of the conflict. An earlier study found the GHP for sleeping sickness had also helped increase efforts towards sleeping sickness control in Uganda, where an effective control programme had also ceased due to years of political unrest and conflict (Caines 2003).

GAEL's role in boosting leprosy programme work is less clear. For example, in all three countries there have been long-standing leprosy programmes run by the German Leprosy and TB Relief Association (GLRA) that have been well financed, and which have emphasised prevention, treatment and care aspects. In the case of leprosy, it is unclear what additional benefit having a leprosy GHP has made to leprosy control efforts. In Uganda the GLRA stated that GAEL funding for leprosy drugs freed GLRA resources, previously spent on drug purchase, for other activities. With hindsight, given the more recent problems between GAEL and ILEP (of which GLRA is a key member), it might have made more sense to have formed a direct partnership between ILEP and Novartis, which would have achieved the same additionality with potentially less partnership politics.

Though not included in the neglected disease list above, malaria continues to represent a high disease burden in the case study countries, and yet continues to receive relatively low levels of funding (compared to other disease programmes such as HIV/AIDS) and less national attention. In these three countries, malaria remains the poor cousin to other national disease control programmes. The Global Fund projects have begun to address this as globally, in GFATM Round 4, US\$3 billion was approved, 13% for TB, 31% for malaria and 56% for HIV/AIDS. Within the countries studied, though, international advocacy from Roll Back Malaria and other malaria related GHPs has failed to galvanise the level of attention and support needed to tackle malaria in high prevalence countries and overall funding, from all sources, remains relatively low compared to the disease burden represented by malaria. Table 2 illustrates this problem in Sierra Leone.

Table 2: Comparison of disease burden and national programme funding – Sierra Leone

	Mortality/100,000	GFATM approved funding	Other funding to national programme
HIV/AIDS	173/100,000	\$ 8,574,258	\$17,000,000 (World Bank)
Malaria	321/100,000	\$12,096,834	No other funding to national programme
TB	63/100,000	\$ 2,569,103	Value of GDF donations unavailable

Reviews of GHPs done to date, and findings from the country studies, indicated that other serious public health problems continue to be neglected, including malnutrition,

sexually transmitted infections, diarrhoeal diseases, and complications of pregnancy and childbirth. In India the growing burden of disease represented by non-communicable diseases is also worrying.

4.4 How are governance arrangements working at country level?

In all countries the focal diseases are managed by the national disease control programmes of the Ministry of Health, whose role is to determine the priority needs and monitor progress. In most cases governance arrangements are based on existing accountability mechanisms within the MoH and any shared responsibility with WHO or UNICEF that exists for these national programmes (e.g. planning, budgeting, procurement and reporting). As with other aspects of GHP functioning, these arrangements are only as strong as what is in place already.

The governance arrangements of the two GHPs that require specific country coordination bodies have mixed reviews amongst stakeholders in country. On the positive side, for those GHPs that require some sort of in-country governance body (GFATM and GAVI), stakeholders agreed that GHP governance requirements had increased the range of participation in decision making about country programmes, with NGOs and civil society having increased levels of involvement.

Stakeholders at national and district/state level also mentioned considerable negative points to GFATM and GAVI governance arrangements. These included:

- The setting up of different coordination groups for financing GHPs is overly burdensome, especially in countries such as Sierra Leone and Uganda where human resource capacity is very weak. The same people often are on the different committees that have been set up.
- Financial and reporting arrangements have little reference to national budget or monitoring and evaluation cycles, where there is insistence on separate reporting formats by financing GHPs.
- In Uganda, similar issues on governance arise as with financial impact. Separate governance arrangements for financing GHPs have led Uganda to opt for the 'verticalisation' of programmes, e.g. where the GFATM project operates as a stand-alone unit from MoH (see Box 1 in the Analysis section, plus Uganda case study for more detail).

4.5 Have GHPs reduced commodity prices and improved access to commodities?

Research into commodity prices at global level provides evidence that GHPs have successfully brought down prices. This reduction in prices is not always apparent at country level or consumer level, where other factors affect the price of drugs and other commodities to the countries. For example, Sierra Leone has received free drugs and vaccines up to recently as the health programme fell under the 'emergency programme' rubric of most donors. As the situation has stabilised and the assistance to the country has switched to development budget lines, the government is having to dedicate part of its national budget to purchasing commodities for the first time in many years. The renewal of user fees at public and NGO health centres has meant that the cost of commodities has also risen for consumers as well. The same can be seen with the case of Insecticide Treated Mosquito Nets (ITNs), where under emergency programmes they were distributed for free, but now have to be purchased, albeit at highly subsidised prices.

Stakeholders in Sierra Leone did acknowledge, though, that GHPs had improved access to vaccine equipment and Hepatitis B vaccine (GAVI), improved TB drugs (GDF) and had allowed a pilot population in Sierra Leone to benefit from ACT for malaria treatment.

In Uganda the MOH has noted a considerable reduction in the cost of TB drugs, due to actions of the Global Drug Facility, while many other commodities continue to be donated to the country. The price to the consumer has fallen, primarily because of the abolition of user fees for health services, and not due to any actions by GHPs.

In India, most GHPs have no downward impact on prices due to a highly competitive domestic manufacturing industry. Stakeholders did note that GHPs had helped to improve the price of, and access to, Hepatitis B vaccine and vaccine equipment (GAVI) as well as improve the security and quality of TB drugs (GDF).

4.6 To what extent do GHPs address the needs of the poor and are gender focused?

The main finding from the country case studies is that GHPs are only as pro-poor or gender sensitive as the policy environment and health systems are that they work within. Literature reviews of GHPs point to the fact that because they address diseases that affect poor people disproportionately, they are inherently pro-poor. The same literature reviews have also found that few GHPs have specific pro-poor objectives (Buse 2004, Caines 2004). Evidence from the country studies indicates that:

- Targeting strategies (geographic and/or particular population groups) employed by government programmes could have some impact on particularly deprived groups;
- Conversely, regions or populations that are disadvantaged by the current health system, or by their remote location, or by conflict do not benefit from GHP supported programmes. There is a real danger of increasing inequalities where the populations of more able sub-national areas benefit more from GHP supported programmes than those living in less advantaged/less able areas;
- Informal charges for using health services, and notionally free services such as immunisation likely contributes to poor uptake of these services. This is despite the fact that the Governments reviewed have substantial pro-poor health policies in place to favour women, children and other disadvantaged groups;
- Health and population data are not disaggregated sufficiently to show whether programmes supported by GHPs reach the poorest or whether women receive their fair share;

4.7 How well do GHP programmes fit with national priorities and programmes?

As all GHPs work through national programmes, and because they address priority diseases in these countries, they are considered to fit well with national strategies. Each GHP has a differing profile within each country. Most people are aware of GFATM and of GAVI at national level, due primarily to their specific in-country coordination mechanisms. Other GHPs have varying degrees of profile within countries, depending on the government's role in promoting the particular GHP. The Uganda study found that all GHPs active in Uganda work towards HSSP targets. In Uganda, with the exception of Haemophilus Influenza type B, all diseases addressed

by the GHPs are considered a priority by MoH, are part of the HSSP and are included in the Minimum Health Care Package or designated district specific priorities.

Sub-national level staff in Sierra Leone and India (e.g. district and state) were generally unaware of the role GHPs played in the programmes that they had to implement. In Uganda, there was higher awareness at district level as a number of GHPs (particularly the funding ones like GAVI and GFATM) require development of workplans, separate accounting and reporting mechanisms from district staff. As district health teams in Uganda have vacancy rates as high as 50%, this work represents a high burden for an already understaffed health system.

This said, there was also a sense that GHPs could be the 'tail wagging the dog', in high aid dependent countries. In Sierra Leone, where the national health strategy has been delivered piecemeal over the last decade, and where there are so many priorities, stakeholders interviewed from both within and outside government felt the government was inclined to chase GHP funding rather than spend time first to prioritise the priorities and develop a new national health strategy. A clear example provided was the imbalance between the priority being given to HIV/AIDS prevention, treatment and care, which has dedicated funding and donations from the World Bank, GFATM and VDP despite fairly low prevalence rates, and the absence of funding for STI prevention and treatment, where the prevalence rate of STIs is much greater and is growing. This is particularly worrying given the close link between STI and HIV infection. Epidemiologically and strategically it would have made more sense to put larger funds into STI prevention and treatment now to complement World Bank funding, rather than adding to the HIV/AIDS pot. Unfortunately this has not been an option provided by a GHP. In countries that are less aid dependent, such as India, there appears to be greater freedom to determine national priorities and to slot GHP support into these as needed.

Polio eradication programmes were also cited as posing serious problems for health systems in all three countries. MOH and district/state staff indicated that National Immunisation Days for polio were a major drain on immunisation resources, while diverting attention and resources from struggling mainstream immunisation programmes. The overall impression given to the study team was that the balance of effort for polio eradication versus support for mainstream programmes was not right

Concerns were raised in other countries about the proliferation of GHPs and other major initiatives in HIV/AIDS in particular. While each individual GHP may fit well with national priorities, taken all together they begin to overwhelm the health system. For example, it is difficult for the health system in Uganda to keep up with all the HIV/AIDS initiatives as they each require slightly different type of technical and co-ordination committees as well as proposal formulation, accounts, reporting, visits from GHPs + MOH etc, both at national and district levels.

5 ANALYSIS/DISCUSSION

5.1 GHPs, typology and health systems

As stated in the 'Results' section of this report, GHPs can only be as effective as the health system within which they work. Most are very dependent on the human resource and infrastructure capacity of the country in order to implement GHP supported programmes effectively and equitably. As can be seen above, this posed problems in all the case study countries. GFATM provides a special case in point (see Box 1).

Box 1: GFATM and Health Systems

Countries that have adopted sector-wide approaches, either because the government is the main funder of public health services, or because external donors have agreed to a SWAP or basket fund, have an uneasy relationship with GFATM. The governance and reporting demands of GFATM are more consistent with project support, which more and more governments are moving away from. Different countries have coped with the tensions of handling GFATM's project orientation within health sector wide strategies in different ways.

In Uganda, the Ministry of Health decided to set up a specific project unit through which GFATM funds pass, and which then reports on GFATM funded activities directly to the GFATM board. The benefits to the MOH include GFATM funds not being included in MOH funding ceilings imposed by the Ministry of Finance and Planning, though there is some indication that this may change in the near future. Many stakeholders, however, feel the disadvantages of this approach far outweigh the benefits in the long term. These disadvantages include the fact that the Ugandan government originally submitted a joint proposal for its HIV/AIDS, malaria and TB requirements to the Global Fund, with a view to GFATM funds then contributing to the health SWAP. However, the Global Fund insisted that three separate proposals be submitted instead, and that funds be governed and accounted for separately to the mechanisms set up for the SWAP. Also, GFATM supported programmes are disassociated from CCM oversight, GFATM funded HIV/AIDS programme have little relationship with the National AIDS Committee and other AIDS related programmes. The resulting fragmentation is clearly inefficient and confusing.

Zambia, which does not yet have a SWAP but which is moving towards greater basket funding for health, has focused the management of GFATM support within the CCM. CCM members have said they are exploring how GFATM funds could be incorporated into the health sector basket funding, a clear difference from how Uganda has approached GFATM. However, they also reiterated that GFATM reporting and governance requirements do not easily lend themselves to sector wide approaches. The principle recipients are 3 NGO bodies and one grouping of line ministries.

In India GFATM is fully integrated into government systems, with the Department of Economic Affairs as the principal recipient and the MOH as the main implementer. The India CCM, once seen as not very inclusive, is now open to wide participation of NGOs. GFATM requirements, backed up by reviews of CCM functioning, are credited with broadening participation of non-establishment organisations in decision making on the three focus diseases of GFATM. Despite the reasonable integration of GFATM into the India health system, officials still find the application process and monitoring and reporting requirements as highly cumbersome, due to poor harmonisation with existing systems.

This study only examined the three case study countries, only one of which has a functioning SWAP. While there is a certain logic in arguing that GHPs should work through SWAPs where they exist, there is no evidence from the case studies for how this can be taken forward.

Different types of GHPs

Evidence from the country studies, and interviews with others indicates that different types of GHPs have a different reliance and relationship on health systems. In general this difference is outlined in the Table 3 below:

Table 3: GHP types and relationship with health system

Type of GHP	Fit with health system	Reliance on health system
Financing: GFATM and GAVI	Better fit with centralised system where main aid instrument is project support	High Reliance - Requires high level input for coordination committees, reporting and accountability
Access, donation: Stop TB, GPEI, GAEL, GAELF, GWEP etc.	Flexible fit with any health system, as donations etc. pass through and are accounted for within existing systems and mechanisms.	High reliance on health system to procure and ensure equitable distribution of commodities and services.

Both financing and access/donation GHPs are highly reliant on having a good functioning health system to 'deliver' the GHP programme. For financing GHPs, programmes are generally run as project-aid through the appropriate National Disease Control Programme (e.g. HIV/AIDS, malaria, EPI etc.). Where these programmes have poor reach and/or ineffective systems, there is a direct impact on the effectiveness of how GHP funding is used. Similarly, where access/donation GHPs are concerned, they impose less immediate burden on government programmes (e.g. no coordination meeting requirements etc.). However, the more distant and hands-off approach does mean an even greater reliance on a well functioning health system, and in particular, an effective National Disease Control Programme. From the country studies there would appear to be little or no relationship between GFATM, CCMs and the access/donation GHPs, indicating either poor national level coordination within those disease control programmes or too many external demands on government, leading it to respond in an ad hoc manner. GAVI, ICCs and access/donation programmes related to immunisation are more joined up, e.g. with ICCs also providing a strategic oversight of National Immunisation Days as part of the polio eradication programme. The team can only speculate about why there is this difference in linking and coordination, though one common denominator in making the links in immunisation is UNICEF's ongoing strong support to country EPI offices.

The integral relationship between GHP programme implementation and health systems has led some to state that the GHPs should include health system strengthening as part of the support they give to countries. The study team feel this needs nuancing, as the inclusion of yet more actors dabbling in health systems is likely to be counter-productive. These issues arise primarily for the financing GHPs (GAVI and GFATM), and less so for the small neglected disease GHPs who have no option but to work through existing systems.

What GHPs can contribute to system strengthening:

- GHPs have played a health systems strengthening role in providing technical assistance to national programmes, from the application phase onwards. GFATM provides technical support for submitting applications, improving governance etc. Concerns raised about GFATM TA is that consultants only come in briefly with a narrow perspective and may not help countries/CCMs see problems in a more holistic fashion;

- GHPs have also invested in training to help strengthen technical capacity (e.g. MIM training of African researchers) and financial systems (GAVI's financial sustainability workshops). GAVI's willingness to fund areas to facilitate improved immunisation programmes (e.g. infrastructure, per diems etc.) is also welcomed by countries;
- Stop TB and GFATM support to India's National TB programme, and especially to expanding the DOTS regime, has improved integration of NGO and private providers into the national programme and the health system more generally;
- Where GHPs do work through government systems, there is some evidence that this has helped governments take on greater ownership of programmes. GAVI's support in Sierra Leone has shifted ownership of the immunisation programme away from UNICEF to the MOHS, with UNICEF's blessing.
- Where countries have introduced a SWAP or other basket-fund approach, financing GHPs should put their funding into the common budget with other donors in order to harmonise with existing national systems while providing support for ensuring monitoring and accounting systems provide the information needed.

Where GHPs could work in a more complementary manner

In conjunction with the above approach, governments and donors should strive towards complementarity of different programmes to support health within countries. One stakeholder interviewed highlighted this, as he reflected on the fact that GHP support to priority programmes had allowed his government to put more emphasis on health system strengthening, with a specific focus on human resource capacity development. Given the constraints health systems place on effective implementation, and the burdens GHPs can place on health systems, a rational way forward must be to invest more and more long term, in health system strengthening, rather than putting increasing amount of funds into GHPs that are primarily concerned with funding or improving access at this point in time. There therefore needs to be more of an explicit connection between health systems support and GHP funding and access programmes if GHP effectiveness is to be improved.

A number of ways to make this explicit connection have been put forward. One way is for donors to 'top slice' their contribution to the financing GHPs, so that a certain percentage is withheld from the overall donation to GFATM or GAVI and invested instead in system strengthening activities. USAID is proposing to 'top slice' for their next round of funding to the Global Fund. Another way is for donors to put extra funds directly into health system support, which is the approach GTZ has taken with its BACKUP Initiative. None of the countries included in the case study were recipients of GTZ BACKUP support.

5.2 Examples of good practice

National Coordination

- *Coordination mechanisms that are inclusive:* GFATM- and GAVI-related coordination committees have improved inclusion and participation of a wider group of stakeholders concerned with GFATM diseases and with immunisation. Their effectiveness is increased in countries that use the same coordination mechanisms for all aspects of the particular condition or disease, and not just for the specific funding of the programme. The GAVI ICCs are stronger in this aspect, as they also often oversee polio eradication and coordinate other immunisation concerns beyond those supported by GAVI.
- *Active roles played key partners:* Good functioning of both the ICC and CCM in Sierra Leone was attributed to the strong, active roles played by the UNICEF and

WHO representatives attending the coordination meetings. This role was widely welcomed by stakeholders, who felt that meetings became unfocused when these representatives were not present. This may be a good practice lesson particular to countries emerging from conflict or other forms of political instability, where leadership needs boosting from non-state actors.

- *Enabling inclusion of non-governmental actors:* In every country studied, non-governmental actors appreciated the fact that they were invited to sit on both the GAVI ICC and Global Fund CCM in country. In Sierra Leone, the Global Fund's principal recipient is a national NGO (Sierra Leone Red Cross Society), which has also just rotated off the GAVI Board as the NGO member. In India, NGOs play a strong role in TB control programmes, encouraged by the Stop TB Partnership in the country.
- *Alignment of key implementers in country for achievement of GHP objectives:* In India, NGO partners work hand in hand with government to implement the government's TB control and polio eradication programmes. In Sierra Leone NGOs have been a vital support to government health programme managers, to the degree that the GLRA leprosy and TB programme has been, in fact, the MOHS programme, though the national TB programme is beginning to move towards greater integration with other service delivery.

GHP Advocacy Roles

- *Strong national advocacy:* National level advocacy is needed to bolster national eradication programmes. The strength of Stop TB in India, where the national TB control programme is strengthened by strong advocacy within government, sits in stark contrast to the profile of the malaria programme in the country. (see India case study for more details).

Reaching the Poor

- *Targeting of specific populations or geographic areas can increase the chances of reaching vulnerable groups.* While targeting is a national strategy employed in India, rather than an internationally recommended GHP strategy, it is a practice that bears close monitoring to see whether other countries should consider a similar approach with their GHP supported programmes.

6 CONCLUSIONS AND RECOMMENDATIONS

Positive additionality of GHPs: Global Health Partnerships offer considerable opportunities for attaining disease control and eradication targets for those diseases covered. The strengths of GHP programmes lie in the fact that they focus attention on a priority disease or health concern (either through product development, funds, drug donations or advocacy work). This both raises the profile of the disease within the country, and where funding or other means of improving access are provided, also gives government and its partners the wherewithal to act.

Some GHPs have been more effective than others in raising the profile and attracting increased resources for specific diseases. GAVI and GPEI have been particularly effective in not only keeping routine immunisation as well as polio eradication in the global and national eye, but in introducing new vaccines (though the need for some of these vaccines are variable at country level from an epidemiological point of view). The Stop TB Partnership has also been effective in strengthening national TB control programmes through advocacy and improving TB drug security and quality. Malaria GHPs have not been as effective at raising the profile of malaria, increasing resources or coordinating the various malaria programmes supported by different GHPs.

Heavy reliance on health systems limits effectiveness and may increase inequalities: The effectiveness of GHP support, especially for those programmes that provide funds or that focus on improving access, is highly reliant on the health system through which that support is implemented. Weaker systems cannot deploy GHP resources as well as stronger systems. This variation is seen not only between countries, but also between districts and states within countries, leading to concerns of contributing to inequality of access to services and health outcomes. The weak pro-poor and vulnerable group focus of GHPs means that outcome variables relating to increasing or decreasing inequalities are not measured as part of evaluating GHPs.

Variable harmonisation/integration with existing health systems leads to substantial transaction costs: In most countries where GHPs operate, the health systems are already under heavy strain due to poor human resource and infrastructure capacity. Additional monitoring and reporting requirements do put a strain on these systems.

Increase efforts for health system strengthening: Much more attention needs to be given by the donor community to health system strengthening, and to making explicit links between programmes that support health systems and the programmes supported by GHPs. However, GHPs themselves should not get involved in health system strengthening, other than the focused technical assistance they currently provide.

Post-conflict and difficult environment countries need special measures: The 'one size fits all' approach of most GHPs puts particular pressures on countries that are politically and socially fragile. The Sierra Leone case points to a number of concerns, including limited capacity for planning and prioritising, very limited absorptive capacity at all levels in the health system, and the potential for access and funding GHPs to exacerbate problems with corruption and accountability. This last concern is very worrying as poor government accountability was at the heart of the original conflict in the country. The situation presented by fragile states necessitates even more concerted effort on the part of multilaterals and bilaterals to provide direct support to the health system. It may make sense for financing and access/donation

GHPs to adopt a slower, more hands on approach with fragile states, identifying strong national partners (either state or non-state) through whom they can work.

As such, the country study teams **recommend** that:

For National Coordination and Alignment

- **The ‘fit’ of GHP funds and donations with MTEFs and national macro-economic policies needs more rigorous study and debate.** This should be taken forward as part of a wider debate about the relationship between the full range of development assistance and MTEFs, and should include the IMF as an active participant. The report of the Millennium Project, due in January 2005, could provide the context for such consideration. Its current draft report recommends increased financing—largely donor financing—for public investments in the poorest countries, and argues that the IMF’s role should entail helping each country to establish a macroeconomic framework around the inflows of donor aid needed to achieve the MDGs rather than around the currently available flow of donor aid.
- **GHPs should work to decrease transaction costs created by extra demands in proposal development, reporting and monitoring by harmonising more with existing government systems and with each other, where there is opportunity for collaboration.** GHPs should seek to align with in-country systems and cycles, for budgeting, financial and programme monitoring, procurement and audit. Where this is not possible then co-operation at an international level to ensure a common approach could help.
- **Where a SWAP or basket fund approach exists in the health sector, financing GHPs in particular should aim to provide funding within the SWAP framework,** rather than parallel to it, to avoid the fragmentation and problems seen in Uganda with the Global Fund. Donors such as DFID who are pro-actively supporting direct national and sector budget aid, as well as GHPs, could lobby the funding GHPs (GFATM and GAVI) to do this.

For health systems

- **Bi-lateral and multi-lateral donors invest more in health system strengthening to complement resources brought in by GHPs.** This is a key finding of this report, the importance of which cannot be overstated. Without health system support GHPs are likely to exacerbate strains within health systems, rather than alleviate them, while also not attaining their stated outcomes. DFID could opt for either the ‘top slicing’ approach or the special programme fund approach to support system strengthening, as both put funds directly into system strengthening projects.
- **GHPs should make more explicit, and be accountable for, pro-poor objectives in their programmes.** Not only should GHP objectives state what the intended impact is on poor people and vulnerable populations, they should also have outcome measures against which their attainment of these objectives can be evaluated.
- **GHPs should take a special approach to difficult environment countries.** All the above recommendations hold true. In addition, funding and access GHPs

need to accompany their programmes with more intensive technical assistance to both the Ministry of Health and the potential service delivery partners. They also need to work in a more staged fashion with their support, to take into account the limited absorptive capacity of ministries, while also seeking complementary arrangements with other long term donors to the health sector to ensure good governance and accountability mechanisms are being built up.

On key disease areas

- **Bilateral and multi-lateral partners should work with malaria related GHPs to enhance the profile of, and funding for, malaria programmes in countries.** Malaria prevention and treatment efforts appear somewhat uncoordinated and haphazard at country level, despite malaria representing a very heavy percentage of the disease burden.
- **Regarding HIV/AIDS, the GHPs should work with country partners to harmonise multiple HIV/AIDS GHP programmes (where multiple ones exist in country) as well as to put into place as soon as possible the three ones.**
- **Careful assessment needs to be done before setting up any new partnerships to tackle other public health problems.** While the country study uncovered a number of public health problems that are not addressed by any partnership (e.g. STIs, diarrhoeal disease) this does not mean a partnership is the best way to begin to make headway in these areas. The proliferation of partnerships is especially confusing at country level and below

APPENDICES

Appendix A	Country Case Study Terms of Reference
Appendix B	India Case Study Report
Appendix C	Sierra Leone Case Study Report
Appendix D	Uganda Case Study Report

Appendix A: Country Case Studies Terms of Reference

Summary

The Aid Effectiveness Group in DFID's Policy Division is engaged in three significant workstreams, to:

- assess the impact of aid channelled through Global Funds and Partnerships (GFPs) in comparison with other aid instruments;
 - determine a set of criteria for donor engagement with GFPs; and
 - identify strategies to increase the effectiveness of the GFPs with which DFID is engaged.
-
- A significant proportion of the GFPs with which DFID engages are concerned with health issues. The Global Health Partnership (GHP) Team within the Aid Effectiveness Group has therefore commissioned a substantial, evidence-based assessment of the impact of the GHPs with which DFID engages at both global and country level, drawing out best practice principles which will guide DFID's future engagement.

Much of the work on the global impact of GHPs should draw on information that is already available; evidence of impact at country level will need to be gathered from selected DFID country offices. The work should be completed by the end of November 2004.

Key questions to be answered by this study

- Have GHPs genuinely delivered additional funds for development within the case study countries, and whether the surge in support for GHPs has outstripped the decline in ODA?;
- Have GHPs addressed diseases that have been neglected by other forms of development assistance?;
- How are governance arrangements for GHPs at country level?;
- How well are GHPs working with country programmes (e.g. how is their fit?)
- To what extent do GHPs address the needs of the poor and to what extent are they gender focused in practice, and in what ways do they operationalise this?
- Have GHPs reduced commodity prices and improved commodity availability in country?

Tasks

The country case study team will :

- Develop interview guide for country visits with input from other GHP team members (see attachment 1);
- Liaise with DFID country office staff to see who should be interviewed during country visits and begin gathering relevant documents;
- Undertake country visits to collect data for informing issues raised in the project's TORs (attachment 2). This will involve interviews with DFID staff, key government staff and other GHP stakeholders in country;

Outputs

The country case study team will :

- produce a report on the country fieldwork
- lead in completing the section of the final report covering an assessment of how GHPs fit with other country processes in the health sector.
- contribute to the sections of the final report covering
 - analysis on GHPs and how they address the needs of the poor and are gender focused
 - assessment of whether GHPs have delivered additional funds
 - assessment of whether GHPs have addressed neglected diseases
- contribute (as necessary) to other report sections
- contribute to the final overview report sections on improving the impact of GHPs and recommendations to DFID

Appendix B:

INDIA CASE STUDY

This paper forms part of the 2004 DFID Study Global Health Partnerships
Assessing the Impact.

Nel Druce
Rajeev Sadanandan

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1 EXECUTIVE SUMMARY

1.1 Background and approach

This study is one of three country case studies for Sierra Leone, Uganda and India. It was commissioned by DFID's Global Health Partnership (GHP) Team as part of a broader assessment of evidence for the impact of the GHPs. Study findings are based on a literature review and over 60 interviews with government officials, representatives of development partners, and civil society (September 1-15 2004). Visits were made to two contrasting states: Rajasthan (one of the five Empowered Action Group states) and Andhra Pradesh.

The key questions addressed by the study concern the following aspects of GHP impact: their focus on neglected diseases; governance and co-ordination arrangements; mobilisation of additional financing; fit with national health programmes; extent to which needs of the poor and women are addressed; and their impact on prices and other aspects of commodity supply.

1.2 Context and challenges

India's per capita GDP of \$2570 is above the average for low-income countries at US\$2040 (2002). However, more than 44% of India's population lives on less than a dollar a day. Public sector allocation to health remains one of the lowest in the world at under 1%, and a low average public spend of \$4 per capita. This is reflected in its under-resourced and highly challenged public health system, especially in the poorest states. Although the poor use publicly provided antenatal care and immunisation services more than the rich, the very poorest benefit least. Public subsidy to the top quintile is three times that to the lowest. A major proportion (up to 80% in some states) of outpatient care is provided by a weakly regulated private sector.

India's ODA is only 2% of central government expenditure. In 2001 the country received per capita official development assistance of US\$2 against an average of US\$10 for the low income. The GHPs themselves contribute less than 5% of the total domestic health expenditure (including major lenders and donors). Low aid dependence means that external partners in health, including the GHPs, have less financial leverage than in other countries, and must rely on credible technical expertise and other influence.

India accounts for 21% of the world's global burden of disease. As eradication efforts for guinea worm, small pox, leprosy and polio result in some successes, the burden of communicable diseases is falling, but they still account for over 50% of DALYs lost, with childhood diseases, malaria and TB as the major contributors. Persistently high rates of maternal mortality and morbidity are linked to high fertility levels. To a large extent, these are the diseases of poverty. Across India, the poorest quintile has more than double the mortality rates, malnutrition, and fertility of the richest quintile.

1.3 Global Health Partnerships in India

The country bears a large share of the world's disease burdens that are also addressed by the GHPs (eg 22% TB and 65% leprosy). Progress toward global targets for diseases of the unfinished agenda therefore depends on a substantial contribution from India, although the burden of disease varies considerably by state.

India's response to these diseases is managed through its centrally sponsored national health programmes, which are delivered at state level. India participates to a greater or lesser extent in seven access GHPs. These aim to provide technical

and/or financial assistance for the prevention and control of the major neglected diseases: Stop TB, Roll Back Malaria, GAELF, GAEL, GPEI, GAVI and GFATM. Of these, three are providing substantial financial assistance: the GFATM, GPEI and GAVI (to a lesser extent). Public sector research institutions are also working with three product development partnerships: MMV, MVI and IAVI.

1.4 Key findings and conclusions

1.4.1 GHP focus on neglected diseases

To a large extent, there is good fit between the GHPs and India's large burden of communicable disease. However, as noted above, it should be noted that non-communicable diseases now contribute over half of all DALYs, and that investment in prevention and care is regarded as very low relative to need.

Excepting polio, India had national programmes in place for all the targeted diseases prior to the GHP, with significant support in place from the World Bank, DFID and USAID for several of them. Although malaria control and prevention is improving, it is not effectively tackling the disease in poor endemic areas. RBM profile and partner support is low in comparison to that of STOP TB. The rise in HIV prevalence is requiring an enhanced national response, and it is clear that GHP finance is enabling India to gear up to ART provision more rapidly than otherwise possible.

India continues to make reasonable progress on achieving its national and global targets for polio, leprosy and LF, although the technical and financial contribution of the GHPs for the latter is very limited. The wholehearted response from India and its partners to the global push for polio may have skewed attention away from routine immunisation, which has deteriorated in recent years. With regard to other neglected diseases, such as kala-azar and Japanese encephalitis, the newly converged vector borne disease programme is addressing these, and they are likely to receive more attention in endemic areas.

1.4.2 Governance and co-ordination issues

All the focal diseases are centrally managed by the national health and family welfare programmes, and there is strong national and state ownership. GHPs contribute the equivalent of less than 5% of India's domestic and external health budget, and hence their financial or other influence on the wider system is unlikely to be significant.

Most of the disease programmes have inter-agency co-ordinating committees and expert groups. These are not convened under a GHP banner, but tend to be stronger where members are partners in a relevant GHP (eg immunisation, STOP TB). The GAVI working group is a subgroup of the Immunisation Interagency Co-ordinating Committee, but is not felt to be fully functional. Decisions about new vaccine strategies were made largely in the absence of co-ordinated GAVI partner inputs. Partner commitment to GAVI may also be overshadowed by the demands of GPEI and polio eradication activities.

There is some evidence that full partner alignment and co-ordination is not taking place, which weakens the impact of the GHPs. For example, the TB programme and NACO have concerns about coherence between GFATM and World Bank procurement rules. Roles were particularly unclear with regard to partner responsibilities to support GFATM processes, which was causing some frustration amongst international partners.

The GFATM has its Country Co-ordinating Mechanism, required as a condition for grant eligibility. While the GFATM's CCM is beginning to strengthen its governance arrangements, it is no substitute for a formally constituted national level body, such as the NAC, and other elements of the three ones. It is possible that focus on the CCM could be inhibiting development of national governance structure.

On the other hand, GHPs are also successfully advocating for the adoption of new and effective stakeholder approaches to strengthened governance and mainstreaming HIV/AIDS. Prior to GFATM's entry into India, involvement of PLHAs by NACO, and support to the newly emerging networks, was reported to be minimal and tokenistic. The active inclusion of the private sector and NGOs in the TB DOTS treatment programme is another example of constituency engagement.

1.4.3 Fit with country priorities and systems effects

STOP TB and GPEI both had substantial national profiles, and were said to be working well by all partners. RBM had the lowest profile of all the partnerships. In general, awareness of the technical partnership even among the senior programme staff at state level tends to be low. This does not necessarily mean low GHP impact, and could reflect strong ownership by the national programme. On the financing side, GFATM was familiar to almost every interviewee.

The extent to which GHP presence and influence is 'felt' in India is linked to the following factors: consensus on, and clear articulation of the overarching vision and strategy by the national level external partners of the international partnership; clear roles, together with understanding of, and ability to finance and deliver, the technical priorities; degree of national involvement in international partnership; sense of national responsibility to contribute to international goals; and strong national ownership giving the programme legitimacy.

There are striking contrasts between the national TB and malaria programmes, in terms of several key dimensions of country effectiveness. While difficult to directly attribute this to the respective GHPs, it is clear that the GHP has had some influence. Possible reasons for STOP TB's success include high level engagement with the GHP board, degree of partner alignment on policy and technical aspects, the role of WHO, and degree to which India is prioritised by the GHP.

There are arguments for stronger state engagement in national programme strategy and consultation. STOP TB's emphasis on strategic planning has had benefits at state as well as national level. This is happening to some extent in AIDS, where state level capacity in strategic planning across a range of stakeholders is a clear need.

With regard to the Fund, technical support is needed for proposal development and management and this requires proper funding and facilitation – at present it is ad hoc and inefficient. Application and re-application procedures are perceived as highly complex and changing. Reporting arrangements are perceived as reasonable in principle, but are not in line with existing donor requirements.

Also, there is some evidence that GHP conditionalities are not being used to best national benefit. For example, drug and vaccine reporting systems can be useful models for the wider system, but it was noted that while reporting (and management) of polio and HepB was generally good, it was very weak for wider routine immunisation vaccines.

Access GHPs (both technical and financing) have influenced the introduction of new technical approaches, technologies and commodities into programmes. Examples

include: GAVI's injection safety equipment (AD syringes); GFATM finance for ART and combination anti-malarials; and MDR TB drugs are being considered through the Green Light Committee.

GHPs are not generally distorting country systems. But it is also now recognised that, for whatever reason, immunisation coverage has fallen drastically in many districts, and efforts are needed to improve it. There are perceptions that the drive for polio eradication contributed to this. It is clear that the introduction of HepB is not a priority for the majority of districts in India just now (except for states where HepB prevalence justifies inclusion in the programme).

1.4.4 Financial additionality and sustainability

There is evidence to suggest that new finance (from new donors) has been generated at national level through the influence of GHPs. Officials linked STOP TB's lobbying activity with the US Congress with USAID's recent decision to finance TB activities in Haryana. The GFATM is perceived to have some influence on recent developments to permit new finance over and above the 10th Plan funding allocation to HIV/AIDS in particular, especially since the Plan had no ART budget line. Pulse Polio has received substantial civil society and other contributions. However it is not clear to which the latter represent additional finance earmarked for polio, as opposed to a reallocation of aid destined for other health purposes.

New financing sources such as the GFATM and GAVI are not perceived to have substituted for other donor funds, although there has been some lack of clarity on TB funding. Effective partnerships can also facilitate the legitimate routing of funds through arrangements with credible agencies, such as WHO and Unicef for technical support (TB and polio). GHPs are felt to be useful for introducing new initiatives that would be challenging to identify short-term finance for through the domestic budget. New funding mechanisms are perceived to sharpen donor and government performance, as the GOI can shop around and negotiate conditionalities. The GHPs are also supporting a culture for more proactive strategic and financial planning (immunisation, TB, HIV/AIDS strategy).

1.4.5 Impact on commodities

Most GHPs have had no overall downward impact on prices, given India's reliance on its domestic and highly competitive generic manufacturers. However, GAVI and Gates Foundation support for HepB vaccine and AD syringes have increased Indian suppliers and reduced prices. Technical support to reach WHO good manufacturing practice, provided by PATH, has enabled several firms to enter the international market, and contribute to competitive pressures on prices.

There is some tension between market development and public health interests. GAVI's global objective to expand the market and signal demand for new vaccines means that more suppliers are keen to enter the market, and GOI is under industry pressure. Meanwhile India is reluctant to scale up access to HepB, especially where immunisation rates are very low and other interventions make more public health sense.

National officials value the flexibility and pragmatic approach taken by facilities such as the GDF. GDF is used as a backstop to safeguard quality TB drug supply in case of any national procurement failure, as well as providing an in kind drug grant. There are some concerns about lack of harmonisation in procurement (notably between the GFATM and the World Bank, which does not recognise WHO pre-qualification status).

1.4.6 Poverty and gender focus

Overall there is a lack of data on pro-poor incidence of programmes – coupled with a widespread but often unfounded assumption that the programmes are reaching the poor. Recent analysis of immunisation coverage (from RCH I's periodic household surveys) shows great disparities between the poorest and richest quintiles.

However, there is a reasonable (0.8) correlation between low quintile membership and scheduled caste and tribal status. This justifies population-based geographical targeting, which is used by several programmes (malaria, leprosy).

There is high awareness of issues affecting women's health and access to care, especially for TB, HIV/AIDS and leprosy. However, although gender disaggregated records are maintained, it is not clear that efforts are made to synthesise the data and consider implications for strategies to address any inequities.

1.5 Recommendations

1.5.1 Partner alignment

Partnerships with clear country mandates are more effective at country level. Mechanisms are needed for the effective communication of the consensus developed by international partners to the country level. This will support GHP partner co-ordination, agreement on different and appropriate roles for partner agencies at national level, and on a strategic plan for delivering and co-ordinating support to the national programme.

1.5.2 NGO and other stakeholders

Partnerships that actively promote NGOs as equal partners are better-known and have more impact at country level eg TB, GAEL, and polio, as opposed to RBM and GAELF. International and national NGOs need to be involved in PPPs at global and country level, in order to leverage efforts for both advocacy and service delivery. There is an equally important role for the private for profit sector, at the national level, given high utilisation rates.

1.5.3 Harmonisation and integration efforts

GHPs (and the country level partners) need to contribute as much as possible to current GOI convergence efforts, by working towards harmonising M&E frameworks, procurement arrangements, financial reporting, and support for strategic planning and budgeting. Any conditionalities should have clear benefits to GOI as a key GHP partner. A balance is needed between system strengthening inputs versus focused interventions – stronger partner alignment is likely with a focused partnership but adverse system affects are more likely.

1.5.4 Effective use of aid instruments

Financing GHPs are a useful and complementary addition to the mix of aid instruments. Traditional bilateral and multilateral support provides flexible and long-term investment frameworks. GFATM and GAVI have introduced very different mechanisms – with higher transaction costs, offset by the short turnaround and willingness to fund new approaches. The GHPs often build on strong existing partnerships between government and bilateral and multilateral agencies. However, financing alone can result in sub-optimal implementation and bottlenecks especially at state level. A strategy is needed to enable technical agencies to support programme delivery, as part of a TA component in the strategic plan.

1.5.5 Pro-poor incidence of GHPs:

In the context of poverty reduction goals, GHP emphasis on pro-poor incidence of programme benefits needs to be explicit in partnership objectives, and advocated at country level. This should include the value of using disaggregated data in developing strategy to reach the very poor. Routine data collection on SES is not recommended, but there is certainly a greater role for periodic household surveys, to generate baseline and outcome/impact data.

2 BACKGROUND AND APPROACH

DFID's development effectiveness team is undertaking a series of studies in 2004 to:

- assess the impact of aid channelled through Global Funds and Partnerships (GFPs) in comparison with other aid instruments;
- determine a set of criteria for donor engagement with GFPs; and
- identify strategies to increase the effectiveness of the GFPs with which DFID is engaged.

A significant proportion of the GFPs with which DFID engages are concerned with health issues. The Global Health Partnership (GHP) Team within the Aid Effectiveness Group has therefore commissioned a substantial, evidence-based assessment of the impact of the GHPs with which DFID engages at both global and country level, drawing out best practice principles which will guide DFID's future engagement.

This study is one of the three country case studies, which aim to provide examples of how GHPs are operating and having effect in different contexts: Sierra Leone, Uganda and India. Each case study team used a similar methodology, to address the key questions below. Review of official and grey literature was complemented by over 60 interviews with government officials, and representatives of development partners, and civil society (September 1-15 2004). Given time limitations, the team focused on the seven access partnerships present in India, but included brief assessments of the three product development partnerships. Visits were made to two contrasting states: Rajasthan (one of the five Empowered Action States, designated for enhanced support) and Andhra Pradesh, one of the southern higher performing states, in terms of health outcomes.

Key questions addressed by the study in India and other countries are:

- Have GHPs addressed diseases that have been neglected by other forms of development assistance?
- What are the strengths and weaknesses of governance and co-ordination arrangements at country and state level?
- Have GHPs delivered additional funds for health? How has this been achieved?
- How well are GHPs working with national health programmes and the wider health sector at state level? Are there any emerging synergies with, or distortions of existing system operations?
- To what extent do GHPs address the needs of the poor, and address gender inequities, through operational programme strategies?
- Have GHPs reduced commodity prices and improved availability of quality and secure supplies?

3 HEALTH AND HEALTH SYSTEMS IN INDIA

3.1 Socio-economic and development status

Globally, India is the second most populous country, with a population of more than one billion. It has a federal government with a strong centre, comprising a union of 29 states and six centrally administered union territories. The states differ widely in their language, climate, ethnic make-up, economic development and social and health indicators. Aggregate national indicators, while useful for international comparisons, hide this variety.

The Indian economy is in a state of transition from a centrally planned economy to a more open one. Agriculture continues to be the major source of employment (58.2%) but contributes only 26% of the gross domestic product. Manufacturing and trade account for 25 and 23 percent respectively of the gross domestic product.

The total gross national income stood at \$2691 billion (in 2002 at purchasing power parity); the fourth largest in the world. In the period 1975 – 2000 the GDP per capita grew at the rate of 3.2% per annum (Economic Survey 2002-2003, Planning Commission of India). The World Bank estimated the per capita gross national income of India at purchasing power parity to be \$2570 (above the average for low income countries at US\$2040) in 2002. However, the share of the poorest quintile in national consumption is estimated to be only 8.1%. More than 44% of India's population lives on less than a dollar a day. India has a high level of income inequality, with a Gini index of 37.8%.

While the country has had some success in controlling the burden of disease and poverty, inequality and inequity in access to services remain high. The Government of India spends poorly on basic services that benefit the poor. For instance it spends 7.2% of its GDP on primary education and only 0.9 % on health care.

India is low aid dependent. In 2001 the country received per capita official development assistance of US\$2 as against an average of US\$10 for the low income and US\$8 for the middle-income countries. The proportion of ODA as a percentage of gross national income was only 0.4% against an average of 2.5% for the low-income countries and 0.4% for the middle-income countries. This constituted only 2% of the central government expenditure (WDR 2004). Figures for individual sectors are not available, but it can be assumed that health receives a small proportion, given the large investments in infrastructure development. The GHP contribution is also a low proportion at less than 5% of total domestic and external financing (Pearson 2004).

Hence the ability of international agencies and other overseas institutions to influence policy in India through the fiscal route is limited. Advocacy and technical support may be a more effective way on influencing policy decisions in India. Since 1995 World Bank has been the major external funding agency for government. The International Development Association loans administered by the Bank are not perceived nor accounted for by GOI as development assistance. Many NGOs access funds outside government from international agencies for health and education.

3.2 India's health status

3.2.1 Human development and health indicators

Health sector in India has seen major achievements since independence (see Table 1 for key health and development indicators). Life expectancy went up from 36 in 1951 to 65 in 2001; the infant mortality rate fell from 146 in 1951 to 68 in 2000. However, it should be noted that there is a wide variation between states. For instance Kerala has a life expectancy of 72; the literacy rate is 90.9% and female to male ratio is 1058.

Unlike the usual pattern, sex ratio in India is skewed in favour of males. For every thousand males there are only 933 females. Reason for this disparity may be the low social position enjoyed by women and the unequal access to education, nutrition and health care services. The ratio is worse, even allowing for the likelihood of more males being born than females, in the 0-6 age group. There are only 927 girls for every thousand boys. This is attributed to the practice of female foeticide in some states, which is linked to the low status of women in society.

Health outcomes are determined by a host of socio-economic factors. These include work participation rate, nutritional security, access to safe drinking water, sanitation and housing, financial protection, ability of women to influence household expenditure decisions and the right of women to inherit and own property. The social and economic marginalisation of scheduled castes and tribes is reflected in their poor health status.

Table 1: Health and development indicators

Indicators (all India)	1981	1991	2001
IMR/1000 live births	110	80	66
U5MR/1000 live births			93
Crude birth rate/000	33.9	32.5	25.5
Crude death rate/000	12.5	11.4	8.4
TFR	3.6	3.3 (97)	3.2
Life expectancy	50	61	65
Literacy % (female 53.7:male75.3)			64.8

Sources: 1. SRS Bulletin, 2000 and 2001, Provisional Estimates.

2. Census of India

3.2.2 Disease burden

India accounts for 21% of the world's global burden of disease. Of this, communicable diseases make up 42%, non-communicable diseases 48% and injuries 10%. As eradication efforts for guinea worm, small pox, leprosy and polio result in some successes, the burden of communicable diseases is falling. However communicable diseases account for over 50% of DALYs lost, with childhood diseases, malaria and TB as the major contributors. Over two million people per year develop active TB, which causes more than 450,000 deaths a year. Nearly two million suffer from malaria; about half of them are affected by *Plasmodium falciparum*.

The three major illnesses that contribute to mortality among children are fever (30%), acute respiratory infection (ARI) (19%), and diarrhoea (19%).¹ Currently, about a third of India's 9.5 million deaths per year are among children. Poorly performing states in terms of under-5 mortality account for three-fifths of all childhood deaths. If total Indian under-5 mortality were that of the best performing third of states, over 1 million child deaths would be avoided annually.

Table 2: Neglected diseases

Disease profiles	1951	1981	2002
Malaria (cases per million)	75	2.7	2.2
Leprosy (per 10,000)	38.1	57.3	3.74
Smallpox	>44,887	Erad.	
Guinea worm		>39,792	Erad.
Polio		2970	265

(Source: National Health Policy, 2002)

Regarding the so called neglected diseases, it is estimated that about 428 million people are living in areas at risk from lymphatic filariasis, with about six million persons suffering from the disease. A total of 484,000 persons are still afflicted by leprosy. Even though polio was to be eradicated by the year 2000, cases are reported even in 2004.

More than five million people are living with HIV in 2003. In six states the epidemic has been generalised with the general population prevalence rates above 1%, including Andhra Pradesh. Providing anti-retroviral treatment to eligible patients will be a major challenge in the years to come.

While India is yet to deal fully with the prevention and treatment of communicable diseases, non-communicable diseases (NCDs) have emerged as a major public health problem, for which there is very limited national and international investment. In 1998, 60 million people were disabled due to NCDs. There were 25 million each suffering from diabetes and cardiovascular diseases, and 2.4 million suffering from cancer. Projections for the year 2020 estimate that around 72.3% of the total deaths will be due to NCDs.

3.2.3 Poverty and inequalities

Overall, about 65% of pregnant women go for antenatal check-ups, but only 34 percent have institutional deliveries and 42 percent have received professional medical care. Only 42 percent of children in the age group of 12-23 months have received all the vaccinations recommended under the Universal Immunisation Programme; 44 percent have received some but not all, and 14 percent have none of the recommended vaccinations.

These figures mask significant variation. Poverty is positively correlated with poor health care utilisation and outcomes. The poorest quintile have more than double the mortality, fertility and malnutrition rates compared to the richest. The poorest also have a larger share of the morbidity from TB and malaria. Recent analysis of immunisation coverage by quintile shows an all

▪ ¹ National Family Health Survey 2

India average of under 40% for the lowest quintile, versus (a low) 55% for the richest.

The poor spend 12 percent of their incomes on treatment as against 2% for the rich. The number of poor who did not seek treatment for ailments they considered serious went up from 15% in 1986 to 24% in 1996.² Yet the richest receive three times as much as the poor of the public subsidy to health care.³

This paradox, with the rich getting a larger share of the limited public spend, when mortality and morbidity levels are higher among the poor, raises the question of how well the public expenditures are targeted to achieve equity. However, given the need of a population exceeding one billion the public sector is unable to meet the demand. The inequity in access, especially by women, the poor and tribal and scheduled caste populations is a major source of concern. The largely unregulated private sector, many of them less than fully qualified providers, which provides more than 80% of health care services also raises the question of quality of care and affordability.

3.3 Health sector: policy and organisation

3.3.1 Health sector policy

Health care and financing is guided by the recent National Health Policy 2002. This acknowledges the major improvements and successes under the 1983 Health Policy but accepts that the public health system has had limited success in meeting the preventive and curative requirements of the general population and that health indicators are still 'unacceptably high'. The growing challenges of non-communicable disease and new threats such as HIV/AIDS are also recognised. NHP 2002 goals are reflected in the Tenth five year Plan, 2002-2007.

▪ ² Misra, R, et al (2003): "India Health Report", Oxford, New Delhi.

▪ ³ Mahal, A. et al (2000): "Who benefits from Public Health spending in India", NCAER, New Delhi

Table 3 Objectives and goals of the National Health Policy 2002

Target (relevant to GHPs in bold)	Date
Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50% on account of TB, Malaria and other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Increase the CPR from 48.2 to 65% by 2007; Bring down the TFR to 2.3 by 2007; Reduce the decadal population growth rate to 16.2%;	2010
Improve the coverage of full ANC from 31.8% to 89% by 2007; Increase the coverage of institutional deliveries/ safe deliveries from 34% / 40.2% to 80% by 2007;	2007
Reduce IMR to 45/1000 by 2007, and to 30/1000 by 2010. Reduce MMR to 100/Lakh	2010
100% coverage of fully immunised children	2010
Improve nutrition and reduce proportion of LBW babies from 30% to 10%	2010
Increase utilisation of public health facilities from current level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
Increase share of Central grants to constitute at least 25% of total state health spending	2010
Increase state sector health spending from 5.5% to 7% of the budget. Further increase to 8%	2005/2010

As set out in India's constitution, health care is under state jurisdiction. Union government responsibility is confined to setting broad policies, regulation of medical education and drugs, setting food safety standards and mobilisation of resources. Through the Centrally Sponsored Schemes, the Union government has retained its ability to finance and influence the national disease control programmes, and family planning and maternal and child health.

This provides an opportunity for standardisation of policy and approaches by the Ministry of Health and Family Welfare in the Union government. It also facilitates

financing and technical partnerships with bilateral and international institutions such as the WHO, the World Bank and the Global Health Partnerships to influence programming across the country.

States generally follow the guidelines provided by the Union government for allocating resources and delivering services, even though they have the flexibility to adapt programmes to their needs. The recent introduction by the government of Andhra Pradesh of Hepatitis B into its routine immunisation service is an example of such independent action.

3.3.2 Health services infrastructure

The focus of the health sector during the last five decades has been to improve access to, and utilisation of, health, family welfare and nutrition services, specifically targeted towards the underserved and underprivileged segments of the population. Towards this objective, a substantial health care infrastructure and manpower at primary, secondary and tertiary levels has been created in the public, private and voluntary sectors. India was the first country in the world to have a government level programme of family welfare and planning.

The major thrust in the eighties was on operationalising WHO's Alma Ata declaration of Health For All by 2000. A Universal Immunisation programme was launched. Access to maternal and child health services were considerably improved under the Child Survival and Safe Motherhood (CSSM) initiatives and Social Safety-Net Programmes.

A three-tiered health infrastructure covers the entire country. At the lowest level is the sub-centre staffed by a multipurpose female and male health worker, catering to a population of 5000. Above that is the Primary Health Centre (PHC) with one or more doctors, nurses, paramedical and supervisory staff with a catchment population of 1,00,000. Specialised health care is provided by the Community Health Centre (CHC) which has four specialist and two generalist doctors. Each CHC is expected to meet the needs of 500,000 people. There are sub-divisional, district and teaching hospitals which provide secondary and tertiary care. There is a large pool of trained human resources (see Table 3).

Table 4: Human resources for health (public sector)

Infrastructure	1951	1981	2001
Sub Centres		51405	137311
Community Health Centres		214	3043
Primary Health Centres	725	5740	22842
Dispensaries			22306
Hospitals			15622
Beds (Pvt & Public)	117,198	569,495	903,952
Doctors (Allopathy)	61,800	268,700	575,647 (MCI)
Nursing Personnel	18,054	143,887	776,355 (INC)

(Source: Health Information of India, 2001)

The NHP identifies key problems facing the health sector as:

- low levels of public investment meaning prescribed norms are not achieved
- widening inequality in coverage
- inappropriateness of inflexible vertical implementation structures
- lack of manpower especially in less developed and rural areas
- failure to make full use of private, NGO and other practitioners
- medical training fails to cover primary care and emerging threats resulting in overspecialisation
- a failure to provide public health services in urban areas
- fragmented IEC approach which relies too much on mass media and fails to reach marginalized groups
- the failure to fully engage with civil society and NGOs which are better placed to take forward some public health activities
- a lack of timely and accurate health management information
- a failure to empower women to improve access to appropriate health services
- a failure to pay attention to issues of medical ethics

3.3.3 Health financing at central and state level

Overall public expenditure on health is 0.9% of the GDP; one of the lowest in the world (average for low income countries, 1.1%). In contrast, private expenditure on health care is 4% of GDP (average for low income countries, 3.2%).

The Union government budgets both external and domestic finances in its central five year plan (currently Tenth Plan, 2002-2007). Once agreed by the National Development Committee and Planning Commission, this budget fixes allocations for the period, which challenges efforts by donors and ministries to provide additional funds. Significant funds are also channelled directly to NGOs and as technical

assistance to non government agencies: this method is used to circumvent the Plan's fiscal limits as well as to finance non government activities. Major new financing for HIV prevention is being channelled direct to NGOs by the Gates Foundation (equivalent to a third of current Plan AIDS budget).

State governments spend about 75% to 90% of the central resources budgeted for under the Tenth Plan, and also allocate an average of 5.5% of state budgetary support to health, for hospital services, staff and health service infrastructure. There is general consensus on the need to increase public expenditure on the health sector and that both the state and the centre have important roles to play. The National Health Policy 2002 suggests that this should be achieved through increases in state allocations to health. The centre will also play a significant role - increasing its contribution from 15 to 25% of state health expenditure.

However, health expenditure as a proportion of Gross State Domestic Product (GSDP) has been declining in many states, particularly in the central and northern regions. Most states are under severe resource constraints and there is a general tendency to cut back expenditure or to seek central funds for activities that the states were funding hitherto.

There is also general recognition that current mechanisms are inadequate in that they pose difficulties for poorer states and rely too much on rigid input based norms. Steps are needed to ensure that flows from the centre are pro poor and flexible enough to allow local needs to be addressed. As of the mid 1990s, states received roughly the same per capita allocation, irrespective of population need.

All external government financing for the programmes is managed at Union level, which has the powers to negotiate and agree funding with external agencies. Hence all the international agencies have to negotiate with and operate through the Government of India. After approval the guidelines for implementation are drawn up and sent to the states chosen for implementation of the programmes.

State officials are rarely involved in consultations with international agencies and others involved in global health partnerships. However, more recently, they have been involved in developing state strategic plans to inform the overall programme plan and budget, for TB and routine immunization for example. A recent exception has been the Global Fund to Fight AIDS, TB and Malaria. Since the fund adopted alternate means of communication and mobilization through NGOs, states are more aware of and have demanded participation in developing proposals for the Fund.

3.3.4 State and district variations

All India figures mask striking regional variations in health and family welfare parameters across India's states and districts. that have deep-rooted socio-economic and cultural reasons, including prevalence of high incidence of poverty, illiteracy and poor empowerment of women. A snapshot of districts categorised according to the Total Fertility Rate (TFR) classification shows that about 21% of the districts in the country fall in the TFR category of less than 2.1. In these districts, about three-quarters of the deliveries are institutional, complete immunization coverage is around 83%, coverage under full antenatal care (ANC) stands at an impressive 74%.

On the other hand, over 26% of districts in the country fall in the TFR category of above 3.5. coverage of institutional deliveries is dismally low around 17%, full antenatal care (ANC) at 19%, complete immunization around 34% and female literacy around 21%. Less than half the girls are over 18 years of age when they marry.

The bulk of the districts in the higher TFR categories fall in the EAG states, with very high proportions in the states of Rajasthan (83%), Bihar (77%), UP (76%), and MP (69%). These impose serious constraints on demand for reproductive and child health services. Poor infrastructure and relatively weak governance have compounded the problem.

Available evidence suggests that the differences are widening, with the southern and western states, including Andhra Pradesh, showing rapid improvement as compared to the central and northern states. These southern and western states demonstrate relatively higher spending, higher utilization of services and more equitable distribution of services than other parts of the country.

Achievement of the Tenth Plan targets will be heavily dependent on the EAG States, which account for only about 45% of the population but over 60% of the projected population growth between 2001 and 2011. The EAG States will determine the time and the magnitude at which the country's population stabilises. This underscores the special focus on EAG states in implementation of RCH II (including immunisation) and in the national health programmes (eg World Bank malaria and leprosy support).

Table 5: Andhra Pradesh and Rajasthan: access and utilisation

Indicator	Andhra Pradesh	Rajasthan (EAG state)
Health spend as % of state income (GSPD)	1.61 (third highest)	1.35 (highest of the 6 EAG states)
Ratio of subsidy to richest versus poorest quintile	1.85	4.95
MMR/10,000	159	670
Safe delivery %	65.2	35.8
ANC %	80	23
Immunisation State average %		
Poorest quintile	70	27
Richest quintile	88	60

Sources: National Human Development Report 2001 and RCH I

3.4 The National Disease Control Programmes

The focal diseases of the global health partnerships have a national disease control programme as their counterpart in the Ministry of Health and Family Welfare. They include TB, malaria (now under an umbrella programme for vector borne diseases including dengue hemorrhagic fever, leishmaniasis, Japanese Encephalitis and lymphatic filariasis), leprosy and HIV/AIDS. The non-communicable diseases covered under national programmes are cancer, blindness, mental health and iodine deficiency disorders. The child health division of the department of family welfare manages immunisation programmes, including polio and hepatitis B. Research is managed by the Indian Council for Medical Research, under the Ministry.

The states implement the programmes either vertically through dedicated machinery funded by the GOI, such as state AIDS control societies, state and district leprosy and TB officers – or through the general health services. The minority of programmes, such as the Enhanced Malaria Control Programme in malaria endemic

districts, have dedicated staff, although there are many TB clinics especially in urban areas. Leprosy teams will be fully integrated by end 2005.

Overall the centralised process fails to take into consideration the differing capacity and needs of states. Often states implement programmes whose goal for the end of the project period they may have achieved years ago on their own. Since the guidelines do not factor in the poor absorptive capacity of some states, the better performing states continue to do well and others remain a problem. This is evident in the case of most of the programmes covered in this paper. (A notable exception is the DOTS programme in Rajasthan, with 100 percent coverage, 63% case detection rate and 87% cure rate. In contrast, average immunisation coverage is under 50%).

The split in policy and implementation also allows for dilution of accountability. States are at liberty to make the changes they want, since the Government of India issues guidelines not directives. However, they tend to follow guidelines issued at the national level. Thus the state programme officers can blame failures on poor guidelines issued by the centre while national managers can blame poor implementation by the state. The state officers we interviewed had adopted the priorities set by and guidelines issued by the national programme managers.

The burden for delivering most of these programmes falls on the multi-purpose outreach worker. Increasing demands, poor capacity of this cadre, the unrealistic population coverage allotted and lack of logistic support in most of the states are major constraints to implementing the programme. The system of outreach workers is weak in low income urban areas, whose populations are thus often denied access. Many programme managers are now trying to tackle the problem with the help of NGOs and local government (Panchayats in rural areas and municipalities in cities).

For further detail on selected programmes, see Annex 3.

3.5 Data sources on health

The most reliable data on demographic and household characteristics are provided by the Census of India conducted every 10 years for over a century. It provides a universal survey of an exhaustive set of parameters. To cover the period in between, the Registrar General of India conducts the National Sample Survey of some households in a set of primary sampling units. The National Sample Survey Organisation also conducts periodic surveys on household expenditures. The 42nd and 52nd round focused on education and health care. This survey provides data on the amount of money households spent on health care, by income fractiles, rural:urban, male:female and scheduled tribes and castes. The data can also be correlated with household expenditures. The National Family Health Survey, the Indian equivalent of Demographic and Health survey is conducted every six years, since 1992 – 93, with an emphasis on indicators for family planning and maternal and child health programmes.

The disease control programmes and the family welfare department of the Ministry of Health and Family Welfare manage vertical programme management information systems, based on data collected by primary level staff. The most comprehensive compilation of this data is the Health Information of India, published annually by the Central Bureau of Health Intelligence. Even though the Central Bureau of Health Intelligence compiles the report, the actual collection of data is done at the state level. Many states publish their health statistics. However, these tend to be mainly according to population group. The Reproductive and Child Health Programme I carried out a household survey in 1998/98. These and other programme surveys

provide data that can be disaggregated according to socio-economic status and which permits quintile and district analysis of immunization coverage for example.

4 FINDINGS: GLOBAL HEALTH PARTNERSHIPS FOR AIDS, TB AND MALARIA

4.1 Tuberculosis

4.1.1 Stop TB and the national programme

With 22% of the global TB burden, India is central to achieving the objectives of the Stop TB Partnership. In 1991 the World Health Assembly adopted the DOTS strategy and set targets for the TB programme to be achieved by 2000. TB was declared a global health emergency in 1993. India's Revised National TB Control Programme, incorporating the DOTS strategy, was developed in the mid 90s, and aims to cover the entire population of India with the DOTS programme by 2005.

The RNTCP is rated as a high performing public health programme in India, with one of the world's best DOTS programmes. It covers a population of 890 million (over 75% of the population) and has achieved a case detection rate of 69% (as against the targeted 70%) and a treatment success rate of 87% (target 85%). It has managed to retain the quality of services in spite of a fairly rapid scale up. The programme has built up a close working relationship with the Stop TB Partnership Secretariat, its partners and the Global Drug Facility.

4.1.2 Governance and fit with national programme

National programme managers acknowledge the contribution of the Stop TB partnership, including the advocacy and financial support from external partners. However, national policy and strategy is clearly set by the government of India in collaboration with technical partners. Exposure visits and study programmes have helped them better understand the global position of TB. The partnership has also publicised the DOTS programme in India as international good practice.

The Health Secretary is an active member of the board of the Stop TB partnership. The programme managers feel that this has improved the standing of the TB Programme and has stimulated international partners to be responsive to India's needs. National programme managers also attribute high-level political commitment and pledges of funds for TB control to the global attention that the disease is attracting due to the emergence of Multi-Drug Resistant (MDR) TB and links with HIV/AIDS. The meeting of the Stop TB Partnership Forum in New Delhi in March 2004 added to the visibility of the programme in India. It involved senior politicians and senior state level and national bureaucrats as participants. This raised the urgency of TB as a public health problem. It also provided an opportunity for the programme personnel in India to highlight their achievements.

India has set up a National Interagency Co-ordination Committee. Partner roles and responsibilities are clearly defined. A high level of technical support is provided by WHO and funded by other donors. The TA has ensured that India remains in tune with international guidelines for management of TB including MDR TB. All partners have agreed to the national guidelines and monitoring system. The partnership also assisted in persuading additional partners to join in the fight against TB. A case in point is World Vision, who were inspired by the Partnership Forum to join the DOTS programme in India.

While recognition of the Stop TB partnership is high in national level, India's involvement is less known in the states, although the red Stop TB logo has been adapted and is used at state and district level. Both the partnership and GOI have

positioned the programme as fully owned by GOI. Only the source of funds for different geographical regions (e.g: DFID in Andhra, USAID for Haryana) was recognised by the states.

4.1.3 Finance and additional resources

Funds for the programme are made available by lending and aid agencies to the Tenth Plan. They are: a World Bank credit of US\$142 million; DFID grant of US\$26 million; DANIDA grant of US \$20.7 million; USAID support of US\$6.58 million. In addition the Global Fund to Fight AIDS, TB and Malaria (GFATM) had awarded US\$8 million in the first round, US\$29 million in the second and US\$26 million in the fourth round. These costs cover the value of drugs, additional training costs and some contractual positions.

The global partnership has enabled the GOI to access additional sources of assistance for the TB programme, including new USAID support to Haryana. The Global Drug Facility (GDF) is also providing drugs for the state of Orissa and to cover a further 200 million population as a commodity grant valued at US\$2 million per annum. There is some evidence of substitution, with respect to DFID and GFATM commitments to Andhra Pradesh. However, the programme is keen to address such issues through its strategic and financial planning process, which will involve a high level meeting with donor partners.

4.1.4 Impact on commodities

Since India is home to most major generic TB drug manufacturers, the impact on national prices was felt to be minimal. However, the procurement services and pre-qualification procedure offered by the Global Drug Facility (and WHO) are a major support to the secure availability of quality drugs. Negotiations with the Global Drug Facility are also taking place for the procurement of the drugs needed for the part of the programme funded by the GFATM award.

India is also keen to avail of the pricing arrangement arrived at by the Green Light Committee for the second-generation TB drugs. The Green Light Committee is helping India put together a proposal for MDR TB, and to set up good quality diagnostic services, especially in certification of national laboratories.

4.1.5 Poverty and gender

TB is perceived in India as a disease of the poor. While the policy of the government of India is that the right to quality treatment is income neutral, the provision of free services in the public sector ensures that the poor benefit more from the programme, given low usage by the better off. However, there is no data on the extent to which the poorest are accessing services.

The policy is also gender neutral. But studies have shown that in India more men than women test sputum positive (3:1). This effect has been maintained even after controlling for the better access to services by men than women. Microscopy centre opening hours and the fact that women are not allowed to travel long distance unaccompanied by male relatives restricts their access. Women with TB symptoms may not seek, or be prevented from seeking, treatment for fear of stigma. Instances are reported where girls engaged to be married had their engagements broken when they tested sputum positive.

There seems to be a clear need to address these barriers to access. But unless the objective of helping the poor is explicitly stated, strategies developed to achieve this objective and the needed data generated and analysed by the system, the poorest of the poor and women with TB may be slipping through the coverage net.

4.1.6 Assessment

Issues

The programme has been successful in three TB proposals for the Global Fund, in part because of its technical competence. However, it has some issues with the monitoring conditionalities of the GFATM, which managers feel are not in line with national indicators adapted from Stop TB's recommendations. There is also lack of coherence in procurement guidelines. Whilst the GFATM guidelines specify inclusion of only WHO prequalified companies (which makes good sense to GOI), the WB continues to require fully open international tendering, which adds to transaction costs.

The programme has covered all the good performing states. In order to reach the target of universal coverage it now has to move into states with poor track record in public health systems. Maintaining the quality and achieving the required success rate will be a major challenge. These threats and challenges present an opportunity for the global TB partners to further engage with the national programme.

Value added

The ability of the partnership to bypass the formal systems in both the key organisations (WHO and GOI) has been helpful to the national programme. Some of the instances cited by the programme officials are:

- One of the partners, RESULTS, arranged for a Congressional Delegation of US to visit India. The partner organisation, using their networks, was able to arrange for the visit in a matter of months. The informal nature of the visit also facilitated stronger advocacy, which has led to commitment of greater funds for longer term by the USAID.
- The Global Drug Facility has covered shortfalls in availability of drugs at short notice, and been flexible in modifying standard combinations and packing to accommodate the requirements of RNTCP. The presence of GDF as a back up system has boosted the confidence of the programme managers that stock outs can be managed much more easily.
- Kerala state, the first to reach 100% coverage with cure rate consistently above 85% has been lagging behind the national average in case detection. The Stop TB partnership and the Social Mobilisation and Training Team of the WHO, in collaboration with the Government of Kerala launched a campaign called Communications for Behavioural Impact (COMBI) to mobilise school children and health workers to increase detection rate for infectious TB cases

The non-government NGO and donor partners in Stop TB play a major role in addressing programme challenges in poorly performing states such as staff absenteeism, poor health awareness and logistics management. While the national programme deals with the programme aspects including diagnostics and treatment, partners also help with community mobilisation. A case in point is the additional mobilisation effected by the DANIDA in Orissa and the NGO projects of World Vision in Andhra Pradesh and CARE in West Bengal (see Box 1).

Perhaps the most significant contribution of the Stop TB Partnership has been its emphasis on civil society and private sector partnership as part of TB programming in

the country. Partnerships have been built at national, states and district levels and are a key ingredient to the success of the programme. The RNTCP actively solicits partnership with the private health care providers and NGOs. The Indian Medical Association has called RNTCP “the friendliest face of the government to the private health care delivery system”. The openness to involve the private sector and NGOs appears to have been influenced by the concept of national PPPs promoted by Stop TB’s international strategy.

More than 3000 private practitioners, even those who do not subscribe to the western theory of medicine, are providing DOTS. Over 750 NGOs are partnering with state governments, with hardly any financial incentive. Both Andhra and Rajasthan have built up several hundred successful partnerships with private providers and NGOs. Many of these partnerships have been initiated at district level.

Box 1 SHIFA India TB Control Project – World Vision, Hyderabad, AP

The SHIFA TB control project, funded by the Canadian International Development Agency, aims to ‘complement and supplement’ RNTCP activities. SHIFA provides IEC, and motivates persons with symptoms to get their sputum examined, often accompanying patients to the microscopy centre. The project depends on the state machinery for diagnosis and supply of drugs. With the help of partner NGOs they identify potential DOTS providers and train them. Once the person tests sputum positive the list of potential DOTS providers is made available to the ANM. The box of medicines is then entrusted to the DOTS provider.

The SHIFA project is an example of how NGO efforts can help government overcome weaknesses in the public health delivery system. When the project was originally developed it was intended for areas where the World Vision had a presence. But at the request of RNTCP programme managers the project moved to cover areas less served by the government machinery and NGOs.

To do this they mobilised the community leaders to form a TB core group and built up partnerships with local NGOs and CBOs. They have involved local leaders such as Sarpanches and have also developed a partnership with the less than fully qualified providers who enjoy considerable patient patronage in the area. They chose not to duplicate the service delivery system, but worked with government service providers to improve the quality. The project supervisors undertake joint supervisory visits with state programme officers. They have also modified project components which were not part of the national programme (e.g: supplementary nutrition, honorarium for DOTS providers).

The SHIFA project joined the Stop TB Partnership as they wanted to be part of a national and international network. They would like the partnership to provide insights into global strategies and share international best practices.

At the national level the Global Health Initiative of the World Economic Forum with the Stop TB partnership has helped put together the India Business Alliance, a coalition of leading corporates from India. Their objective is to bring together companies to work with GOI for the promotion of DOTS. Over 80 companies are involved in programme delivery. The programme also involves major employers from other ministries such as Railways, Steel and Mines and Labour.

4.2 Malaria

4.2.1 RBM and the national control programme

Malaria is a major public health concern in the northeastern states, including Rajasthan, and in Andhra, with over 90% of cases in poor rural areas. Activities are led by the new national umbrella programme for vector-borne diseases, established in 2003/04, as part of GOI's convergence policy. GOI provides additional support to the 100 worst affected tribal and coastal districts in 8 states through the World Bank supported Enhanced Malaria Control Programme, and has also been successful in a Round 4 GFATM application.

The programme is managed as a vertical programme to district level, although it is integrated into the multi-purpose primary level services. A 1997 World Bank evaluation found low disbursement, with a focus on less effective strategies such as vector control. However, although the programme is perceived to have 'modernised', it has reached a case plateau, with over 2 million cases still reported annually, and many more suspected.

While there have clearly been renewed and positive efforts since the late 1990s to tackle malaria, Roll Back Malaria appears to have had little role in this. Some interviewees at national level felt that new approaches and significant advocacy are needed to tackle this. Although strategies such as early detection and prompt treatment and ITNs have been introduced, it is not clear that the state programmes have fully taken them up, and environmental measures are still felt to be most important. An indication of the programme's capacity may be reflected in the fact that the GFATM's Technical Review Panel submitted three sets of comments on the Round 4 proposal, that needed to be addressed before funding was agreed.

4.2.2 Governance and fit with national programme

Name recognition and profile of RBM is extremely low, and non-existent in Rajasthan and Andhra. However, while officials were not aware of RBM's purpose and four key strategies, they did perceive the national programme to have been influenced by the global consensus on early detection, prompt treatment and prevention. The Health Secretary is a recent member of the RBM Board, but it is unclear if this has or will have any influence (cf TB). Few senior officials and development partners felt that RBM could add significant value in India, given its perceived focus on, and relevance to Africa.

Officials in Rajasthan appeared unaware of the RBM 'demonstration district' in the state, one of several designated in India. National interviewees also questioned the value of these sites, which had not made progress beyond initial epidemiological and behavioural surveys carried out by the Malaria Research Centre, with RBM inputs.

At state level, officials are delivering the vertical programme according to national guidelines, but providing radical presumptive treatment has been difficult due to lack of blister packs until this year. There was a widespread assumption, not based on evidence, that resistance to chloroquine was exaggerated. Officials reported a shift in emphasis from environmental vector control measures to early detection and prompt treatment, and prevention with ITNs. The increased focus on these strategies is attributed mainly to World Bank technical assistance and to its commodity financing. However, officials at all levels remain sceptical of the feasibility of promoting ITNs for prevention. While bednet distribution was reported to have increased, utilisation is still low, attributed mainly to the hot and humid climate and outdoor sleeping practices. The NGO LEPRRA, involved in malaria control in Andhra, shared this view.

Unlike several African countries, there is no tradition of using untreated nets, which makes promotion more difficult.

4.2.3 Finance and additional resources

In addition to domestic finance, programme funding for commodities and TA is provided by an IDA loan administered through the WB's EMCP (1997 – 2003, extended to 2005). The programme has secured Round 4 GFATM funding through the GFATM for xxx, including an allocation for artemisinin combination therapy, a new and expensive treatment for resistant malaria, based on resistance levels in several districts. None of the officials interviewed at state level was aware of the GFATM proposal, and implementation plans had not been developed. Commitment (and interest in malaria) among other development partners is not high, although USAID is considering support and the World Bank is likely to fund activities within the newly converged vector borne diseases programme.

4.2.4 Commodities

GOI will purchase artemisinin combination blister packs from local sources, as opposed to entering an agreement with WHO and Novartis for the co-formulated Coartem. Demand for ITNs is beginning to stimulate local manufacturers in some areas, but this is growing very slowly.

4.2.5 Poverty and gender

Malaria mainly affects poor and marginalised communities in rural tribal and coastal areas, and in low-income urban areas. Although there is no data on programme incidence and impact regarding socio-economic groups, the programme uses geographical targeting strategies to reach these populations in specific target districts. There appeared to be no specific strategy for pregnant women, eg intermittent preventive treatment.

4.2.6 Assessment

As mentioned above, RBM has very low profile, and limited added value in India. Little advocacy appears to have taken place with GOI or development partners.

A notable absence is national PPPs (and lack of RBM promotion of such a strategy was also observed by the 2002 RBM evaluation team). There is no evidence of innovative approaches to promoting ITNs, through social marketing, despite India's success in other sectors and its proven value in increasing utilisation of ITNs.

Although efforts to involve the private providers have started, given the extent of treatment seeking in the private sector, few public-private partnerships were reported at state level. In some states such as Orissa, community drug distributors (chloroquine) have been identified, to support prompt referral for treatment. Some NGOs have initiated dialogue with state governments in AP and Rajasthan. For instance LEPRAs, which has been actively seeking engagement in AIDS, TB and malaria, has been involved in early diagnosis and treatment, social marketing of ITNs, vector control and community mobilisation in 112 villages in Andhra.

4.3 Global Fund to Fight AIDS, TB and Malaria

4.3.1 Scope of activities

Although India felt that its success rate with the GFATM was low at first, it has won seven bids, with an overall financial value of nearly US\$500 million:

- Round 1: community DOTS scale up in India's three new states and in urban Chennai through NGO contracting and public-private partnerships (agreed April 03)
- Round 2: DOTS in 56 districts in UP and Bihar and an urban DOTS component (agreed April 04); HIV prevention and care for mothers, their families and PLWHA through scaling up PMTCT services (and ARVs); (agreed May 2004)
- Round 3: Expansion of public-private sector interventions in HIV and TB prevention and treatment (agreement in process)
- Round 4: ARV treatment scale up by NACO and new NGO Consortium in six high prevalence states, including Andhra; TB DOTS scale up in AP and Orissa; malaria prevention and treatment in marginalised endemic areas.

Of these, Round 4's HIV/AIDS treatment access proposal is the largest, at US\$165 million. Implementation activities began 18 months ago for the Round 1 TB proposal. Funds have only recently been released to states for Round 2 programme activities. Review by the Round 1 Local Fiduciary Agent (World Bank) has deemed the programme 85% successful as measured against its objectives, with over 65% funds disbursed according to budget. Tighter financial management was recommended at state level. The Country Co-ordinating Mechanism gave the programme a high grading and recommended that the Fund provide the second disbursement.

4.3.2 Fit with national programmes

Proposals financed by the Fund clearly address national priorities. TB funds will contribute to national level DOTS coverage by end 2005, and to financing scaling up of public-private partnerships for DOTS contracts with NGOs and private providers. Malaria finance will enable treatment and prevention interventions in some of the most marginalised endemic areas, including the use of ACTs in resistant areas. For TB and malaria, GFATM funds were seen as an appropriate source of finance to fund parts of a larger strategic plan. Even if the GFATM funds had not been made available, these programmes would have been implemented through funds from other sources.

Concerning HIV/AIDS, the picture is more complex. India had initiated PMTCT in 11 pilot sites in 2001, with Unicef support, and this experience was the basis for developing the PMTCT proposal. Without the GFATM, it is likely that the PMTCT programme would have been scaled up with domestic resources, considering the general support for the welfare of children, and its low additional cost (Unicef has negotiated a drug donation from Cipla). The GFATM funding appears to have raised the profile of the HIV/TB Programme, although the National AIDS Control Programme has a pre-existing component for the management of HIV/TB co-infection.

In December 2003, GOI announced that it was initiating its ART treatment programme. The announcement was perceived as a political move by the outgoing Minister, and also influenced by Indian industry and by the WHO 3x5 Initiative. Given the lack of transparency in the making of the decision to introduce treatment, it is difficult to say if the possibility of funding by GFATM had been a persuading factor.

GFATM is certainly seen as favourably disposed to treatment proposals, and an ally of WHO and UNAIDS.

GFATM is perceived as providing bridging finance for the ART programme, while donors consider covering it under new proposals from 2006. However, the GOI, and state level programmes and institutions are widely felt to be ill prepared for treatment expansion. Although a few centres of excellence exist, state level expertise is very patchy, and drug supply is inadequate and unreliable. As yet, there is little sign of a strongly supported central strategy for treatment access and adherence although states are being encouraged to start providing services. ART is currently included only in specific AIDS units at tertiary level – it is very unclear whether and how will be developed at lower levels. There is also concern that AIDS treatment agendas may take over prevention funding. The low prevalence states, including Rajasthan, are planning a collective consultation to lobby for additional resources for the 'high risk, high priority' status, arguing that unless inputs are made now, prevalence will reach higher levels very quickly.

4.3.3 Governance arrangements

The GOI's Department of Economic Affairs (DEA) is the Principal Recipient (PR) for all seven proposals. MOH is the main implementer, through the government national programmes, and with contracts for NGOs and the private sector. There are some concerns about conflict of interest, given that both are government bodies. LFAs include the WB and UNOPs. In Round 4, an NGO, the Population Foundation of India (PFI), is the designated PR for the 10% of the grant that is directed to the NGO Consortium, which includes the Indian Network of People Living with HIV/AIDS (INP+).

The inclusion of a non-governmental PR is broadly viewed as a progressive move. MOH concerns about accountability have been reduced by PFI's establishment profile. It is headed by a former Family Welfare Secretary, has collaborated with respected corporate partners and has a past record in managing a large consortium of NGOs for maternal and child health.

As required by Fund eligibility criteria, a CCM has been set up, chaired by the Health Secretary. It was reported that in Jan 2002, there was little information provided to NGOs and no transparency. NGOs were subordinate as opposed to equal partners. Significant progress has been made since then. The CCM is now widely perceived to be becoming a more effective governance structure, less government-led, more transparent and working in line with GFATM directives.

The CCM includes representatives from different social segments and technical fields. Inclusive approaches, as laid down in Fund guidelines, are stimulating the greater involvement of people living with HIV in both governance and implementation, and consideration of treatment as well as prevention needs. INP+ (Indian Network of People Living with HIV/AIDS) has been a CCM member from inception. There is increased participation of NGOs involved in malaria and TB, as well as HIV/AIDS.

Recommendations made in a case study of the CCM (one of 20 such commissioned by the GFATM in early 2004) were felt to be very timely and have largely already been implemented. For example, a Vice-chair has been elected, state government and regional NGO participation facilitated and a wider range of members from government ministries (in addition to health) and other stakeholders included. Outstanding issues concern the election/selection of representative members, given the paucity of umbrella groups or federated NGO networks (excepting INP+). Many

also feel that state level representation and consultation is still weak, and that in the longer term, regional CCMs might be appropriate.

4.3.4 Finance and additionality

According to Gates Foundation analysis of NACO published figures, the total budget pre-GFATM amounted to US\$110 million (Gates 40, WB 35, GOI 8, USAID 13.5, others 13.5), mainly for prevention. The annualised GFATM grant for ART is therefore about a quarter of the overall budget.

Grants are for five years, but agreements are signed only for two, given the Fund's own liquidity issues. This means major risk and uncertainty for the GOI, and has substantial implications for GOI planning.

The GFTAM specifies that its funds should be additional to existing finance. However, the addition of finance over and above agreed programme budgets has been an issue in India, prior to the Fund. All external funds are managed by the DEA. Annual and five year budgets that draw on domestic and earmarked external funds are developed by budget holders and agreed by the National Development Committee. To control public spending, these decisions effectively set a fiscal cap on the annual budget and the five-year plans. Increasing the allocation is not permitted, except through providing TA to government, or funding NGOs directly.

This has meant that any additional grants accepted during the year displace domestic spending, which is rolled forward, along with delaying associated activities. This may also act as a disincentive for some donors to contribute to public sector budgets. Expenditure through DFID's sexual health project may have been delayed due to this issue. Only four or five social sector ministries benefit from such unplanned income, and until now the issue has not been proactively tackled, given the high costs of political and administrative reform, despite low public sector allocations to these budget lines.

However, the new Union government has made a commitment to the Common Minimum Programme for the social sectors, and various mechanisms to lift the cap have been proposed by the NDC and the Planning Commission. It seems that the size of Fund grants may also have provided an additional incentive to GOI to review these fiscal expenditure rules. The CCM, relevant authorities such as the MOH, MOF and DEA and the GFATM itself are actively tackling this issue in a flexible and proactive manner. The Round 4 ART proposal was agreed on a case by case basis. Indeed, there was no budget line for ART spending and a new one was created following GFATM decision.

Interviewees felt that the GFATM should be more aware and proactive in its dealings with government, with respect to anticipating macro-economic constraints to implementing some of its conditions. On the other hand, the Fund has been flexible in accepting GOI proposals before the additionality question has been fully resolved.

4.3.5 Impact on commodities

It is too early to assess the impact of additional finance on commodity prices and security. Unlike the World Bank, which requires competitive and open international procurement, the Fund permits tendering with the companies that have pre-qualified through STOP TB's GDF and the other WHO services for AIDS and malaria (for TB drugs, ARVs, ACTs etc), many of which are based in India.

The national TB programme is already considering the use of the GDF as a back up procurement agent, thus reducing transaction costs, and ensuring an uninterrupted

supply of high quality drugs. Impact on price is unlikely to be substantial, although larger demand for ARVs in India could lead to good deals with India's generic companies. The Clinton Foundation is keen to support negotiations if needed. The introduction of ACTs may be delayed due to pending approval with registration authorities, inclusion in the national formulary etc. India likely to use blister packs of SP and artemether, not Novartis' co-formulated Co-artem, and increased demand may drive down prices of these products. The Fund's TRP comments on the malaria proposal suggests that the programme should maximise the market stimulus to increase local production of long lasting treated nets, and that WHO's prequalifying standards could be reflected at national level, to reduce transaction costs for the GOI.

4.3.6 Poverty and gender issues

All the proposals discuss the impact of the diseases on poor people, and gender specific issues. Pro-poor benefit incidence is assumed for TB and malaria, given geographical targeting. As yet, implementation plans for the ART programme are in development. Criteria supplied to the Fund indicate that children under 15, HIV positive mothers and anyone seeking treatment from government hospitals will be eligible (according to clinical criteria).

Given the costs of treatment in the private sector, it is likely that the usual quality and stigma barriers to the better-off seeking publicly provided curative care may not be in place. This could certainly mean that the poor (especially women) may miss out unless specifically targeted, and provided with help to cover the many costs associated with accessing care. The INP+'s district based community mobilisation strategies, funded through the programme, will certainly help increase awareness and support for people with HIV on treatment. But NACO may need to work on increasing access to treatment of sub-populations considered vulnerable to HIV through the NGO networks already in place for prevention.

Box 2 GFATM HIV/AIDS support in Andhra Pradesh

Andhra's State AIDS Control Society received its first GFATM funds in August 04 (Round 2). Funds will be managed and reported as a separate line item, and this is not perceived as significant in terms of transaction costs. Focused on PMTCT, which started in May 2002. AP now has 37 sites at all district and maternity hospitals. It is estimated that about 12% pregnant women are accessing services, including HIV positive women referred by private sector. Unicef has provided consultants for capacity building, and supplies of nevirapine (donated by Cipla), gloves and drugs for post-exposure prophylaxis. In a successful PPP, LEpra has been contracted to provide very substantial and well regarded support to AP's 97 voluntary counselling and testing centres and the 37 PMCT centres.

Significant GFATM additionality includes: follow up of women who access testing centres but don't come for delivery (overall only 50% institutional delivery); treatment for eligible mothers, and possibly other children and husband; and expansion to area hospitals with over 1000 deliveries a year. AP SACS has some concern about the feasibility of targets, and the programme indicators not yet reviewed for concordance with existing monitoring system. Round 3 will bring funding for VCTs at Community Health Centres, and Round 4, support to ART centres.

AP does not appear to have participated in the design of the proposals to the GFATM, although officials were involved in the Jan 04 ART national consultation. NACO have provided a WHO funded post for an ART officer, but this is not filled yet

by the SACS. Technical capacity is a major issue, especially at district level. Issues include overload on SACS and DACS (where AIDS officer is leprosy, and not nec right expertise). Unicef has provided posts to some districts, which are felt to be doing better.

Gates Foundation prevention funding started in early 2004, and most NGO contracts in AP for trucker and sex worker outreach are now funded. SACS has been informally liaising, but is considering an MOU with Gates. An overall strategic plan is needed, together with a consultative forum.

GFATM and HIV/AIDS in Rajasthan

Unlike AP Rajasthan has not been identified as a priority state for ART. Officials were asked to develop the proposal very late, and although they submitted a proposal, it was not taken forward, with no reason given. This calls into question the rationale of asking states to make proposals when there is no clear intention to involve them. The Health secretary was not aware of the CCM state representation debate. Overall, it seems that the 'low prevalence' states are fully engaged with GFATM processes by the centre.

4.3.7 Issues

Value added

The GFATM offers a new financing mechanism. It is perceived as rather inflexible and cumbersome by officials, in comparison with the flexibility provided through MOUs with the UN, WB loan agreements and financing procedures with bilaterals. It is also perceived as 'soft money' by external partners, with as yet untested accountability and implementation planning frameworks to ensure that results are delivered.

On the other hand, it provides speedy access to grant funding, backed up by a strong sense of country leadership. The new source of financing is invigorating, bringing with it opportunities to expand new strategies, for which a domestic budget may not have been available in the near future and traditional donors may have been less willing to finance. The Fund was referred to as a handle (cf hand and lever) to help scaling up the activities identified as priorities by the GOI.

The Fund is promoting and facilitating the introduction of new technologies and innovative approaches. For example, Round 4 malaria proposal includes supply of ACTs for areas with resistant malaria. TB activities include scaled up PPPs with the private sector, and innovative models for community based treatment supervision. AIDS finance has enabled the PMTCT programme to develop in 17 district hospitals and to finance the new ART programme, launched in Dec 2003 (to reach over 170,000 patients by end 2005).

GFATM is supporting best practice and putting issues on the agenda, such as involving people living with HIV, that have not been addressed before. Wider participation also means that the MOH tendency to medicalise health interventions is weakened, resulting in alliances between people living with AIDS and stronger community based models. The longer term challenge will be AIDS mainstreaming, as the Fund is so far rather health biased.

Although the Fund is a financing mechanism, comments from the Technical Review Panel, and from the technical team visit once a proposal has been agreed, are also promoting refinement and improvement of strategies. High quality and informed comments are noted eg (for malaria) consumer preferences for the private sector and how to involve informal providers, commodity market stimulation, monitoring resistance against ART-SP combination. Responses to these technical queries are required to progress the grant process. The strong national ownership of the CCM means that GFATM technical feedback can be provided in an open and transparent way, and is accepted as positive criticism.

Unlike other international health partnerships, GFATM has also stimulated direct communication with civil society through such agencies as Partners Forum, international NGOs and civil society alliances. This has generated high levels of awareness about the funds and the need to get the national CCM members to listen to the voice of the civil society. CCM has had to respond to it. CCM is the only forum where the NGOs get to meet National AIDS Control Programme Managers and to hold them accountable. This may have positive spinoffs for other parts of the AIDS control programme too.

Issues

Complex processes and need for technical capacity

The preparation of proposals requires very substantial inputs. India used external WHO, WB, USAID, UNAIDS and other assistance to prepare a composite proposal very quickly. Some resentment was expressed by Fund partners about being taken for granted in this process by the Fund. Complex guidelines and frequent changes in requirements (from Round to Round, and also for disbursement requests) are viewed as very cumbersome and the cause of some frustration. Officials also expressed wider concerns that proposals from the poorest countries continue to be rejected, possibly because they lack access to the capacity required to develop a proposal.

While capacity building should not be main aim of a programme, some inputs have been included where required. Access to technical support should not be the major challenge, but it was clear that there was little co-ordination among development partners, or any agreements to finance necessary inputs. Planning and implementation for the ARV treatment programme is likely to be complex.

Accountability concerns

A major issue of concern is that the CCM, although simply a fiduciary mechanism, could be drawing attention from developing a national co-ordinating structure for AIDS. India has a national committee, which was referred to as 'dysfunctional', but no concrete plans for a national multi stakeholder commission. This could be detrimental the development of the 'three ones', and creation of inclusive governance and strategic planning for AIDS across all sectors (ie mainstreaming).

There is unclear accountability and risk of conflict of interest. The distinct functions of the CCM, LFA, PR and implementer are not yet clear – who is ultimately responsible for success or failure, and who is authorised to make that judgement? If a programme is deemed weak, it is very unclear who arbitrates at national or fund level – as yet there are no clear appeal procedures, and the Fund lacks a technical review function. There are particular concerns about the lack of a credible *national* technical review function, especially where the LFA has no technical expertise. Concerns about project design, accounting and reporting – the Fund seen as a soft financier, and accountability could be weak in comparison to other development partners.

The CCM does not necessarily have the capacity to monitor and review. There may be a role for an independent technical monitoring function, commissioned by CCM, and approved by the Fund. It appears that the Fund is still considering these issues too.

Management and co-ordination

The Fund generates substantial communication, management and administrative tasks, and a Secretariat has been recommended. The CCM has designated a working sub committee to consult with the Fund and develop TORs and financing proposals. There are strong arguments, especially in light of the need for AIDS mainstreaming and MOH role as implementor, for the Secretariat to be independent and located outside the MOH. However, the range of generic functions and responsibilities, and financing options, are yet to be clarified, by the CCM. One option could be funding through extra budgetary support from a UN organisation such as UNAIDS or WHO. The Fund also has not come forward with guidelines on Secretariat establishment.

Despite the CCM, co-ordination needs strengthening. There are issues concerning dialogue between GOI and partners, concerning possible financial substitution. This risk has arisen in relation to TB in AP (currently DFID supported, but also in GFATM Round 4). There was little evidence for strong communication between major Fund partners (World Bank, Gates Foundation, DFID, USAID, UN agencies etc) at country level, and this was resulting in some confusion and frustration, especially in relation to programme reporting transparency and financing of TA. UN agency supporting roles to the CCM are especially unclear, although some are strongly engaged with the Fund at international level (WHO and UNAIDS). A Secretariat would undoubtedly assist with this, but a separate forum for core Fund partners has been proposed, possibly in addition to the expanded UN Theme Group.

It does seem that the GFATM may be stimulating stronger donor communication and GOI planning. The TB and malaria programmes (under the umbrella VB) are now more actively developing programme strategic plans, and strengthening donor consultation and co-ordination of inputs through revitalised Inter Agency Co-ordinating Committees.

Systems integration and harmonisation

Funds are destined for specific states, and activities are fully integrated into the national public health programmes, to be managed by them. However, the first Round 1 proposal included an NGO, Round 2 had three NGO partners, and Round 4 an NGO Consortium, with a strong public private mix.

There is a danger that Fund reporting requirements require setting up parallel M&E systems. GFATM may need to be more flexible with respect to TB programme monitoring, which already uses standards recommended by Stop TB and WHO. NACO's M&E system has overall 5000 reporting units, and there should be opportunities for technical inputs to improve rather than duplicate it.

Fund requirements need to be met through development and strengthening of one system, not the introduction of a new one. This reflects wider problems in donor requirements and multiplicity of formats for financial and performance reporting, which the GOI is actively addressing through convergence and harmonisation efforts.

5 FINDINGS: GHPS FOR IMMUNISATION (POLIO AND HEPATITIS B)

5.1 Global Polio Eradication Programme

5.1.1 National programme

India adopted the strategy of pulse polio campaigns in 1995 to eradicate polio, following a feasibility study undertaken with vaccines worth US\$500,000 provided by the Rotary International, a member of the Global Polio Eradication Initiative. Initially it was confined to children aged up to 3 years. From December 1996 the campaign covered all children up to 5 years.

The primary implementer of the Polio Eradication Campaign in India is the Ministry of Health and Family Welfare. Vaccine management (except procurement), training, logistics and M&E are managed by the health department. A significant portion of the funds is kept outside the system, with the concurrence of GOI, for social mobilisation and communication campaigns (Unicef) and technical support (WHO). Vaccine procurement of vaccine is managed by UNICEF. The National Polio Surveillance Project, started in 1997 and managed by the WHO, is funded by donor agencies, to conduct Acute Flaccid Paralysis surveillance in every district. While this project works with the state level and national programme managers, it operates outside the health system.

Intensity of eradication efforts increased in 1999 with house-to-house visits during National Immunisation Days (NIDs). Conducting a NID calls for high levels of local planning and community mobilisation, and place significant demands on primary level staff, who are supported by infrastructure and personnel of other government departments and Panchayat Raj institutions.

In terms of achieving reduction of incidence of polio the programme has been a success. Prevalence fell to 268 in 2001. According to programme managers this generated a lot of optimism and some complacency. However in 2002 India had 1600 cases of confirmed polio, and the deadline was pushed from December 2004 to 2005. Both Andhra and Rajasthan experienced outbreaks in 2002. After intense efforts, prevalence was brought down to 225 cases in 2003. As part of the final push towards eradication in 2004 India will have five rounds of National Immunisation Days in 2006 with an additional Sub National Immunisation Day for high risk states including Andhra and Rajasthan.

5.1.2 Fit with priorities and governance

The World Health Assembly goal, and the advocacy of partners in the Global Polio Eradication Initiative appear to have stimulated the GOI to attempt polio eradication. Even now, the fact that India is one of the remaining polio endemic regions, to be tackled before polio can be eliminated from the world, is a motivating factor at the national and state levels. The constant pressure maintained by GPEI partners ensures that this factor is pressed home, while in turn, GOI expects international support for what is ultimately a global public good. Several interviewees noted that while meetings of the Inter-agency Co-ordinating Committee for Immunisation were dominated by polio, they also felt that the 'partnership worked well' in terms of co-ordination and pooling of effort.

Mobilisation of funds by the Initiative has been another reason for polio remaining a national priority. The campaign has cost more than US\$3 billion. The unique and high visibility of the programme's goal at the national and peripheral level has been cited as another strength of partnership. The spectacular fall in new cases gave the

impression that success was imminent and that only a final sustained effort was needed.

The epidemic of 2002 appears to have been a rude shock to programme managers at the national and state level. Programme managers in Andhra attributed this to complacency generated by the state's remaining polio free for a long period. It also exposed the vulnerability of any part of India so long as the entire country is not polio free. Both Andhra and Rajasthan programme managers attributed cases to epidemics in adjoining states. Neither appeared to be slackening on the effort to control polio in spite of the obvious pressure on the health system.

National and state officials are worried that the final reservoir of the virus is in two states that do not appear to be giving the effort the needed intensity. This raises the question of when eradication and certification is indeed possible and how long the political, financial and system commitments can last. If certain states decide to stop the campaign, given the coverage of routine immunisation in the country it is likely that at least some of the gains, and the opportunity for eradication may be lost.

5.1.3 Finance and additionality

The additional contribution of bilateral agencies has helped fund the campaign's enormous cost. The USAID has contributed US\$900 million, DFID £225 million pounds, the European Union 240 million Euros and DANIDA US\$180 million, and US\$600 million mobilised by the Rotary Foundation. It is not clear to what extent these are additional funds that would otherwise have not been allocated to India. Although the eradication of polio is a global public good, some of the bilateral funding was drawn from funds earmarked for aid to India, and reduced funding to other programmes.

Resource mobilisation was possible due to the high priority accorded to polio eradication by the international partners of the Global Polio Eradication Initiative, including the government of India. The shared priority of the partnership and the government enabled the Initiative to leverage the additional support. The common commitment also made it possible for the DFID and USAID to keep their bilateral assistance outside the government machinery and access high end TA to support the programme.

5.1.4 Impact on commodity prices

The increased demand for oral polio vaccines, generated by the continuing and stepped up campaign, would have had an impact on the prices. More importantly, the strategy to eliminate polio using the cheaper OPV without involving the Injectable Polio Vaccine, as recommended by some experts would also have influenced the price of both the vaccines.

Box 3 Rotary International and the Polio Eradication Initiative

Rotary International and their member units in India has been a very active partner, advocating for and supporting the polio eradication campaign. They were also associated with the World Health Assembly 1987 resolution, which adopted the strategy for polio eradication.

The Government of India was initially reluctant to commence the campaign. However the Rotary persuaded the Government of Delhi state to conduct two mass immunisation days. Armed with the success of the initiative, the WHO and Rotary approached the government of India. They also advocated with the state governments, who also agreed to support the initiative. Since then they have been associated with implementation of every National Immunisation Day Campaign, especially in the advocacy and social mobilisation components.

The involvement of Rotary is a successful partnership in operation. Outside the formal system, Rotary has been able to leverage their flexibility in providing support other agencies cannot provide, including in advocacy with leading religious leaders. They are involved at the international, national, state, district and the town level. There is perfect alignment of strategy at all levels, high degree of focus and willingness to innovate at local levels. They have raised funds at different levels, contributed their time, used their reach to make available locally relevant support such as food, transportation and accommodation and used their flexibility (and high level informal influence) as a non-government organisation to mobilise political and community support.

Rotary also demonstrates the weaknesses of a global health partnership. GPEI's narrow focus on a clearly defined target precludes distraction by competing claims. A focused partnership is very useful when there is a definite target to be achieved in a clearly defined, short time span. Their aim is to get over barriers in the short term, without waiting for or investing in system improvement. But the reality that, without strengthening the systems for routine immunisation, eradication may not be possible has demonstrated the weakness of their strategy.

5.1.5 Poverty impact

Since the polio eradication campaign covers the entire population, emphasis has been on ensuring universal access. The campaign has communication and social mobilisation strategies to ensure that the populations generally left uncovered are brought into the campaign. The polio eradication campaign, by the nature of the effort, appears to have achieved in covering children at least in states where it has been a success. The lessons learnt here could be used to improve the equity of access in routine immunisation.

But for routine immunisation coverage, household surveys conducted as part of the first phase of the Reproductive and Child Health Programme have shown wide disparities based on income and regional differentials in access to full immunisation coverage. At the national level, while the richest quintile has coverage above 50% that of the poorest quintile falls below 40%. The disparity is higher in the states that perform poorly on routine immunisation. Nearly 24% of the districts have less than a quarter of their children fully immunised. This significant failure may jeopardise the impact of polio activities as infants are missing out on polio immunisation as part of routine activities.

5.1.6 Assessment

Risks and benefits of single issue focus

Routine immunisation coverage failures were widely acknowledged among respondents to be of major concern in India, with immunisation coverage rates below 25% in nearly a quarter of India's 294 districts, and under 50% in a further third (2003 RCH data), and reported diphtheria and measles outbreaks.

Interviewees were concerned about the impact of the polio campaign on routine services. Many are now questioning the wisdom of focusing on a single disease when immunisation coverage in the country is low and children are vulnerable to other diseases as well. Immunisation for the other vaccine preventable diseases is not promoted so vigorously. The massive mobilisation and IEC has generated fatigue, and also creates an impression among health workers and mothers that they only need to receive polio drops. This could have serious implication for the fate of routine immunisation in the country. Household visits to provide polio drops has removed the incentive for bringing the child to health facilities for immunisation (and other services).

This raises the question of whether the promotion of polio eradication by the GPEI and its partners coincided with real or perceived national priorities. Would the interests of the children of India have been better served by focusing on strengthening the routine immunisation levels to above 70% and then pushing for eradication? Did the additional funds mobilised by the GPEI distort priorities? In a country where the children suffer from many vaccine preventable diseases would the authorities have perceived the need to focus on one disease if it weren't for sponsorship from the international community?

Opinions differ. Most public health authorities are convinced that without a good routine immunisation the effort for polio eradication may not succeed. (One of the interviewees called it the 'Achilles Heel' in the war against polio). Polio immunisation coverage is high where routine immunisation is good. The weakness of the health system for supporting routine immunisation, (the lack of personnel through vacancy or absenteeism, poor cold chain maintenance and poor data on children eligible for immunisation) has also affected the capacity of the states to conduct the National Immunisation Day (NID) campaign.

But there is no hard evidence to show that the NIDs have had a negative impact on immunisation. Programme officers at every level admit that there has been a high degree of fatigue among health workers and the community with the increasing number of NIDs. There is also a tendency on the part of health workers to neglect other work; in view of the importance programme managers give to polio.

On the other hand the aggressive campaigns that precedes the polio campaign, the micro-planning done for effective campaign and the high level of importance attached to the campaign may have served to raise the importance of all immunisations.

The Polio Eradication Initiative is planned to fade away once the task has been achieved. The scale of resource and social mobilisation generated by the initiative cannot be sustained. But the programme has initiated beneficial spin offs, such as micro-planning and vaccine monitoring and management skills which can be used by the system to strengthen other health interventions. The scale of global and national mobilisation achieved by a shared vision may initiate similar efforts regarding other diseases on the verge of elimination.

There are demands that the scope of the National Polio Surveillance Programme, set up under the Polio Eradication Initiative, be scaled up to cover other Vaccine Preventable Diseases or even other infectious diseases by linking up with the nascent National Disease Surveillance Programme.

Value added by the partnership

It appears highly unlikely that India would have agreed to the Polio Eradication Campaign in the nineties without the active advocacy carried out by the GPEI partners. Once the commitment was obtained, the partners at the international and national level helped mobilise the additional resources and supported champions of the initiative within government to mobilise funds from the national and state budgets. GPEI partners have very clear roles: Unicef is involved in mobilisation, and WHO in setting up the surveillance network, and providing significant TA.

They have also supported the implementation of the campaign. Some of the partners set up high voltage communication campaigns, contracted brand ambassadors and helped organise events that brought together prominent persons from different fields. This changed the perception of the campaign from a health activity to a national mobilisation. They also worked on political advocacy and when the Muslim community, for example, was found to have reservations about the programme they arranged to have endorsements from Muslim clerics, community leaders and academic institutions to influence the community. It is unlikely that government, without the partners, could mobilise the support of this magnitude.

In India, it would have been unlikely that the government would have continued to invest so much time and effort in one programme for so long if it weren't for the huge and sustained support the partners have generated for the programme. And this was based on a consensus, overcoming the reservations of some agencies. The Inter Agency Co-ordination Committee is often cited as a successful model of co-ordination mechanism. It is also a tribute to the commitment and mobilisation of partners that reservations regarding the eradication strategy (eg cases of vaccine-associated polio), and the possible negative impact of the programme on routine immunisation have not entered the public discourse.

5.2 GAVI

5.2.1 GAVI scope of programme

GAVI has committed \$40 million each to India, Indonesia and China from the 'new vaccines' window. In India GAVI has agreed to supporting the introduction by the National Immunisation Programme of Hepatitis B into a number of targeted pilot areas across India, starting in mid 2002 for two years. These include 15 (poorly performing) low-income metropolitan areas, including one each in AP and Rajasthan, and 33 better performing rural districts (including 2 in AP). GAVI is supplying vaccine for immunising infants alongside the three routine DPT doses. In addition, AD (auto-disabled) syringes are also being provided by GAVI for the first time in India in the pilot areas.

There is slow progress in many pilot projects, with coverage only reaching 43% in urban pilots by end 2003, and 56% in rural districts (with 18 at less than 50%). Although district uptake is being monitored for GAVI reporting purposes, there are no additional strengthening inputs. Pilots will be reviewed after 2 years to assess impact and system capacity to take up new intervention, plus issues linked with injection safety.

GAVI partners, Gates Foundation and PATH, also developed a separate MOU in 2001 between the state of AP and the Gates Foundation, to provide Hepatitis B as part of routine immunisation to all infants in all 23 districts by end of 2003 (designated AP's Year of Immunisation). The programme is being managed by PATH's Children's Vaccine Programme, based in a project office located in AP's directorate of health.

As well as Hep B, the programme provides AD syringes, vaccine vial monitors and technical support in programme management and strengthening. It has achieved some success in improving overall coverage rates, as well as cold chain management. The initiative has high-level political support at the state level, and was launched by AP's Chief Minister. PATH programme staff attribute the success of the programme to this, and to technical support, and to strong planning and partnership with district level officials. However, public officials are less certain about sustainability beyond the five-year programme, as well as overall GOI policy directions.

5.2.2 Governance and fit with national priorities

GAVI's support to pilot HepB immunisation is welcomed in principle by technical staff in both the programme and external agencies. But many respondents questioned the wisdom of adding new (and costly) vaccines, in the absence of intensive programme management and system strengthening efforts. There is some regret that the HepB pilots do not include any strengthening activities, except for specific training and IEC. It will be important to compare HepB GAVI sites with AP PATH assisted sites, which did include system inputs.

It is very unclear if and how GOI will scale up the pilots in the longer term. Their profile appears low, in spite of the significance of the decision to introduce a new vaccine. In Rajasthan, although the immunisation programme officer was managing the pilot in Jaipur, the State Health Secretary was not even aware that it was taking place. In AP, technical officials expressed only moderate enthusiasm for the Gates programme, and did not appear to be confident that AP government would continue it. They felt that it had been negotiated and introduced by the Chief Minister in dialogue with Bill Gates, as a populist move, in view of demand among middle classes and desire for a feasible and high performing project - a quick win. There is a case for introducing HepB in the higher prevalence (and higher performing) southern states where there is both popular demand and public health need.

India has not sought nor entered into an agreement with GAVI for funding towards Immunisation Service Strengthening. Instead, support to strengthen immunisation services was provided by through an IDA loan by the WB in the late 90s. At that time, the problems facing immunisation were not fully apparent, with the majority of districts reporting over 80% coverage.

The Immunisation's programme's Interagency Co-ordinating Committee acts as the GAVI ICC, and includes GAVI partners. However, it does not appear that development partners in the ICC played a strong or collective role as GAVI partners, with respect to developing a strategic and shared perspective on the pros and cons of introducing Hep B. This was partly attributed to the overwhelming and urgent pressures on all partners to mobilise resources and activities for eradicating polio, which has meant that issues concerning routine immunisation and new vaccines have been pushed down the agenda.

5.2.3 Finance and additionality

Over 98% of routine immunisation costs are currently provided by GOI. GAVI funding amounts to US\$4 million for the HepB pilots. GAVI pilot funds are additional, but are not substantial in overall terms, and are for commodities only. The programme is underspent and felt to be underperforming. India, as a GAVI client, has been requested to prepare an Financial Sustainability Plan. It has, perhaps understandably, been reluctant to invest time in this, given that the vast majority of expenses are met through the domestic budget. However, this reluctance could also be linked to India's lack of intention to scale up the vaccine.

The remaining India allocation of US\$36 million has been agreed by GAVI to fund AD syringes under RCHII. In light of falling coverage rates, WHO has been working with GOI's RCH II team on developing a new immunisation strategy. This now requires about 14% external funds (excluding WB loan).

The AP state government MOU commits it to phase in state financing to cover total additional costs in five years. Already reported to be providing 60%. Sustainability, given AP's overall deficits, is a concern.

5.2.4 Commodities

Commodities for GAVI pilots are financed by GAVI, and supplied by Unicef to the state level for the pilot areas by GOI. During the first year, PATH purchased AP commodities through Unicef. However, prices were felt to be high and there was interest in stimulating the supply in India. A national tender for AP supply reduced price from Unicef's 60RS to less than 14RS, and competition is expected to drive prices down further. Unicef's high price was also due to 45% import taxes charged to AP (would be exempted at GOI level). Likewise, AD syringes cost over 15RS when procured internationally. Two companies are now supplying, with the cost down to 2RS. Local companies are also supplying injection disposal equipment (plastic containers to every ANM and needle cutters to 14,000 PHCs). PATH has also provided assistance to several local companies in achieving WHO certification/pre-qualification for good manufacturing practice – thus enabling a stronger India presence in the international market.

5.2.5 Poverty and gender impact

The RCHI periodic household surveys permit immunisation and other family welfare data to be disaggregated according to socio economic quintile. The data show that the lowest quintile, even in the best performing states, consistently has poorer access to immunisation services. This would include infants receiving Hep B in AP, a good performer where in 1998/99, fully immunised coverage of the poorest was high at 70%, and efforts in AP are ensuring that under-performing districts are supported. As mentioned above, the data for the GAVI districts is much patchier. Coverage is under 50% for the poorest urban areas, and there are no resources to target poor households. The RCH surveys also allows gender differentials to be identified. In the wider immunisation strategy, several strategies are included to ensure that poorest quintile is reached. The survey also establishes a high correlation between scheduled caste and tribe with the lowest quintile, which justifies selected geographical and population group targeting.

5.2.6 Assessment

Some GOI respondents felt a lack of sufficient advocacy on GAVI's part (and lack of agreement among its partners at national level), in terms of failing to support the development of India's strategy. Questions include: can new vaccines be used to stimulate system strengthening – by revitalising interest in routine immunisation? Could GAVI have influenced key components of the delivery system, as it has done

in the case of AD syringes for injection safety? What should India's long-term strategy for introducing new vaccines be?

There is reasonable consensus on the need to improve injection safety. Concerns have grown considerably, linked with HIV, with a major study showing over 63% of injections to be unsafe. Although public health advocates would prefer Universal Precautions to be promoted, this is not realistic in the short term, especially for staff working in difficult rural conditions.

The Health Minister announced GOI commitment to introduce AD syringes in all sectors in July 04, and there is an expert national injection safety committee. GAVI partners do support their inclusion into RCHII budget. However, a major outstanding issue is the development of an appropriate disposal system. The PATH programme has developed an appropriate system for AP that is both environmentally sensitive and uses local recycling businesses. This does not appear to have been taken up in GAVI pilot projects, where disposal guidelines were reported to be lacking. Rajasthan officials expressed concern that no guidelines had been promoted by GOI for an effective disposal system in their pilot district.

Although the national programme's working group has expressed interest in PATH's experience, neither GOI nor GAVI appear to have been very proactive in promoting lessons and scaling up the AP experience in the GAVI pilot areas. GOI has adapted PATH's training materials for GAVI sites. PATH has also introduced its disposal system to the private sector through national and local Indian Medical Association.

The agreement of GAVI to use of its funds only for AD syringes is seen as unusual. Several respondents felt that eligible states could have been offered the opportunity to include Hep B in their immunisation programmes. The GOI's decision to undertake pilots appears to be a short-term compromise – to satisfy public health sceptics, industry lobbyists, GAVI, and the southern state governments.

However, many perceive the GOI's decision to opt for a new vaccine to reflect a misconception of the role of GAVI in a large country such as India, that was not at first eligible for the Immunisation Services Strengthening window. The decision also reflects the GOI's commitment to fund immunisation through domestic sources (which are defined to include IDA loans).

It also seems that GOI may have been under some pressure to introduce Hep B, and that the pilots were a short term and expedient solution. There is a perception that the AP Gates partnership influenced GAVI to approach GOI. More than one respondent attributed GAVI's interest in introducing Hep B in India to the wider need to grow the vaccine market and reduce global prices. Indian industry also has an interest in the market. Public demand is quite high in southern states, with AP HepB coverage already at 30% through the private sector. Pharma companies have been providing subsidised HepB in states including AP in schools, thus creating demand. Kerala offers the vaccine as part of immunisation in the public sector, but charges for it (as opposed to other vaccines).

There are some doubts regarding the reliability of data informing the decision. Hepatitis B is perceived as a 'meso-endemic' public health problem in some Indian states (reaching prevalence levels of up to 6% mainly in the south). Hep B was referred to by one official as 'an induced threat', included partly because it is logistically easy to offer with DPT. When asked to choose between Hep B and other new vaccines, interviewees typically selected neo-natal tetanus or rubella. Given the price of the vaccine (over 15 times greater than other routine ones), there is no

convincing costs-benefits evidence base on which to make the decision to introduce the vaccine.

6 FINDINGS: NEGLECTED DISEASES (LEPROSY AND LF)

6.1 GAEL

6.1.1 Scope of leprosy programme

India accounts for about 65% of the global leprosy burden, and introduced leprosy activities in the 1950s. Following the introduction of new WHO Multi Drug Therapy (MDT) guidelines in 1981, MDT was scaled up nation-wide in 1983. Modified Leprosy Elimination Campaigns, including IEC, training, case detection and prompt MDT, have been carried out in all states at risk since 1997, with the fifth taking place in 2004. Active case finding was introduced in 2000. In addition, 1,440 three-year special projects continue in areas where higher prevalence pockets exist.

By 2004, national case prevalence had come down to 2.3 per 10,000, with 16 states reaching the elimination level of less than 1. Eleven states contribute 90% of the current caseload, including AP. Although Rajasthan had achieved elimination overall by 2000, levels are between 1-2/10,000 in 3 districts which have low income urban populations or are near the border with UP (where nearly a quarter of India's cases are found).

6.1.2 Fit with priorities and governance

Leprosy elimination by 2005 is a National Health Policy 2002 target, and the programme is a long-standing one with very active NGO involvement. In contrast to other communicable diseases, the 2003 MOHFW report highlights India's contribution to international efforts to eliminate the disease. GAEL is not mentioned, but the report cites the WHA elimination commitment in 1991, and refers to WHO's leadership, the strong commitment of endemic countries, and active support of NGOs/voluntary organisations and donor agencies, including mention of Novartis' MDT donation.

International NGOs are very active in India, working through the ILEP Consortium. LEPRO is working in several AP districts, and the German Leprosy Relief Organisation in Rajasthan. At national level, NGOs have formed an alliance, and allocate state-wise responsibilities. Although there is no formal committee involving NGOs, there is regular consultation with GOI and agreement on guidelines and policy.

6.1.3 Commodities

MDT is now provided as a donation by Novartis, via an MOU with WHO. However, the team heard reports that the useful drug regimen prescribed for single lesions had been withdrawn by WHO from international guidelines, possibly because it was not manufactured by Novartis.

6.1.4 Finance and additionality

The leprosy elimination goal has clearly resulted in additional financing from bilateral agencies and international NGOs, based in countries including Sweden, Denmark, UK, Germany and Belgium. However, the extent to which advocacy by GAEL, as opposed to ILEP, mobilised this support is not clear. Substantial funding was provided through a WB IDA loan in the late 90s, which continues in its second phase to Dec 2004. Further WB finance is unlikely, given impending elimination success.

6.1.5 Poverty and gender

Although the 2000 evaluation of the National Leprosy Eradication Programme reported good progress, greater efforts were recommended to reach populations in marginalised rural and low income urban areas, on the basis of data collected. The evaluation included a household survey in representative sample populations in endemic districts in the five worst affected states. Survey data were disaggregated according to household membership of disadvantaged groups, which yielded some information about socio-economic status. At the time of the evaluation, in sample populations, case prevalence of leprosy was 51.9 per 10,000 below the poverty line, and 67.8 in scheduled castes, compared to only 22.8 in other populations. Awareness of effective treatment options was also lower in the former groups. More recent analysis has not been carried out, but the programme has a clear targeting strategy for outreach.

Some gender inequalities are also reported in treatment access, given reluctance of young women and families to seek treatment because of stigma and poor marriage prospects. Service providers are aware of this potential gap, and it is being addressed through IEC and house-to-house visits. Monthly targets have now been abolished, as it was felt that they contributed to misreporting and reporting delays.

6.1.6 Assessment

Value added

National, state officials and NGOs are agreed that the elimination is on course and should be achieved within the targeted period. The National Leprosy Eradication Programme remains in place at national and state level, but leprosy teams are now integrating into the district general health care system, with leprosy officers doubling as AIDS officers in Andhra Pradesh. Full team and service integration is planned during 2005/06. Partner NGOs are increasingly taking on TB DOTS and other health activities. Leprosy microscopy services and technical staff are being transferred to TB services. Care, support and rehabilitation are provided through general district and primary health services.

The extent of NGO involvement in leprosy elimination, and its acknowledgement by GOI, is striking, in comparison with most other national programmes (asides from TB). State and district leprosy societies number over 290 nationally. ILEP is recognised in its annual report by MOHFW as an active partner, and members are supporting the programme in 13 states with 138 district technical support teams in 231 districts, involved in integration activities as well as treatment and care. State level programme officers also acknowledge their support. NGOs also showed high comfort levels in working with government at the national and state levels. Priorities are technical support, quality assurance and project management. NGOs are especially active in marginal areas where public health infrastructure is weak.

Issues

At the international level, as reported in GAEL's 2003 evaluation, disagreement and debate continue between WHO and ILEP about appropriate technical strategies and the balance between care of disabilities and treatment of new cases. ILEP left GAEL in 2003, and has not rejoined. However, interviewees in government and ILEP members such as LEPRA were confident that this was not affecting impact on the ground.

As with other countries, there are concerns that the achievement of elimination targets will curtail all leprosy activities – a certain level of activity will be required to maintain elimination rates, given the long incubation period, and need for

rehabilitation services. There is concern among NGOs that the government's closing down care institutions is leaving a gap in services. There is also some anxiety amongst networks of people living with HIV/AIDS about leprosy and AIDS convergence, given risks of stigma. And, given the fact that impact of AIDS on leprosy as a co-infection is an unknown, public health experts are also worried whether increasing HIV prevalence could see a resurgence of leprosy.

6.2 GAELF

6.2.1 Scope of the national programme

LF is endemic in 20 states and Union Territories, mainly in the centre and south, with around 400 million people at risk, and over 1% infected. Activities related to its elimination are led by the new national umbrella programme for vector-borne diseases, established in 2003/04, as part of GOI's convergence policy. The LF control programme was started in 1996, and is being implemented through 206 specialised filaria control units, 199 clinics and 27 survey units, mainly in endemic urban areas. Rural prevention and care services are provided through district PHC systems. Central assistance of provided to endemic states. The internationally recommended strategy (annual single dose MDA) was provided in 13 districts in 2000, increasing to 31 of the 201 endemic districts in seven states in 2003. MDA is planned to expand to all districts in 2004. The strategy also includes morbidity and disability management. There are some frustrations at central level about the low profile of the programme, linked to slow progress of the programme's scale up. Several poorly performing states are failing to spend allocated resources.

6.2.2 Governance and fit with national programme

The elimination of LF by 2015 is a national priority, as set out in the 2002 National Health Policy. The LF programme is one of the oldest national programmes, and has been in place since 1996, before the Global Alliance was established. GOI is a member of GAELF. National programme staff are aware of GAELF, of GAELF's recommended strategies and the global agreement with GSK for the albendazole donation. The Alliance is felt to have contributed to developing stronger international commitment to eliminate the disease. The second Alliance partners meeting was held in India. Apart from this, the Alliance does not appear to have a substantial profile or influence at country level, and does not feature in the programme's co-ordinating committee discussions. However, WHO (as lead GAELF technical partner) plays a significant role through a highly-regarded NPO, who is embedded within the programme.

Senior officials strongly emphasise the importance of India-owned policy development with respect to introducing new LF strategies. For example, since 2000, the Alliance has advocated for two technical strategies – mass drug administration and combination therapy. At state level there was still some scepticism about MDA – and officials were keen to see study results, having some doubts about effectiveness. While MDA is broadly accepted as an effective strategy, there is less agreement on how to deliver it (mass treatment days etc) and the best form of community based education.

Combination therapy was perceived to have been 'suddenly' introduced by WHO, and linked to GSK's donation offer. Small studies in other contexts demonstrate that combination therapy is more effective and only required for 5 years, versus 7-8 years of monotherapy. However, a recent Cochrane review, cited in a 2004 evaluation of DFID support to GAELF's technical support centre in the UK, has questioned the evidence base for including albendazole.

The matter was reviewed by a national task force that is now overseeing the development of the Indian evidence base for the effectiveness of combination therapy for LF. Trials are taking place in several districts in Kerala and Tamil Nadu, and results after 2 years show some increased effectiveness (reduced parasite load and anaemia levels). In India, there are also some concerns (and negative publicity in pilot states) about increased side effects from combination therapy, although these are not life threatening. It is felt that introduction of second drug was handled badly, so that side effects were blamed on it.

The team was told that decision about combination therapy would be taken in 2005 by a national expert committee, following results from trial districts, when three years treatment will have been in place, compared with five years MDA DEC alone. Kerala and TN governments were reported to have agreed to implement the pilots partly because of the effectiveness of combination therapy introduced in Sri Lanka.

6.2.3 Financing issues

LF is largely financed by the GOI. GAELF has facilitated the donation of albendazole, and US\$100,000, to support MDA and community-based education strategies in the pilot districts. Otherwise, no additional national funding is attributed to Alliance activities at national or international level. Indeed, WHO SEARO reported a wide misunderstanding on the part of region's governments, that the Alliance was a resource mobilisation mechanism as opposed to an advocate with other partners. Generally, it does not appear that countries have been successful in raising significant external funds in the region. Hence it is unlikely that India's albendazole review is affecting finance leverage.

The converged programme is developing a new five-year strategy and budget, to cover the five major vector borne diseases of poverty (malaria, LF, Japanese encephalitis, dengue, kala-azar). This will be the basis for a new WB proposal for a consolidated approach to all five diseases, as opposed to former projects for leprosy and malaria only.

6.2.4 Commodity issues

The monotherapy DEC is locally procured at extremely competitive prices. GAELF has had no influence on achieving these. While GAELF would facilitate access to the GSK donated product, GOI is understandably unwilling to accept donated drugs, and advocate their consumption, just because they are free, and before there is a strong rationale for improved outcomes in the Indian context. MOH has some concerns about transaction costs and sustainability, with respect to guarantees for GSK's commitment to supply free until elimination achieved, and GSK's wider motivations in market development (no free lunch).

6.2.5 Poverty and gender

There is no data on programme incidence for the poor. However, given the strong association of the disease with poverty and poor sanitation, and its very high incidence among the poor, it is likely that the poor will gain most from the MDA programmes. Officials are dubious about the value gained from monitoring impact on the poor, given costs involved. However, stigma associated with the disease also means that richer households might be unwilling to accept MDA, which could jeopardise elimination efforts, and hence benefits for the poorest. This has major implications for outreach and education efforts. For example, association with stigma and poverty means that focused campaign approaches (such as NIDs) tend to be avoided by richer households who prefer to seek private treatment, and could deter better off families from using public health services.

6.2.6 Assessment

Over half the population at risk of LF lives in India, so adoption and scale up of the most effective strategies, in the Indian context, are crucial. Limited influence of the Alliance means that its impact on the wider health system has been neutral and minimal. Regarding national policy, it is unlikely that enhanced Alliance advocacy now would have any effect on GOI's decision making processes, and might indeed lead to a retrenchment of positions. WHO is providing a valued neutral channel for the dissemination of technical information, support for the decision-making process and strategy design.

Next year's expert committee may decide in favour of scaling up MDA and combination therapy, if the data is sufficiently convincing. The wider benefits of deworming from albendazole are also acknowledged. Further Alliance inputs at that time may be welcomed. However, as one interviewee put it, the question is 'what kinds of funding or other support would be acceptable to GOI, in terms of fit with national policy and strategies?' For example, the Alliance is perceived to emphasise public health measures over individual care and rehabilitation. The programme would prefer a package to support both prevention and care, and would be keen to reduce the opportunity and transaction costs of accepting external assistance.

7 FINDINGS: R&D PARTNERSHIPS

7.1 IAVI, MMV, MVI

Given time limitations, the research partnerships active in India were not the focus of this study. Interviews took place with IAVI and senior ICMR officials, but not with private sector partners, and covered IAVI and MMV only. Three partnerships are active:

- Medicines for Malaria venture, which with WHO's TDR, has been involved in products development with India's Malaria Research Centre and with Ranbaxy;
- Malaria Vaccine Initiative, working through PATH with the International Centre for Genetic Engineering and Biotechnology, and Bharat Biotech International Ltd to develop a vaccine for P vivax;
- IAVI, the International AIDS Vaccine Initiative, which is designing trials and initiating public-private partnerships for candidate products developed by a US biotech.

ICMR officials reported a positive experience of the partnerships – emphasising the importance of being co-operative and assertive, expressing a strong commitment to the 'access chain', in terms of up front consideration of acceptability, affordability and feasibility of use by most vulnerable/poorest.

IAVI has acted as a very useful broker between GOI/ICMR and the biotech company to develop a model that ensures:

- Ownership of IP of any product for India and regional market (biotech keeps IP over rest of world) (A similar model has been developed with Ranbaxy)
- Development of product to tackle HIV strain in India
- Control over price offered by any manufacturer
- Technology transfer of MVA technology to Indian researchers and companies, of value for many potential products

With respect to IAVI's role in India, IAVI's 2003 evaluation reported positive experiences of IAVI's advocacy and community preparedness approaches. IAVI emphasises the role of GOI in the driving seat, and is working across the various ministries involved. It is involving representatives from the widest range of interest groups, although its presence at state level is possibly less than hoped for.

Early tensions concerning IAVI's mission for preventive vaccines (as opposed to therapeutic ones) with people living with HIV have been largely resolved. And, since India has now announced its ARV treatment programme, ethical issues regarding standards of care have been resolved. One major issue is the need for a balance between community and policy maker preparedness, versus the risk of engendering a false sense of security about vaccine readiness, and hence loss of focus on behaviour change for prevention (which is certainly not the case.)

8 SUMMARY FINDINGS AND CONCLUSIONS

8.1 GHP focus on neglected diseases

India participates to a greater or lesser extent in seven access partnerships that aim to provide technical and/or financial assistance to the prevention and control of major neglected diseases: Stop TB, Roll Back Malaria, GAELF, GAEL, GPEI, GAVI and GFATM. To a large extent, there is good fit between the GHPs and India's burden of communicable disease. However, it should be noted that non-communicable diseases now contribute over half of all DALYs, and that investment in prevention and care is regarded as very low relative to need.

Communicable diseases contribute to over 40% of the burden of disease, with substantial contributions from TB, malaria and childhood diseases (including vaccine preventable illnesses). However, although the malaria control and prevention is improving, it is not effectively tackling the disease in poor endemic areas, and RBM profile and partner support is low in comparison to that of STOP TB (see box 3). The rise in HIV prevalence is requiring an enhanced national response, and it is clear that GHP finance is enabling India to gear up to ART provision more rapidly than otherwise possible.

Leprosy, polio and LF are a smaller proportion of India's communicable diseases, and India continues to seriously address its needed contribution to achieving eradication targets. The focus on polio eradication may have affected routine immunisation coverage. It is now universally recognised that, for whatever reason, immunisation coverage has fallen drastically in many districts, and major efforts are needed to improve it. It is not clear that the introduction of HepB is a public health priority for India just now (except for states where HepB prevalence, and immunisation coverage, justify inclusion in the programme).

With regard to other neglected tropical diseases, such as kala-azar and Japanese encephalitis, the newly converged vector borne disease programme is addressing these, and they are likely to receive more attention in endemic areas. Although trachoma is prevalent in India, it is also limited to very localised areas. India has an integrated blindness prevention and control programme, based on Vision 2020 principles, and is not a candidate for the ITI.

8.2 Governance and accountability issues

All the focal diseases are centrally managed by the national health and family welfare programmes, and there is strong national and state ownership. Indeed, excepting polio, all the GHP focal issues were covered under GOI national programmes prior to the development of the international GHP itself. Most of the disease programmes have inter-agency co-ordinating committees and expert groups. These are not convened under the relevant GHP banner, but tend to be stronger where many partners are involved in a key GHP (eg immunisation, STOP TB). Leprosy NGOs convene their own Alliance, and meet regularly with GOI, but the GAEL presence is non-existent.

Most of the GHPs have limited physical presence at country level. There are two exceptions: the new GAVI Hepatitis B partnership is co-ordinated by a WHO programme officer financed through the GAVI grant. The GAVI working group is a subgroup of the Interagency Co-ordinating Committee, but is not fully functional and meetings are rarely called by GOI, and decisions about new vaccine strategies were made largely in the absence of co-ordinated GAVI partner inputs. Partner

commitment to GAVI may also be overshadowed by the demands of GPEI and polio eradication activities.

The GFATM has its Country Co-ordinating Mechanism, required as a condition for grant eligibility. While the GFATM's CCM is beginning to strengthen its governance arrangements, it is no substitute for a formally constituted national level body, such as the NAC, and other elements of the three ones. Although ultimately simply a fiduciary mechanism, it is possible that focus on the CCM could be inhibiting development of national governance structure. On the other hand, civil society, state and private sector involvement could be helping to build an enabling policy environment for strengthened governance and mainstreaming HIV/AIDS.

The partnerships can enable rapid action to take place, in terms of linking international, regional and national level initiatives, and accelerate processes. For example, the Health Sec. recently took part in a high level delegation organised by the Stop TB Secretariat to Bangladesh, to build political and government commitment to DOTS. This was organised quickly and without bureaucracy, which would have been a lengthy and cumbersome process if organised by WHO or the GOI. The division between technical advocacy and implementation on ground is especially useful for WHO – clear separation is made between technical inputs (evidence based approach, etc) versus lobbying and advocacy functions more appropriately carried out by the wider partnership.

GHPs are also successfully advocating and facilitating the adoption of new and effective stakeholder approaches. These include the inclusion of GIPA (Greater Involvement of People living with AIDS) principles into HIV/AIDS prevention, treatment and care. Prior to GFATM funded programmes, involvement of PLHAs by NACO, and support to the newly emerging networks, was minimal and tokenistic. The active inclusion of the private sector and NGOs in the TB programme is another example of constituency engagement.

8.3 Fit with country programmes and priorities

In general, awareness even among senior programme staff of the technical partnership tends to be low, although this does not necessarily mean low GHP impact. STOP TB and polio both had substantial profiles, and were said to be working well by all partners. RBM had the lowest profile of all the partnerships. On the financing side, GFATM was familiar to almost every interviewee.

The extent to which GHP presence and influence is 'felt' in India is linked to the following factors:

- Consensus on, and clear articulation of the overarching vision and strategy by the national level external partners of the international partnership. This, coupled with a strong global brand, is key to effective delivery of partnership goals, especially noted by interviewees for STOP TB and polio eradication.
- Effective external partner platform at country level eg polio and TB versus GAVI and GFATM
- Clear roles, together with understanding of, and ability to deliver, the technical priorities – depends much on partner commitments and financing, especially for WHO (eg TB and polio). Roles were particularly unclear with regard to partner responsibilities to support GFATM processes. This was causing frustration amongst international partners.
- High degree of national involvement in international partnership – India was a DOTS pioneer, and the continued priority given to TB is partly attributed to the current Health Secretary's active Board membership

- Strong sense of national responsibility to contribute to international goals – linked also to expectation of international support for global public goods such as the eradication of polio.
- Strong national ownership gives the programme legitimacy, but tends to be accompanied by low state awareness of the GHP. While this is not necessarily required, there are arguments for stronger state engagement in national programme strategy and consultation. The GHP partners could advocate more strongly for building this capacity. This is happening to some extent in AIDS, where state level capacity in strategic planning across a range of stakeholders is a clear need. Stop TB's emphasis on strategic planning has had benefits at state as well as national level
- Where WHO's technical inputs are significant and financed by other GHP partners, GHPs appeared more influential. WHO is viewed as the key technical partner in most of the GHPs, and highly respected NPOs are embedded within the national programmes (LF, TB). WHO NPOs interviewed were keen to differentiate between the WHO departmental and partnership identities, and ensure the difference between neutral technical advise and advocacy activities of the wider partnership.

There is some evidence that full partner alignment and co-ordination is not taking place. This weakens the impact of the GHPs. For example, the TB programme and NACO have concerns about coherence between GFATM and World Bank procurement rules. There is also some weak co-ordination and misunderstanding between GOI and partners, for example in duplication DFID and GFATM grants for TB funding in AP. The MOH is addressing this through its five-year strategy and budget, and a strategic planning meeting involving existing and potential donors due before end 2004, led by Health Sec.

There is weak alignment concerning GFATM and GAVI, where external partners do not appear to be working together as a group of GHP partners to develop a coherent position on key issues and to co-ordinate support for GOI. TA is needed for proposal development and management and this requires proper funding and facilitation – at present it is ad hoc and inefficient. Application and re-application procedures are perceived as highly complex and changing. Reporting arrangements are perceived as reasonable in principle, but are not in line with existing donor requirements.

GHPs are felt to be useful for introducing new initiatives that would challenge the domestic budget, and other external partners, in the short term. Access GHPs (both technical and financing) have influenced the introduction of new technical approaches, technologies and commodities into programmes. Examples include: GAVI's injection safety equipment (AD syringes); GFATM finance for ART and combination anti-malarials; and MDR TB drugs are being considered through the Green Light Committee.

GHPs are not distorting country systems, and are generally perceived as neutral or useful. But it is also now recognised that, for whatever reason, immunisation coverage has fallen drastically in many districts, and efforts are needed to improve it. There are perceptions that the drive for polio eradication may have contributed to this. It is also clear that the introduction of HepB is not a priority for the majority of districts in India just now (except for states where HepB prevalence justifies inclusion in the programme).

It is also clear that greater efforts to support GOI convergence are needed – in terms of developing harmonised M&E frameworks, procurement arrangements, financial

reporting, and support for strategic planning and budgeting. Ideally such efforts are part of a programme strategic plan.

Also, there is some evidence that GHP conditionalities are not being used to best national benefit. For example, drug and vaccine reporting systems can be useful models for the wider system, but it was noted that while reporting (and management) of polio and HepB was generally good, it was very weak for wider routine immunisation vaccines.

Comparison of Stop TB and RBM

There are striking contrasts between TB and malaria, in terms of several key dimensions of country effectiveness. TB is a clear government priority, and STOP TB's technical strategies are fully utilised. While malaria is perceived as important, it is not reducing, state level delivery is not clearly in line with national strategy and several informants referred to the need for fresh thinking. It is difficult to directly attribute all these issues to the GHPs (eg weak national leadership), but it is clear that the ways of working of the GHP have had some influence. The reasons include links with GHP board, partner alignment, the role of WHO, clarity and relevance of technical strategy, and degree to which India is prioritised by GHP.

Indicator of GHP influence	TB	Malaria
Awareness of global programme	High at central level Red STOP TB logo adapted by the national programme and all state societies	RBM rarely recognised as a relevant brand, and unknown at state level (even in Rajasthan where RBM has a pilot district)
Level GOI priority, ownership and involvement in partnership at international level	GHP has succeeded in raising TB to a national priority and getting full buy-in to the DOTS strategy. Health Sec is STOP TB Board member, and involved in regional advocacy (country visits). Strong programme manager and programme staff.	Appears to be a lower GOI priority, even though India a Board member. Less forward looking and open national leadership. Could be a reflection of the low level of advocacy carried out by RBM is India is not a priority country. Many interviewees felt RBM was Africa-centric
Strategic focus and operational and financial planning	TB strategic plan in development, GOI has a clear strategic plan and resources are sought to finance the plan; with high level donor meeting planned (success of TB resource mobilisation means that careful financial planning needed to prevent substitution eg DFID and GFATM AP funding)	Modern malaria programme – eg some shift from reliance on environmental measures - but large numbers of cases persist. Four RBM demonstration districts are only at assessment stage, and have low profile. Perceived to have unclear rationale and value to national programme. Strategic plan in development. Hope that newly converged vector borne disease programme will bring in fresh approaches.
Felt relevance of, and enthusiasm for, technical strategies	Highly committed and knowledgeable officials at all levels (national, state, district). GFATM Round 1 activities	Although national programme promotes new strategies in endemic areas (eg ITNs, presumptive 2-drug treatment), state

	given high score by WB team (the LFA). Well trained network of TB consultants covering all RNTCP districts.	implementers did not appear totally convinced. Rationale does not appear to have been explained to them. ITN distribution low, no social marketing, slow introduction of blister combination packs, reliance on blood smear positive for radical treatment
Take up of innovation	Very impressive PPP implementation of DOTS with private for profit and not for profit providers (as promoted by STOP TB)	Some NGO involvement in district societies (IEC and bednets) Minimal private sector involvement (also lacking in RBM's strategy, noted in 2002 evaluation)
Global partner buy-in including NGOs, and WHO role	Strong WHO TA presence at centre and states. DFID and others Many organisations have signed up to STOP TB website and are active nationally	Some scepticism about RBM's relevance among development partners incl. WB. Lower level of WHO inputs (and finance for them). V few international NGOs involved. Those that have done so due to their assessment of its burden on the communities they work not part of a partnership strategy.
Commodity issues	GDF valued as a flexible and practical instrument to help ensure secure and high quality drug supply (no impact on prices vis a vis India generics procured by the national programme).	The innovation of blister packs is a local innovation to a local problem. If ACT is scaled up and ITNs made more acceptable it will persuade Indian manufacturers to go in for high volume, low price strategies
Resource mobilisation	Long standing partners eg DFID. New USAID commitment attributed to political advocacy in the US through the global partnership. Three GFATM grants successful.	Low on RBM partner agenda (no DFID, USAID finance). WB will be supporting new programme. Round 4 proposal only agreed after 3 sets of comments – TRP highly critical.

8.4 Financial additionality and sustainability

There is evidence to suggest that new finance (from new donors) has been generated at national level through the influence of GHPs. For example, STOP TB facilitated UK and US parliamentary delegations to visit DOTS programmes, co-ordinated by the organisation 'RESULTS', a member of the partnership. Officials linked this lobbying activity with USAID's recent decision to finance TB activities in Haryana.

The GFATM, the only GHP providing major financial support is also perceived to have some influence on recent developments to permit new finance over and above the 10th Plan funding allocation to HIV/AIDS in particular, especially since the Plan

had no ART budget line. Although still taking place on a case by case basis, this may support other donors to lobby for additional social sector spending (in the Common Minimum Programme policy context). In the longer term this may facilitate funding by other donors such as DFID and USAID.

New financing sources such as the GFATM and GAVI are not perceived to have substituted for other donor funds, although there has been some lack of clarity on TB funding. Effective partnerships can also facilitate the legitimate routing of funds through arrangements with credible agencies, such as WHO and Unicef for technical support (TB and polio). GHPs are felt to be useful for introducing new initiatives that would be challenging to identify short-term finance for through the domestic budget. Eg AP MOU with GAVI and Gates includes a commitment to substitute external with state level finance over 5 years. New funding mechanisms are perceived to sharpen donor and government performance, as the GOI can shop around and negotiate conditionalities. The GHPs are also supporting a culture for more proactive strategic and financial planning (immunisation, TB, HIV/AIDS strategy).

Effective partnerships can also route funds through non-traditional sources. In the case of polio, Rotary Foundation raised and made available funds from diverse donors such as bilaterals, UN foundation and individuals. However it is not clear to which the latter represent additional finance earmarked for polio, as opposed to a reallocation of aid destined for other health purposes. The alliance also persuaded governments and bilateral donor agencies to park funds outside government funds for TA. The preferred route appears to be the WHO, which has high acceptability in government circles.

8.5 Commodities

Most GHPs have had no overall downward impact on prices, given India's reliance on its domestic and highly competitive generic manufacturers. However, GAVI and Gates support for Hep B has increased supply of the vaccine, and reduced price substantially in India (also of AD syringes). PATH has also provided technical support to national firms to enable prequalification through WHO's scheme, which enables them to enter the global market. Some possible conflicts of interest are perceived, in terms of international industry pressure on GAVI to increase demand for so called '\$ vaccines', and Board membership by R&D industry. GOI has also been under lobbying pressure by local industry.

The GDF is used as a backstop to safeguard quality TB drug supply in case of any national failure in local procurement. National officials greatly value the flexibility and pragmatic approach taken by the GDF. GDF has also provided an in-kind grant of TB drugs (made in India) to the national TB programme (one fifth of drug supply, covering 200 million population). The GDF has also approved supply of a different co-formulation, and offered direct procurement support to the programme, to assist purchase of TB drugs financed through GFATM.

Unlike the World Bank, which requires competitive and open international procurement, the Fund permits tendering only with the companies that have pre-qualified through STOP TB's GDF and the other WHO services for AIDS and malaria (for TB drugs, ARVs, ACTs etc), many of which are based in India. Harmonisation of procurement practices is strongly recommended by GOI.

GOI is a member of GAELF, but has decided not to add albendazole to the MDA regimen, until of proven benefit for India. GOI is unwilling to accept drugs ('no free lunch') just because they are free, and in absence of rationale in Indian context. Has some sustainability concerns, in terms of GSK's commitment to supply free until

elimination achieved. However, Kerala and TN state governments agreed to pilots partly because of the effectiveness of combination therapy in Sri Lanka, with which they share ethnic and geographical similarities.

8.6 Poverty and gender equity

Overall there is a lack of data on pro-poor incidence of programmes – and also a low awareness of the value of such data in developing strategies. Across all programmes, there is an assumption that programme incidence is pro-poor, and that poor people self-select to use public services, while the better off avoid them. This justification fails to address the structural barriers to access faced by the poor. The lack of concern with the extent of progressivity of programmes is worrying, and may mean that the poorest quintile may be getting left out (as indeed indicated by immunisation data).

This is reinforced by recent evidence that in most states the rich appropriate the subsidy provided by government. Routine systems do not (and should not) attempt to collect detailed socio-economic data. A wealth of information is provided in India's regular national household surveys and 10 year census, but it mainly focuses on family welfare indicators, and on population groups categorised by sex, rural/urban scheduled caste and tribal status, and religion. It lacks appropriate socio-economic variables (such as asset indices) to provide disaggregated information on health outcomes for the poorest.

However there are some useful models. The RCH I 1998/99 and other household surveys yields valuable information about immunisation coverage, according to quintile and district coverage. It also indicates a reasonable (0.8) correlation between low quintiles and SC or ST status, which justifies population based geographical targeting – this is used by several programmes (malaria, leprosy). The leprosy programme's 2000 evaluation also provides useful data to help targeting the most vulnerable. There is higher awareness of issues affecting women's health and access to care, especially for TB, HIV/AIDS and leprosy. However, although records of patient sex are maintained, it is not clear that efforts are made to synthesise the data and consider implications for strategies to address any inequities.

9 RECOMMENDATIONS

9.1 Partner alignment

Broad consensus and agreement on the overall GHP vision and strategy is needed among international partners at the international level. Stronger efforts are also needed for the effective translation of this to the country level, to support GHP partner co-ordination, and agreement on different and appropriate roles. This would facilitate a shared partner view to help develop the country strategy with the national partners. It is essential to keep the partnership active at both international and national levels, so that partners have an identity as GHP partners in addition to that of their own agency. (Lack of this linked to weak partner co-ordination and development of common stands eg GAVI and GFATM)

9.2 NGO and other stakeholders

Partnerships that actively promote NGOs as equal partners are better known and more successful at country level eg TB, GAEL, and polio, as opposed to RBM and GAELF. International NGOs need to be involved as partners at global and country level, in order to leverage efforts for both advocacy and service delivery. There is an equally important role for the private for profit sector. However, extreme caution needed with respect to involving companies with direct private interests in governance roles at either national or international level due to potential COIs. (GHPs can be vulnerable to political and industry hijack)

9.3 Harmonisation and integration efforts

GHPs (and the country level partners) need to contribute as much as possible to GOI convergence efforts. GHPs and partners need to work towards harmonising M&E frameworks, procurement arrangements, financial reporting, and support for strategic planning and budgeting. Ideally such efforts are part of a programme strategic plan. Any conditionalities should have clear benefits to GOI as a key GHP partner – eg reporting requirements should be potential model for GOI, governance requirements should benefit wider stake holders eg GFATM CCM. A balance is needed between system strengthening versus focused interventions – stronger partner alignment is likely with a focused partnership issue but adverse system affects are more likely. Eg polio and RI.

9.4 Financing and technical focus

Financing GHPs are a useful and complementary addition to the mix of aid instruments and should continue. Traditional bilateral and multilateral support provides flexible and long-term investment frameworks. GFATM and GAVI have introduced very different mechanisms – with higher transaction costs, offset by the short turnaround and willingness to fund new approaches. The GHPs often build on strong existing partnerships between government and bilateral and multilateral agencies. But there is a major need for institutional mechanisms to neutrally co-ordinate and administrate the process eg GFATM Secretariat. However, financing alone can result in sub-optimal implementation and bottlenecks especially at state level. Critical to develop clear partner roles, and to finance where needed eg WHO. A budget line is needed to enable technical agencies to support implementation, as part of TA component in programme plan.

9.5 Pro-poor incidence of GHPs

In the context of poverty reduction goals, GHP emphasis on pro-poor incidence of programme benefits needs to be more explicit, overtly promoted and supported at country level, and ought to be reflected at all parts of the programme. More advocacy

is needed of the value of disaggregated data in developing strategy to reach the very poor. For instance the situational analysis should look at factors that inhibit service take-up, the implementation strategy needs to address these bottlenecks and M&E needs to collect indicators on access by different sub-populations, especially the most vulnerable. Routine data collection on SES is not recommended, but there is certainly a greater role for periodic household surveys, to generate baseline and outcome/impact data. Geographical and population group targeting should be effective, given the high correlation between scheduled castes and tribes, with poverty. Rural women, migrant labour and the most poor in urban areas are also highly vulnerable.

ANNEX 1: PERSONS MET

MOHFW, GOI

Mr Rajesh Bhushan, Finance Director (incl. GFATM)
Dr PL Joshi, Additional Director, National Vector Borne Disease Control Programmes
Dr Roop Kumari (LF Programme Officer)
Dr LS Chauhan, Deputy Director General, Revised National TB Control Programme
Dr P Salil, Joint Director, NACO
Dr GPS Dhillon, Deputy Director General, Leprosy (formerly DDG, Malaria)
Dr Barkarkati, Consultant, Leprosy

MOHFW, Andhra Pradesh

Mr Venkata Ramana, Family Welfare Commissioner
Ms K Damayanthi, Project Director, AP State AIDS Control Society (APSACS)
Dr P Somasekhar Reddy, Add. Project Director, APSACS
Dr MV Ramana Rao, Joint Director, APSACS
Dr K Satyarath, PPTCT Consultant (Unicef, former APSACS)
Dr S Chandra Shekar Goud, Add. Director Health (malaria and LF)
Dr Rajenda Prasad, State Immunisation Officer
Dr Gopal Krishna Rao, State Immunisation (former)

MOHFW, Rajasthan

Ms Rugmini Haldia, Principal Health Secretary
Mr GS Sandhu, Health Secretary
Mr OP Meena, Commissioner, Family Welfare
Dr DK Jain, State TB Officer
Dr K.N.Gupta, District TB Officer, Jaipur
Dr O.P. Saxena, State Cold Chain Officer
Dr Dhandoria, State Leprosy Officer
Dr Sadya Prakash Yadav, State Malaria Officer
Dr Alka Sharma, Rajasthan State AIDS Control Society
Mr Panyat, Demographer

Indian Council for Medical Research

Dr Lalit Kant, Senior Deputy Director General (Epidemiology and Communicable Diseases)
Dr Ambujam Kapur, Deputy Director (Policy and Planning)
Dr Sarala K Subbarao, Medical Scientist (former Director, Centre for Malaria Research)

International Agencies

WHO

Dr Salim Habayeb, WHO Representative
Dr D Lobo, WHO SEARO, Communicable Diseases
Dr Suvanand Sahu, NPO TB
Dr Sobhan Sarkar, National Technical Adviser on Polio (until recently DDG Immunisation)
Dr BK Rao, NPO LF
Dr P Francis, NPO Immunisation
Dr RK Pal, NPO Hepatitis B
Dr Sampath Krishnan, WHO Surveillance Network (incl. polio)

UNAIDS

Dr Kenneth Wind-Andersen, Country Co-ordinator
Dr SN Misra, Consultant to UNAIDS

UNICEF

Ms Erma Manoncourt, Deputy Director
Dr Marzio Babilio, Chief, Health
Ms Vidya Ganesh, Programme Officer, HIV/AIDS

World Bank India

Dr GNV Ramana, Senior Public Health Specialist (Immunisation)
Dr K Sudhakar, Senior Health Specialist (HIV/AIDS and GFATM)
Dr Peter Berman, Lead Economist

DFID

Ms Joanna Reid, Senior Health Adviser
Dr Ranjana Kumar, Health Adviser
Ms Lipika Nanda, Health Adviser

Bill and Melinda Gates Foundation (India AIDS Initiative)

Mr Ashok Alexander, Director

USAID, Office of Population, Health and Nutrition

Ms Meri Sinnitt, Division Chief, HIV/AIDS and Infectious Disease

US Centers for Disease Control and Prevention, Global AIDS Program

Ms Dora Warren, Country Director, India

Civil Society and NGOS**Indian Network for People living with HIV/AIDS**

Mr KK Abraham, President (Vice Chair GFATM CCM)

ACT-UP, India

Mr Bobby John

Population Foundation of India

Mr AR Nanda, Exec Director (former Secretary, Family Welfare)
Dr Kumudha Aruldas, Joint Director, Programmes

Confederation of Indian Industry

Ms Shefali Chaturvedi, Deputy Director

Engender Health

Ms Jyothi Malhotra

IAVI

Ms Anjali Nayyar, Country Director
Ms Sweta Das, India Project Co-ordinator

PATH (AP)

Dr Satish B Kaipilyawar, Project Co-ordinator, Children's Vaccine Program

LEPRA, India (AP)

Dr (Capt) PV Ranganadha Rao, Chief Executive

World Vision (AP)

Ms Christy Solomon, M&E Officer
Ms Blessie Madhukar, M&E Officer

ICHAP (India-Canada Collaborative HIV/AIDS Project) Rajasthan

Dr Priyamvada Singh, Programme Co-ordinator

Rotary International, Delhi

Mr Raman Bhatia, Member, India National PolioPlus Committee

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ANNEX 3: NATIONAL PROGRAMMES FOR AIDS, TB AND MALARIA (NEEDS EDIT)

TB control programme

India has had a National Tuberculosis Control Programme [NTP] since 1962. Even though the efficacy of the Directly Observed Treatment was proved in India in the fifties TB does not appear to have gained the prominence population control and Malaria did. Plagued by improper diagnosis, chronic shortage of drugs and non-completion of treatment the programme did not achieve its objectives. A comprehensive review of the programme in 1992 recommended revision of the strategy. Based on the recommendations a Revised National TB Control Programme, incorporating DOTS strategy, was developed. Started on a pilot basis, the programme was scaled up beginning 1998. Programme aims to cover the entire population of India with DOTS programme by 2005.

Management of the programme at national level is by the Central TB Division, (CTD) which is a part of the Department of Health. This division is responsible for preparation of technical guidelines, training modules, quality control, programme and financial monitoring, procurement of drugs and mobilisation and distribution of funds. At the state level too the programme is managed as part of the health department, through a State TB Cell headed by a State TB Officer (Some states have autonomous State TB Societies). At the district level the District TB Officer oversees the programme.

In the rural areas service provision is embedded in one of the units of the health services, often the Community Health Centre (CHC) or a Primary Health Centre (PHC). In the urban areas this is integrated into the municipal health services. A Tuberculosis control unit (TU) located in these hospitals provides TB services to a population of 500,000. The unit consists of a Medical officer in charge of TB, a Senior TB Laboratory Supervisor and a Senior TB treatment Supervisor. Their work includes implementation, supervision of diagnosis and treatment, maintaining TB registers and reporting. Sputum microscopy is done in microscopy centres (which is provided at the rate of one centre per 100,000 population). Directly observed treatment is provided by the multi-purpose Health Workers, other health department personnel such as the pharmacists, community health volunteers and private providers.

National AIDS control programme

HIV was detected in India in 1986. Since then it has been reported from every part of India. The HIV/AIDS epidemic in India is a collection of differing epidemics. The north east has an IDU driven epidemic, with the virus subtype similar to the one seen in South East Asia. In most part of India it is spread by multipartner sexual contact and is more prevalent among populations that are judged to be at higher risk. But at least in six states the epidemic has been generalised with the general population prevalence rates above 1%. Each of these states have populations higher than most countries of the world. Hence any small increase in the prevalence rates translate into large numbers of persons living with the virus. India is slated to become the country with the largest number of HIV positive people.

The first phase of the National AIDS Control Programme, supported by the World Bank/IDA, DFID, EC and USAID was initiated in 1992. When it ended in 1999, the National AIDS Control Organisation had been set up with counterpart institutions at state level, national sentinel surveillance system had been instituted and blood safety levels had been improved from 30 to 90%. Less effective were the measures to raise

awareness in the general population, improve STI treatment, increase the consistent use of condoms and ensure that the marginalized populations who were more vulnerable to HIV had access to preventive services. Based on the lessons learnt second phase of the National AIDS Control Programme was launched in 1999 with a \$ 191 million loan from IDA, DFID support of \$ 23 million and two USAID projects worth \$ 37 million. The Canadian International Development Agency and AusAID joined the programme later. The NACP II had three programme components – Priority targeted intervention programme for vulnerable groups, preventive programmes for general community and low cost AIDS care – and two system strengthening parts – strengthen capacity to implement the NACP II and to improve intersectoral collaboration. Interim evaluation of the project show mixed results; there have been significant improvements but the objectives are far from achieved. During currency of the project India also published the National AIDS Prevention and Control Policy, which is in line with the UN positions on the epidemic.

The project had emphasised prevention at the cost of treatment. Treatment was confined to conservative management of opportunistic infections. But demand for treatment from the increasing number of infected, who were effectively organised into networks, the dropping prices mostly by the generic drugs manufactured by Indian companies and pressure from international communities persuaded India into announce the initiation of ART for certain category of persons. It is now obvious that the programme managers, under criticism for management an epidemic that showed no sign of slowing down, persuaded the Minister to announce the programme without doing their homework.

The sheer complexity of delivering ART through a health system as wide and weak as India was not factored in. A proper financial analysis was not conducted. Time and effort was not invested in developing capacity for delivery. As against a target of 100,000, treatment is available for less than 1000 . Had the GFATM support not come through it is unlikely that funds would have been available to finance even part of the target. It is also possible that programme managers were eager to avail of the opportunity of the offer of funding for the 3 by 5 initiative. They may have pre-empted the GFATM by announcing their decision being confident that the Indian proposal would be supported by WHO and UNAIDS, two members of the board of GFATM and sponsors of the 3 by 5 initiative. If this is true GFATM has been an effective ally of WHO and UNAIDS in persuading India to adopt their priority for treatment. India is about begin planning for the next phase of the AIDS Control programme. GFATM grant may have ensured that ART is a major component of the next phase.

Malaria programme

Although about 80% of the population live in low endemic zones, malaria is a major public health concern in the northeastern states, including Rajasthan, and in AP. About 10% of cases are reported from urban areas. *P falciparum* and *vivax* are both prevalent, with the former now dominating in rural (tribal) areas. In the 1970s and 80s, the vertical programme was perceived as very successful, but, with primary level integration and competing health and family welfare priorities in the early 90s, incidence increased. A 1997 World Bank evaluation found low disbursement, with a focus on less effective strategies such as vector control. More recently, performance has improved somewhat, with full uptake of central funds by most states, an emphasis on more effective strategies, and a gradual reduction in incidence and deaths, in 79 of the 100 districts. In Jan 2004, the WB review team noted a 30% reduction in morbidity against the 10% target.

However, although the programme is perceived to have 'modernised', it has reached a case plateau, with over 2 million cases still reported annually. New approaches are

needed to tackle this. GOI provides additional support to the 100 worst affected tribal and coastal districts in 8 states through the World Bank supported Enhanced Malaria Control Programme. The programme is now managed as a vertical programme to district level, although it is integrated into the multi-purpose primary level service delivery duties.

Strategies are: early detection and prompt treatment; integrated vector control, including indoor spraying with a variety of insecticides; ITN distribution with a small co-payment focus on pregnant women and children; and epidemic response teams (following floods etc). The ANM is involved in active case finding through her regular two weekly house visits in endemic districts, and she provides presumptive treatment of fever with chloroquine (guidelines indicate to combine with primaquine in resistant areas); follow up radical treatment is provided on basis of microscopy diagnosis at PHC level. Delay between detection and treatment has been reduced somewhat by strategies including rapid diagnostic tests, and community volunteers. State and district malaria control societies include local NGOs and are involved in IEC, and bednet sales and re-treatment efforts. Passive case finding is increasing, as more families are aware of need to seek prompt treatment.

However, at national level, Pf chloroquine resistance is reported in xx districts in the north eastern states, as per GFATM Round 4 proposal. While officials are familiar with dealing with insecticide resistance, drug resistance is assumed to be low or non-existent at state level, and felt to be exaggerated by private providers. However, in Rajasthan, resistance surveillance is planned. ACTs supplied through the EMCP are used very occasionally for cerebral malaria. In Rajasthan, the malaria officer was aware of artemether sales in the private sector.

Although efforts to involve the private providers have started, given the extent of treatment seeking in the private sector, few public-private partnerships were reported at state level. In some states such as Orissa, community drug distributors (chloroquine) have been identified, to support prompt referral for treatment. Some NGOs have been collaborating with state governments in AP and Rajasthan. For instance LEPRA, has been involved in early diagnosis and treatment, social marketing of ITNs, vector control and community mobilisation in 112 villages in AP.

Appendix C:

SIERRA LEONE

This paper forms part of the 2004 DFID Study Global Health Partnerships - Assessing the Impact.

Cindy Carlson and Jennifer Sancho

EXECUTIVE SUMMARY

Sierra Leone was chosen as a case study country for this project as it represents an example of a difficult development partner. It is a low income country which has recently emerged from over a decade of civil conflict, characterised by destruction of basic infrastructure and brutalisation of the civilian population. As a result of this instability, it ranks last in the human development index ratings (Human Development Report 2004) with a HDI rating of 0.273 (2002).

The health system in Sierra Leone is very centralized and highly aid dependent, a reflection of the recent conflict in the country and ongoing rehabilitation efforts by major donors and NGOs. Most health structures (hospitals and health centers) have benefited from reconstruction assistance and many were operated by NGOs, or received technical assistance from NGOs both during the conflict and the post-conflict phase. Many of these NGOs are now phasing out their programmes and handing operations back to the Ministry of Health and its staff. The main aid instruments supporting the health system are various forms of project and programme assistance, providing earmarked funding. Two of the large donors (World Bank and European Union) provide health system strengthening assistance to the Ministry of Health while also running programmes to continue the rehabilitation of health services in three to four districts each. Decentralisation of health system management is being phased in this year (2004). In general, the health system is characterised by weak human resource capacity at national, district and health service delivery levels, by weak accountability throughout the system and by high costs to users of health services (despite national policies to exempt pregnant women, children and the poor from service charges).

The top five health problems for adults and children aged over 5 in the country are, in order of priority: malaria, acute respiratory infection, malnutrition, onchocerciasis and other eye problems and skin diseases. For children under 5, the top five health problems are: prematurity, malaria, acute respiratory infection, infantile diarrhoea and malnutrition.

The study team were able to identify seven Global Health Partnerships with some programme activity in Sierra Leone: GFATM, GAVI, RBM, Stop TB, VDP, GAEL and APOC. GFATM and GAVI are the most prominent and have been assisting programmes in Sierra Leone since 2002, primarily by funding activities that compliment ongoing disease control efforts. The other GHPs listed have a lower profile, with some only just starting up, or working primarily through other organisations, such as WHO or the German Leprosy and TB Relief Association.

The country study team sought to answer the six country case study questions, while also analysing the functioning of GHPs within Sierra Leone's unique health system context. Stakeholders in Sierra Leone were unanimous in their opinion that GHPs had provided additional (rather than replacement) funding for most of the diseases they were set up to address. They also felt that it was only by virtue of GHP support that onchocerciasis activities could recommence.

Stakeholders also raised a number of concerns about GHPs in Sierra Leone.

- In terms of neglected diseases, malaria, which is highly endemic and causes over 40% of hospital admissions in both adults and children under 5, remains under-resourced by all development partners in Sierra Leone, including the relevant GHPs.

- Regarding fit with national priorities and health system, GHPs work through national disease control programmes. The poor health infrastructure and weak human resource capacity therefore limits how effective GHP support can be. Stakeholders interviewed were worried about MOHS capacity to meet the varied governance and reporting requirements of different GHPs, and felt that a more streamlined approach would be more appropriate.

The study team conclusions and recommendations were as follows:

Preliminary Conclusions and Recommendations

The GHPs will only be as effective as the health system itself. In a post-conflict country such as Sierra Leone, that is just beginning the long road to recovery, the way GHPs operate require special measures.

- **Streamline country coordination mechanisms:** The weakness of government structures mean that country level coordination mechanisms need to be streamlined to reduce transaction costs. One suggestion from MoHS staff, and endorsed by UN staff, was GHPs should work through existing MoHS led coordinating mechanisms rather than setting up new coordinating structures. The functions of the CCM and ICC could be integrated into this mechanism. It would also provide a means for the MOHS to ensure all health priorities are visible, rather than just those that are supported by GHPs or other vertical programmes;
- **Increase levels of technical assistance:** Low human resource capacity, especially for working at a strategic level, requires additional technical assistance. This does not necessarily need to come in as external TA from the GHPs, but could be negotiated with in-country implementing partners in the first instance;
- **Raise the profile of, and support to, the National Malaria Control Programme:** It is possible that funding recently received through GFATM will help the malaria control programme to be more strategic and to coordinate malaria prevention and control measures. However, it is still under-resourced and needs further support if the high prevalence of malaria is to be reduced in the country.
- **Compliment GHP assistance with health system strengthening:** The current 'light touch' modus operandi of most GHPs is not appropriate in Sierra Leone as it has led to:
 - Confusion around what is required to correspond to GHP requirements for coordination and reporting;
 - Programmes that do not reach the most vulnerable in the population, and in the worst case;
 - Encouragement of corrupt practices.

However, this does not mean that GHPs should therefore take on health system strengthening as another area of work. In Sierra Leone, for example, there are already three major donors providing support to health systems strengthening, and even these three are finding it difficult to coordinate and harmonise their approaches. Any new partners in this area would lead to greater confusion.

1 INTRODUCTION

1.1 Background and Health System Information

Sierra Leone is a low income country which has recently emerged from over a decade of civil conflict, characterised by destruction of basic infrastructure and brutalisation of the civilian population. As a result of this instability, it ranks last in the human development index ratings (Human Development Report 2004) with a HDI rating of 0.273 (2002).

In October 1999, the UN Security Council established the UN Mission in Sierra Leone (UNAMSIL) and the scope of operations were expanded in 2000 and 2001 in response to the increasing severity of the humanitarian crisis. In January 2002, peace was officially restored and the process of reintegration and handover to Government was initiated. However Sierra Leone has a poorer socio-economic infrastructure at the beginning of the 21st century than it did 30 years ago. Low wages, petty corruption and poor quality basic services are all features of public services which directly impact on the health sector.

The health system is characterized by a high degree of centralization, moving towards decentralization (primarily deconcentration) in the next few years. The primary aid instrument is project/programme support, reflecting the post-conflict nature of aid to the country. Some aid goes directly into Ministry of Health accounts, though this is earmarked for specific activities. There is no basket fund or non-earmarked funding for the health sector at this time. Further contextual information is available in Appendix 4.

1.2. Methodology of the case study

The Sierra Leone case study was undertaken through reviewing documents available on the web (mostly through individual GHP websites) and within Sierra Leone. This document review was complemented by interviews with key stakeholders at national and district level within Sierra Leone. While the initial unit of analysis was the disease or health issue that the GHPs known to be in Sierra Leone were covering, this report focuses on the operations of the GHPs themselves, setting their operation within the wider context of the Sierra Leone health sector [and the international aid architecture within the country].

The list of documents consulted is available in Appendix 1 and the list of stakeholders interviewed is available in Appendix 2.

2 COUNTRY CONTEXT

2.1 Key Country Statistics

Table 2.1: Summary Table of Key Statistics on Sierra Leone

Location	▪ Western Africa, bordering the North Atlantic Ocean, between Guinea and Liberia		
Area	Total: 71,740 Km ²	Land: 71,620 Km ²	Water: 120 Km ²
Land boundaries	958 Km		
Coastline	402 Km		
Climate	Tropical; hot; humid; summer rainy season (May-October); winter dry season		
Terrain	Coastal belt of mangrove swamps, wooded hill country, upland plateau, mountains in East / North		
Natural resources	Diamonds, titanium ore, bauxite, iron ore, gold, chromites, timber and fish		
Land use (1993 estimates)	Arable land	7%	
	Permanent crops	1%	
	Permanent pastures	31%	
	Forests and woodland	28%	
	Others	33%	
Environmental issues	Rapid population growth, over harvesting of timber and slash and burn agriculture resulting in deforestation and soil exhaustion, civil war depleting natural resources, over fishing by foreign fleets		
Population	5.6 million (projection for 2001)		
	0-14 years	44.7%	
	15-64 years	52.1%	
	>65 years	3.2%	
Population growth	2.6%		
Birth rate	45 births per 1,000 population		
Death rate	19 deaths per 1,000 population		
Infant mortality	170 per 1,000 live births		
Under 5 mortality	286 per 1,000 live births		
Maternal mortality	1,800 per 100,000 live births		
Life expectancy at birth	37 years		
Fertility rate	6 children born per woman		
Ethnic groups	20 native tribes: Temne 30%, Mende 30%, others 30%, Creole 10% (descendants of freed slaves who were settled in the Freetown area in the late 18 th century), refugees from Liberia, small numbers of Europeans, Lebanese, Pakistanis and Indians		
Religions	Muslims: 60%	Christians: 30%	Indigenous beliefs: 10%
Literacy	Muslims: 31.4%	Christians: 45.4%	Indigenous beliefs: 18.2%
Languages	English (official, regular use limited), Mende (South), Temne (North), Krio (English based Creole, a lingua franca, first language for 10% but understood by 95%)		

Source: EU Project: Inception Report 2003

Appendix 3 gives further summary details.

2.2 Development Partners (DPs)

The main donors in SL are World Bank (and the IMF), European Union through ECHO, EDF, African Development Bank (ADB) and DFID. Although not classified as donors, there are several intermediary financial agents in the form of International NGOs (INGOs) operating in SL funded through international sources and other donors e.g. the German Tuberculosis and Leprosy Relief Association (GLRA), OXFAM, CARE. The UN agencies also play a financial intermediary role as well as implementation support, mainly through the GoSL. INGOs operations are a mixture of humanitarian relief and emergency operations and development initiatives, although more geared to the former because of the nature of the funding available to SL in the recent years.

2.3 DFID Policy in Sierra Leone

DFID is operating under a long term partnership agreement for development between the GoSL and the British Government signed by the President and the Secretary of State for DFID in February 2003. The agreement sets out a poverty reduction framework for 2002-2012 with annual benchmarks and indicators of progress that are jointly decided by both governments and sets out realistic targets for each annual period. Six areas of action were identified for joint working and support from DFID, which include (specific relevance to health are expanded):

1. resolving conflict
2. improving standards of governance and combating corruption
3. reforming the security sector
4. reducing poverty
 - σ develop and implement a PRS in a participatory manner with a view to making significant progress on the MDGs
5. ensuring macroeconomic stability
 - σ remain on track with IMR and other partners to ensure economic targets covered in poverty and growth facility are met
 - σ continue development of MTEF, implemented in fiscal year 2002, in consultation with other partners
 - σ progressively reduce military expenditure consistent with improved security nationally and regionally
6. developing human resources
 - σ set targets for social sector spending in line with SER as part of PRSP process
 - σ priority social sector spending in education, health, water and basic infrastructure will be ring fenced to ensure adequate allocation to the sectors
 - σ ensure relative balance between different levels of education and continue to prioritise universal access to good quality primary education

DFID support to SL is about £40 million a year since 2003, of which it was agreed that £10million would be direct budget support with a possible movement of tranches of £5m based on achievement of annual targets. No increase has been made, because of slow progress with the key target of completion of the PRSP. This support is not earmarked for social sectors awaiting the results of the PRSP. The EU also provides direct budget support to the GoSL.

2.4 Health Situation

Main health indicators for Sierra Leone, including prevalence rates of the main diseases can be found in Table 2.2.

Table 2.2 – Main health indicators for Sierra Leone

Key health indices	Sierra Leone
% infants exclusively breast fed at 4 months old	2%
Immunisation rate (% 12-23 month fully immunised against DPT)	46%
Stunting prevalence	34%
Underweight prevalence	27%
Wasting prevalence	10%
Child diarrhoeal disease incidence	25%
Acute respiratory infection incidence	9%
Ill with fever (suspected malaria) incidence	46%
Malaria as % of outpatient visits	40.3%
Malaria – attributed contribution to U5 mortality	38.3%
HIV prevalence (% of adults) – females 15-24	4.9%
Tuberculosis incidence	5421/100,000
Leprosy prevalence	0.9/10,000
% Anaemia in pregnant women	82%
% deliveries attended by skilled personnel	42%
Access to safe water (% households)	n/a
Health Services	
Health service utilisation rate	0.5 contacts/year/person
Number of Peripheral Health Units (active)	417
Number of District Hospitals (active)	23
Number of Tertiary Hospitals (active)	9

The priority diseases in Sierra Leone, by order of epidemiological importance are indicated in Table 2.3 .

Table 2.3 – Principle causes of morbidity in Sierra Leone (2002)

9.6 Principle causes of morbidity < 5 years	Principle causes of morbidity > 5 years
1. Prematurity	1. Malaria
2. Malaria	2. Acute respiratory infection
3. Acute Respiratory Infections	3. Malnutrition
4. Infantile Diarrhoea	4. Onchocerciasis and other eye conditions
5. Malnutrition	5. Skin diseases
6. Ophthalmic Neonatal	6. TB/Leprosy
7. Worms	7. Anaemia
8. Skin diseases	8. Sexually Transmitted Infections
9. Wounds	9. Hypertension
10. Measles	10. Diabetes
	11. Psychosocial trauma
	12. Schistosomiasis

Source: Ministry of Health and Sanitation (2002) Information Sheet – 1st July 2002

Data issues

- Absolute lack of routinely reported and reliable data – MMR, IMR and CMR based on MICS 2001 completed during resurgence of conflict
- Denominator issues: Baseline of 1985 census for population data, projections are based on previous projections so caution is advised on extrapolation either based on absolute values or even trends and patterns (2003 census postponed to December 2004)
- Disaggregated data by District, sub district, gender, age, income not collected or reliable due to combination of factors above
- Annex 3 shows variation of reported data from 3 main sources: WB development report, EU inception report 2003, Health Sector Review PRSP 2004, but generally no consistent value in most reports – although as tables show variation is probably significantly minimal – difficult to determine any real trend or pattern based on chronological dates of reports
- District visited attempts to show disaggregated data by age, sub-district, gender but on closer examination, not related to any actual count but rather on same projection basis as national data
- Main issue is lack of progress or at best stagnating health status as compared to West Africa neighbours which, although also high, are showing downward trends in infant and maternal mortality
- Maternal mortality reporting compounded by under reporting and misclassification – of 19 reported maternal deaths in MICS, 5 potentially related to abortion.

The overall problem with data can be seen in Appendix 3, where different sources are shown to provide different sets of data for the same variables.

3. GLOBAL HEALTH PARTNERSHIPS

A limited number of Global Health Partnerships operate in Sierra Leone at present. While the numbers are growing, the study team found it difficult to ascertain which partnerships were actually contributing to health services from discussions with MoHS staff and other development partners. This may be due to the fact that many of the donations and much of the technical assistance provided from GHPs come through WHO, and are therefore considered to be from WHO. Table 3.1 provides an overview of GHPs identified categorized by typology.

Table 3.1 – Global Health Partnerships with some relationship in Sierra Leone

Pre-access, approval, marketing preparedness	LIC registration, community	Financing	Technical Support, Access, systems strengthening and donations
		GFATM	VDP
		GAVI	GAEL
			APOC
			Stop TB
			RBM

A few notes on those GHPs where we were able to find little information:

Roll Back Malaria would appear to have provided some technical assistance and materials to the MOHS, though we were not able to find a more involved role. This may be because everyone's minds were concentrated on having just received Global Fund financing for the National Malaria Programme.

APOC has just begun to assist with the restart of onchocerciasis prevention and control in Sierra Leone. Sierra Leone has been designated a Special Intervention Zone by APOC. All funding transits through WHO, which is supporting the revitalization of programme activities.

Stop TB's involvement in Sierra Leone is exclusively through the donation of drugs from the Global Drug Facility. This also comes through WHO to the MOHS and its implementing partner, the German Leprosy and TB Relief Association.

GHPs with a more extensive 'presence' in Sierra Leone are outlined in more detail below.

3.1. GFATM

3.1.1 *Scope of programme*

To date, the GFATM only funds activities related to tuberculosis, based on a successful round 2 proposal. Sierra Leone had requested a total of US\$5.5m and was awarded US\$2.5m for the first 2 years. They are currently in the 3rd quarter of year 1, and are not reporting any significant delays in the submission of accounting reports or replenishment of funding. They have only just been notified of their success for the Malaria and HIV/AIDS proposals fourth round, with the first 2 year allocations of US\$12m and US\$17m respectively.

3.1.2 Fit with national health priorities

The design of the GF TB programme is that the funding obtained from the GFATM would be complementary to resources from GoSL, German Tuberculosis and Leprosy Relief Association (GLRA), WB Health Sector Development Project and the Global (Tb) Drug Facility. The Principal Recipient is the Sierra Leone Red Cross Society (SRC) and the sub recipients include the National Control Tuberculosis Programme (NCTP), Council of Churches Sierra Leone (CCSL), the America Refugee Committee (ARC) International, World Vision Sierra Leone (WVSL) and the Central Statistics Office (CSO). In practice, the resources provided to the NCTP would be focused on four Districts, which were not being covered by any other partner, but some activities are geared nationally. The GLRA is a 'sub-sub recipient' via the GOSL.

The recently approved malaria programme sees a move to a greater fit between diseases of epidemiological significance (e.g. malaria) and funding for prevention and care. However, it should also be noted that HIV/AIDS still received even more funding than malaria, and this despite the fact that the National AIDS Secretariat has already received a \$15 million loan from the World Bank for the period 2002 – 2006.

3.1.3 Governance

The Country Coordinating Committee (CCM) was established de novo for overseeing the drafting of the proposal and oversight of the GFATM. The Chair of the CCM is the Minister of Health and the Vice Chair is the Country Coordinator of the Children's Christian Fund (CCF) (the latter in place in last 6 months replacing ARC as country coordinator moved on to another posting). The LFA is Price Waterhouse Coopers (PWC) Ghana. The CCM is reported to be meeting regularly and monthly and has been gaining in momentum and credibility with the implementation of the GFATM.

The SRC, as PR, has established a separate project coordination unit, the GFATM unit, in order to efficiently fulfil its responsibility and up to this time, the PR has been acting as the secretariat for the CCM. In the interest of transparency and effectiveness, it is intended that the CCM will be strengthened in terms of clarifying criteria for membership, roles of members, decision-making processes and establishing a dedicated secretariat distinct from the PR. In order to expedite decision-making, a CCM Technical Committee was set up as a subcommittee of the CCM. The TC also meets monthly and now that funds are flowing expects to change to meeting on a quarterly basis. The role of the TC is to review annual work plans of the SRs and to support the PR in approving allocation of funding.

The PR has further convened a smaller technical committee comprising of the SRs to manage a quarterly reporting and replenishment process, once annual work plans and budgets have been approved by the CCM, LFA and the GFATM for funding. The TB Technical Committee meets quarterly to review the past quarter's performance and agree corrective measures, and then the SRs are given 2 weeks to submit proposals for the next quarter's activities. The PR reviews each SR quarterly proposal for consistency with the annual work plan and the agreed changes of the review meeting. These are then submitted to the GFATM for funding. Quarterly reporting, although time consuming, is seen as a good means for early recognition of and corrective action for emerging problems. The PR has retained responsibility for monitoring and evaluation of the GF TB programme, with support from the GLRA, and collates the agreed monitoring data through the review process. This function will be further strengthened through the recruitment of an M&E officer to the SRC unit, and training by the GLRA for the unit.

It is intended that these mechanisms will be used for the oversight of the Malaria component. The National HIV/AIDS Secretariat (NAS), established within the Office of the President, has been proposed to be the PR for the HIV/AIDS Component. The management arrangements as proposed for these 4th round awards will be subject to final approval by the GFATM.

3.1.4 Financing

A separate bank account has been established in a commercial bank under the name of SRC to manage the receipt and disbursement of GFATM funds. SRC accounting procedures were accepted by the GFATM as satisfactory, based on the review by the LFA, and in turn the SRC with support from the LFA have signed off on the financial management systems of the SRs. The LFA provided start up support in the design and establishment of a spreadsheet-based financial tracking systems; no computerized financial management system is operational. The first quarter report has recently been submitted to the LFA and approved with successful replenishment for the next quarter.

3.1.5 Poverty and Gender

There are no specific operational policies with respect to poverty or gender for the CCM or the PR in terms of assessing work plans or proposals. However, the fit with national policy of exemption of cost recovery charges for children under 5 and pregnant women, as well as the intention that the GF TB Programme will provide funding for four rural districts (which were the last to be demilitarised) does in principle give the programme a more implicit focus on reaching the poorest in Sierra Leone. The paucity of reliable data disaggregated by gender, age or economic status does not allow clear tracking of impact of any programme to this level.

3.1.6 Commodities

The entire cycle of commodities management for the National TB Control Programme is currently done by GLRA on behalf of the NTCP and this is maintained separately from the Government CMS. Therefore, the design of the GF TB Programme and procurement to date have not included drugs and supplies specific to TB services as these are being provided separately by the GLRA (now for expanding DOTS) and the Global Drug Facility. For the latter, the procurement cycle is managed by WHO SL to the GDF (hosted by Stop TB/WHO Geneva), who procures from UN IAPSO, and drugs are consigned directly to WHO SL, which in turn delivers to the GLRA managed storage and distribution system on behalf of the NTCP. The GLRA is in the process of handover of services to the NTCP based on a strategy of integration at the DOTS treatment centre, PHUs and community based care.

The PR uses SRC procurement procedures to procure on behalf of the SRs if they are so requested by the SRs and has been approved in the workplan. For the programme to date, this has included motorbikes and microscopes.

The PR is aware that these arrangements will have to be reexamined in order to implement the GF Malaria Programme, as they will be expected to approve the processes for procurement and tracking of commodities for malaria control, possibly through the CMS system.

3.2 Global Alliance for Vaccines and Immunisation

3.2.1 Scope of the programme

The GAVI support to Sierra Leone is complementary to the ongoing EPI programme in the country, supported by UNICEF through the MoHS. GAVI's funding provides the following:

- incentives to staff carrying out routine vaccinations
- supervision funds
- diesel/petroleum for the cold chain
- vehicle maintenance
- yellow fever antigen.

The government is planning to apply for funding to introduce Hepatitis B vaccine in the next year.

This support is provided to every district in the country and is managed through the MoHS.

3.2.2 Fit with national programme and priorities

GAVI's support is highly complementary to the government's ongoing programme, providing support in areas that other donors will not (e.g. fuel and incentive payments). Childhood immunisation remains a national priority, and while UNICEF covers most aspects of the programme, GAVI support is determined entirely by the MoHS priorities and gaps.

The main criticism levelled by some stakeholders about GAVI is the burden it places on countries in terms of a reporting cycle that doesn't correspond to national planning and reporting cycles, and the insistence on developing a financial sustainability plan. MoHS officials felt that they did not have the capacity to develop a concrete sustainability plan and that it is unrealistic to expect them to do so.

3.2.3 Governance

Governance of all immunisation activities is provided through the National Inter-Agency Coordinating Committee. Before GAVI funding was approved, the ICC met only sporadically, usually when UNICEF was about to carry out a National Immunisation Day. Once GAVI funding was approved, the GAVI programme sent in technical assistance to provide training for the ICC so that members would better understand their role. Since then, the ICC has slowly taken on a more focused coordinating role, and larger role. The Committee is chaired by the Minister of Health or her representative.

3.2.4 Financing

GAVI funding is provided directly to the MoHS and is deposited into a specific GAVI account. The government's application to GAVI was approved in 2001 for funding of US\$ 180,000. The 2004 contribution was costed at approximately \$250,000.

3.2.5 Commodities

As noted above, GAVI in Sierra Leone brings in few commodities. Those that are provided are donated to the government and are brought in through the government's own procurement and distribution systems. Unlike UNICEF provided vaccine, which is consigned to and distributed by UNICEF, all GAVI materials are ordered by, consigned to and distributed by the MoHS. As the MoHS has developed better mechanisms for handling vaccine materials due to working with GAVI, UNICEF now plans to hand over reception of all vaccines to the government with the next order. The MoHS is already involved in forecasting antigen need and ordering new vaccine from UNICEF.

3.2.6 Poverty and gender

Vaccines are supposed to be provided for free throughout the country, and in that sense, the immunisation programme is pro-poor. However, due to problems within the health system, anecdotal evidence indicates that all immunisations, and even the immunisation card, have to be purchased from government health units. UNICEF is planning to carry out a survey in the near future to determine the scale of the problem as informal charging dissuades women from bringing their children for immunisation, and is particularly harmful to the most vulnerable children in the country.

It would also appear that incentive payments from GAVI funding are not reaching the mobile vaccination teams they were intended for in many districts. This has contributed to low uptake of immunisation in many areas.

3.2.7 Value added

Informants felt that the main value added provided by GAVI is the degree of buy-in GAVI involvement has achieved from the GoSL. Prior to GAVI funding, the MoHS considered immunisation as UNICEF's sphere and never included immunisation-related programming in its planning with other donors. Through working with MoHS and its partners in the ICC, and through putting funding directly into an MoHS account, the GAVI programme is seen to have substantially increased government interest in and accountability for the national immunisation programme. Further achievements include raising the profile of children's health within the MoHS.

3.3 Global Alliance to Eliminate Leprosy

GAEL's involvement in Sierra Leone would appear to be limited to donating Novartis MDT leprosy drugs through WHO to the GOSL TB/Leprosy programme. The GLRA was a member of GAEL through its association with the International Federation of Leprosy Associations (ILEP). However, ILEP has since left the partnership with GAEL as "we did not share the views of WHO on the leprosy elimination goal to be reached by the end of 2005"⁴. The commodity flow of donated drugs is as described for the TB programme above.

3.4 Viramune Development Programme

3.4.1 Scope of programme

▪ ⁴ Wiegandt A. (2004) personal communication

The VDP provides viramune as requested from the HIV/AIDS Resource Group (previously the National HIV/AIDS Control Programme) located in the NAS. There is no cost to the programme to the point of delivery of the drugs.

3.4.2 Fit with health sector

The VDP assumes that the request is based on an established PMTCT programme, though Sierra Leone does not yet have a PMTCT programme. They appear not to do any direct validation for themselves or quality assurance of the protocols or storage and distribution chain. The ARG felt that the VDP could offer the country technical support, in setting up the PMTCT, developing protocols and estimating supply requirements. This had to be done using other resources (TA provided through the GoSL/WB SHARP).

3.4.3 Governance

No specific governance arrangements are required.

3.4.4 Financing

No specific financing arrangements are required, as this is intended as a drug donation programme.

3.4.5 Poverty and Gender

These are assumed within the overall purpose of the programme, e.g. donated viramune will be used for increasing access to ARVs for poorer women who would normally not have access. However, as the PMTCT programme itself has not been established it is impossible to say whether it will in fact be pro-poor. The initial distribution of Viramune will be confined to Freetown, and a PMTCT programme coordinator has just been appointed to start up this programme.

3.4.6 Commodities

Based on the request from the ARG, the VDP shipped directly to the consignee indicated in the request. It is left to the ARG to store and distribute. The ARG is in the first stages of establishing the PMTCT programme, the quantity shipped was less than that requested, but they have been assured by the VDP that based on utilization, quantities can be increased.

4 KEY ISSUES ARISING

4.1 Have GHPs genuinely delivered additional funds for tackling the disease they target?

On review of the documentation in country and interviews with key stakeholders, the answer to this question is an unqualified 'yes'. EPI and TB, and now malaria and HIV/AIDS are all receiving additional funds due to financing from GHPs. The Onchocerciasis programme, much needed with the growing incidence of the disease, is just being restarted due to the availability of APOC funds.

4.2 Have GHPs addressed diseases that have been neglected by other forms of development?

If 'neglected disease' is understood to mean a low prevalence, communicable disease, then it would appear that GHPs in Sierra Leone are making an added contribution to at least one neglected disease, onchocerciasis. The main 'neglected diseases, are onchocerciasis, leprosy and lymphatic filariasis. Sierra Leone receives support indirectly via the WHO for both onchocerciasis (APOC), and for leprosy (GAEL). Initial work is being done to scope out a future programme for lymphatic filariasis. While APOC is helping to restart the Onchocerciasis control programme, it is unclear the extent of added value GAEL is making to what has already been a very successful leprosy control programme in Sierra Leone.

However, we would also argue that malaria could be considered a neglected disease as to date malaria programming has received little donor support in Sierra Leone, despite being the leading cause of morbidity in adults and children, and the leading cause of mortality in children. **Malaria-related GHPs would appear to have been slower to contribute to the national malaria programme, despite the heavy burden of disease that malaria represents.**

It is also notable that while Schistosomiasis ranks 10th in the causes of >5 morbidity in Sierra Leone, the country is not a recipient of SCI support, and would benefit from SCI activities as they expand to other countries.

4.3 How are governance arrangements working?

Various stakeholders were generally positive about both the ICC and the CCM in Sierra Leone, though we received mixed views. Positive aspects included:

- They have provided a forum for all partners to access information about national programmes that they previously didn't have access to;
- By involving government closely in coordination of activities through these coordinating committees they have facilitated greater 'buy-in' from government. For example, it was felt that prior to the existence of the ICC, government considered anything to do with immunisation to be UNICEF's domain. The ICC has helped government to take greater responsibility for the national immunisation programme.
- Having a national NGO (the Sierra Leone Red Cross Society) as the principal recipient for both the TB and Malaria funding is highly innovative in West Africa, and **unusual** globally.

Some of the weaker aspects of the governance arrangements include:

- Coordinating committees were problematic at start-up and had a number of teething problems;
- A number of people expressed concern that there did not appear to be clear terms of reference for the committees, and that meetings did not appear to have much purpose – though more recently this has improved. Ministry staff have concurred that this has been an issue, and that some start-up TA could have helped ease the operation of both the ICC and CCM;
- **A more significant point made by a number of stakeholders is that the Ministry of Health in Sierra Leone has very limited HR capacity. Having several coordinating mechanisms is seen as fairly burdensome, especially as the same people from both the MoHS, donors and NGOs attend the various coordination meetings. This overlap brings with it high transaction costs for all concerned. This feature is well illustrated in Figure 1 below;**
- Related to this, there is a disconnect between the governance mechanisms of the ICC and the CCM, and those of the MoHS, as reporting cycles, budget cycles and now the PRSP do not link up. This also incurs additional time from government and other stakeholders.

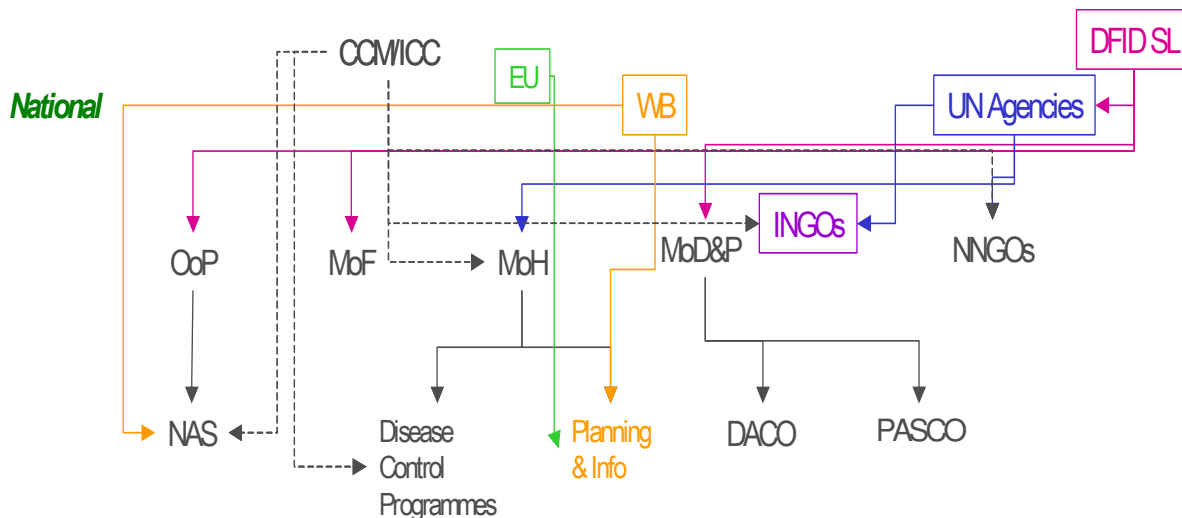


Figure 1 illustrates the health planning process factoring in GHPs

4.4 To what extent are GHPs pro-poor and gender focused?

The epidemiology of GHP target diseases in Sierra Leone does indicate that the poorest people are those that are hardest hit by those diseases. Also, the GoSL has made some effort to incorporate pro-poor policies at a national level by calling for exemptions from cost-recovery schemes for pregnant and lactating women, children, the elderly and poor people. It has been estimated that these groups make up 60% of the population.

However, the weaknesses of the current health system, outlined above, has meant that the assistance provided by GHPs does not easily reach poor people, and so the impact on their health is negligible.

- Distribution networks for vaccines and ITNs are poor, especially to peripheral health units;

- Formal and informal charging at health units reduces access to services even further for poor people;
- As a result there is a very low uptake of vaccines and ITNs throughout the country.

4.5 Have GHPs reduced commodity prices?

GHPs providing assistance to Sierra Leone are providing commodities for free at present. The country has benefited from a fair amount of donated commodities prior to GHP activities as humanitarian assistance also brought in donated drugs and other materials.

Commodity prices to the consumer are set in a way that appears irrelevant to the actual cost of the drug or materials. The recently introduced cost-recovery scheme is not supported by any national standard for pricing or management. Health units do not generally post the prices of commodities that they sell to service users, nor do they post charges for 'fees-for-service' paid to providers. What price the service user pays seems to be up to individual negotiation.

The weaknesses in the health system and in commodity delivery in particular will need watching as the new drugs supplied through GFATM are brought in to the country.

4.6 How well are GHPs working with country programmes and the health system?

The GHPs work through the major national disease control programmes. As GHPs lend themselves to a project approach to aid, rather than a more integrated or systems approach, they currently fit in fairly well to how the MOHS works. However, this does reinforce the project-by-project nature of MOHS, increases transaction costs in a health system that has very weak capacity and could be a deterrent for moving towards more integrated approaches in future. On the other hand, a project approach is probably the most appropriate way to ensure that GHP programmes are delivered while the Sierra Leone health system takes time to rebuild its human and infrastructure capabilities, and while concerns over governance and accountability remain high.

Stakeholders interviewed felt that GHPs were strengthening country programmes. This has been done in a number of ways:

- The process required for applying for GHP funding has helped the MoHS develop national programme strategies, especially for malaria, that did not exist before.
- Similarly GFATM funding for HIV/AIDS will ensure that ARV protocols are set up;
- The funding itself has meant that programme managers for EPI, TB, malaria and HIV all have resources to work with.

On a more critical note, stakeholders also felt that the existence of the GHPs, with their emphasis on specific diseases, has meant that government pursues programmes where the funding is, rather than developing overarching health sector strategies.

- Malaria programmes remain under-funded, especially relative to the disease burden represented by the disease, and relative to funding provided to other control programmes. GHPs have not provided the levels of technical assistance needed by the national malaria control programme, nor assisted in advocating increased resources to help with prevention and treatment in the country.
- The EC programme managers indicated that there is an apparent rise in the incidence of STIs nationally, but there is no national strategy for STI. Treatment protocols have been developed (as part of the World Bank HIV/AIDS programme) but have not been integrated into MCH or reproductive health care, nor are STIs currently being tackled as part of the national HIV/AIDS programme.
- Some informants, including those in the MoHS, felt that in a country that is as donor dependent as Sierra Leone external donor priorities can easily 'trump' national priority setting (e.g. the extensive funding available for HIV/AIDS programming vs malaria programming).

It is unclear at present how GHPs will work with new decentralized structures. It is presumed that, as in other countries with decentralized health systems, GHP support to national programmes will devolve to the extent that national programmes devolve to district level or below.

5. PRELIMINARY CONCLUSIONS AND RECOMMENDATIONS

The GHPs will only be as effective as the health system itself. In a post-conflict country such as Sierra Leone, that is just beginning the long road to recovery, the way GHPs operate require special measures.

- 5.1. **Streamline country coordination mechanisms:** The weakness of government structures mean that country level coordination mechanisms need to be streamlined to reduce transaction costs. One suggestion from MoHS staff, and endorsed by UN staff, was GHPs should work through existing MoHS led coordinating mechanisms rather than setting up new coordinating structures. The functions of the CCM and ICC could be integrated into this mechanism. It would also provide a means for the MOHS to ensure all health priorities are visible, rather than just those that are supported by GHPs or other vertical programmes;
- 5.2. **Increase levels of technical assistance:** Low human resource capacity, especially for working at a strategic level, requires additional technical assistance. This does not necessarily need to come in as external TA from the GHPs, but could be negotiated with in-country implementing partners in the first instance;
- 5.3. **Raise the profile of, and support to, the National Malaria Control Programme:** It is possible that funding recently received through GFATM will help the malaria control programme to be more strategic and to coordinate malaria prevention and control measures. However, it is still under-resourced and needs further support if the high prevalence of malaria is to be reduced in the country.
- 5.4. **Compliment GHP assistance with health system strengthening:** The current 'light touch' modus operandi of most GHPs is not appropriate in Sierra Leone as it has led to:
 - Confusion around what is required to correspond to GHP requirements for coordination and reporting;
 - Programmes that do not reach the most vulnerable in the population, and in the worst case;
 - Encouragement of corrupt practices.

However, this does not mean that GHPs should therefore take on health system strengthening as another area of work. In Sierra Leone, for example, there are already three major donors providing support to health systems strengthening, and even these three are finding it difficult to coordinate and harmonise their approaches. Any new partners in this area would lead to greater confusion.

Annex 1

List of documents reviewed

	Report on the Public service Reform Programme Phase I for period Nov 2003 to April 2004, Public Service Reform Unit, Governance Reform Secretariat	May 2004
	Report on the Public Expenditure Tracking Survey (PETS) for financial year 2002 selected expenditures, PETS Task Team, Ministry of Finance	May 2004
	Current/future health sector interventions by cost center, Director Planning and Information, MoHS: Annex 4 Annual Health Review 2002 Rolling Plan and budget 2003-2005	2003
	Inception Report: Sierra Leone Health Sector Support Programme (HSSP): Sofreco, 2003	2003
	Sierra Leone Health Sector Review 2004, Final Report: Consultancy support to PASCOS for PRSP Preparation: Akim Gibril, Tom Kargbo, Bailah Leigh, Andy O'Connell	June 2004
	<p>Bampoe V, Torbieu S, Dresden E. (2003) Back to office report: Assessment of MRC Primary Health Units handed over to the MoHS in Bo District – 29 September to 3 October 2003.</p> <p>GAVI (2002) Sierra Leone December 2002. GAVI website</p> <p>German Leprosy and TB Relief Agency (2003) Annual Report 2003: National Leprosy/TB Control Programme, Sierra Leone. GLRA Support Project.</p> <p>Gibril A., Kargbo T., Leigh B., O'Connell A. (2004) Sierra Leone Health Sector Review. Freetown: British Council</p> <p>Government of Sierra Leone (2000) Survey Report on the Status of Women and Children in Sierra Leone at the end of the Decade. Freetown: Ministry of Development and Economic Planning.</p> <p>Ministry of Health and Sanitation (2002) Information Sheet – 1st July 2002</p>	

Annex 2 List of persons met

Government of Sierra Leone

Dr. Clifford Kamara	Director of Planning and Information, MoHS
Dr. Alhassan Sesay	Director of Disease Prevention and Control
Dr. S. Kamara	Programme Manager, Malaria
Dr. F. Dafé	Programme Manager, TB and Leprosy
Dr. Magnus Gborie	Programme Manager, MCH/EPI
Prof. Sidi Alghali	Director, National HIV/AIDS Secretariat
Dr. Brima Kargbo	Programme Manager, HIV/AIDS
Dr Byram Josiah	Coordinator, Poverty Alleviation Strategy
Coordination Office (PASCO)	
Dr. Samuel Smith	District Medical Officer, Bombali District

International Organisations

Dr. Joaquim Sewaka	Representative, WHO
Dr. Aboubacry Tall	Representative, UNICEF
Dr. Keddrick Kini Kiawoin	Health/Nutrition Officer, UNICEF
Ms. Karen Genty	European Union
Dr. Pascal Crepin	EU Technical Adviser, MoHS
Dr. Pierre Capdegelle	EU Team Leader Health Sector Support Project
Mr. Jim Maund	DFID, West Africa
Ms. Alison	DFID, West Africa
Frederic Malardeau	Head of Mission Action Contre le Faim
Jane Shenton	Acting Director, MSF-Holland
Nick Webber	Director, CARE International in Sierra Leone
Kelland Stevenson	Deputy Director, CARE
Michael Possmeir	Merlin Acting Director
Femi	Merlin Medical Coordinator

National Organisations

Mr. Arthur Cummings	Secretary General, Sierra Leone Red Cross
Mrs. Amelia Gaba	Health programme manager, SL Red Cross
Mrs. Olive Stubba	Community health programmes, SL Red Cross
Mr Morlai-Buya Kamara	Project Coordinator GFATM Unit, SRC

Annex 3

Summary Tables documenting variance in statistics from various sources

Key health indices	Sierra Leone(1)	Sierra Leone(2)	Sierra Leone(3)
Population (millions)	5.2 million	5.2	5.6
urban		37.3	
Average annual population growth rate (%)	2.1		2.6
Per capita income (US\$)	140	146	
% of poor living in rural areas	62		
% population with <\$1 day		57 (2001) 70 (2004)	
Illiteracy Rate (% ages 15 and above)	37		70
females			81
males			69
%of children attending primary school			42
females			38
males			52
Public expenditure on health (% of GDP)	4.3		
% health of national budget			11.4 (exc interest foll HIPC)
Private health expenditure (% of total health expenditure)	40		
% of donor input to national budget			

Source: 1. World Bank (2003) *World Development Indicators 03*. Washington, DC: The World Bank

2. Sierra Leone Health Sector Review (2004)

3. EU HSSP Project Inception Report (2003)

Table 2: Key health indices

Key health indices	Sierra Leone	Sierra Leone(2)	Sierra Leone(3)
Life expectancy (years at birth)	37.4	34.5	37
Infant Mortality Rate (IMR = deaths per 1,000 live births)	165	182	170
Maternal Mortality Ratio (MMR = deaths per 100,000 live births)	NA/2100 (1995)	1800	1800 ± 800
Under 5 Child mortality rate (CMR = deaths per 1,000 live births)		316	286
% infants exclusively breast fed at 4 months old			2%
Immunisation rate (% 12-23 month fully immunised against DPT)			46%
Access to safe water		54	
Access to sanitation		20	
Access to health services		40?	
HIV prevalence (% of adults) – females 15-24	7.5*	4.9*	4.9*
Total Fertility Rate (TFR = births per woman)	5.6	6.5	6
Contraceptive Prevalence Rate	NA	4	na
% Anaemia in pregnant women			82%
% deliveries attended by skilled personnel			42%
Access to safe water (% households)	NA		na
Health Services			
Number of Peripheral Health Units (active)			
Number of District Hospitals (active)			

Source: 1. World Bank (2003) *World Development Indicators 03*. Washington, DC: The World Bank

2. Sierra Leone Health Sector Review (2004)

3. EU HSSP Project Inception Report (2003)

4. * CDC Report 2004 based on survey 2003 confirmatory testing reports national prevalence of 0.9% and Freetown at 1.9%

Annex 4 : Supplementary Information on Sierra Leone

1. Epidemiology of specific diseases

Malaria

Malaria is endemic in Sierra Leone and is one of the most serious public health problems, especially in the post conflict era. While the entire population is at risk, with malaria accounting for over 40.3% of outpatients visits, the most vulnerable groups are under 5 year olds, pregnant women, refugees and returnees. In the U5 age group, it is responsible for 47% of outpatient morbidity, 37.6% of hospital admissions of which 17.6% die. Mortality attributed to malaria is 38.3% among U5s and 25.4% overall. It is first on the list of Government priority diseases and a major threat to socioeconomic development with an estimated 7-12 days lost on average per episode of malaria. In a national survey 1995, 87.1% of pregnant women were anaemic, with an estimated 70% due to malaria. In another study in 2003, 37.1% of pregnant women had malaria. The increasing resistance to hitherto effective and relatively affordable antimalarial drugs compounds the problem.⁵

HIV/AIDS

The recent population-based HIV/AIDS survey, "HIV/AIDS Seroprevalence and Behavioral Risk Factor Survey in Sierra Leone, CDC, April 2002" was conducted to provide baseline estimates of HIV prevalence and risk factors in the general population. The authors reported preliminary HIV prevalence results of 4.9%, however further confirmatory testing at the CDC reference laboratory (including Western Blots) resulted in a revised prevalence estimate of 0.9%. Local VCT and antenatal data and UNAIDS estimates, though based on limited data, suggest a higher HIV prevalence of between 3 and 7%.

While there is some uncertainty about the true HIV prevalence in Sierra Leone, all figures suggest that there has been a significant increase in prevalence as compared to the 0.09% HIV prevalence in a survey of 9000 households in the Northern Province in 1993 by the Aaron Diamond AIDS Research Center, (Zhiwei, Luckay et al., 1997).

Also, many major ingredients for an explosive increase in HIV transmission are present following the end of the protracted conflict, these include:

- ▶ Systematic sexual violence during the conflict (13% of household respondents reported some form of war-related sexual violence⁶: Of women who reported contact with Revolutionary United Front (RUF) forces half reported experiencing sexual violence)
- ▶ Deployment of Peacekeeping Troops from Higher Prevalence Countries (In 2001/2002, there were as many as 17,500 UNAMSIL troops from 31 different countries in Sierra Leone; estimated 32% of troops in Sierra Leone come from areas with national prevalence of HIV infection greater than 5% and reports of a thriving sex trade around most military camps.)
- ▶ Demobilization and reintegration of ex-combatants and the deployment of the SL military across the Country⁷;

▪ ⁵ National Roll Back Malaria Strategic Plan 2004-2008 (Draft)

▪ ⁶ A study released by Physicians for Human Rights (PHR), with support from UNAMSIL, "War-Related Sexual Violence in Sierra Leone: A Population-Based Assessment"; Human Rights Watch World Report 2001

▪ ⁷ only 8 percent of respondents knew three correct routes of HIV transmission, although 77 percent were able to identify sex as one response. Only 18% of military respondents used a condom at last sexual encounter, (RSLAF Report 2002).

- ▶ Population Movement among Internally Displaced Persons (IDP), Returnees, and Liberian Refugees (approximately 213,500 IDPs have been resettled to their areas of origin⁸; over 100,000 returnees were repatriated to their areas of origin from Guinea and Liberia⁹; over 37,000 Liberians have entered Sierra Leone as refugees in the South and the West⁴)

Tuberculosis: The registered incidence of tuberculosis has steadily increased in the last 5 years from 3160 cases/100,000 population in 1999 to 5421 cases/100,000 population in 2003. Some of this increase may be due to artifact, in that people infected with TB may have gone undetected for some time due to the conflict, especially in the Eastern and Northern provinces. The notification rate per 100,000 population varies from 196/100,000 in Western Area to 14/100,000 in Pujehun District.¹⁰ Case detection efficiency is only 45% and it is unlikely that Sierra Leone will meet its target of increasing efficiency to 70% by 2005.

The DOTS regimen being delivered up to mid-2003 was a fixed dose combination of RH (Rifampicin, Isoniazid) and EH (Ethambutol, Isoniazid). This was replaced in the second half of the year by a four dose combination blister pack for all cases in the intensive phase, while the continuation phase offered EH in a combination tablet.

Tuberculosis diagnosis and care is provided primarily through diagnostic centres run jointly by the German Leprosy and TB Relief Association and the MoHS. The MoHS is beginning to try and integrate diagnosis and treatment into PHUs and hospitals in a few districts as well, but the bulk of TB services are run through the diagnostic centres.

Leprosy: The prevalence of leprosy is 0.9 per 10,000 population. Five districts have leprosy prevalence of more than 1 case/10,000, with the highest reported prevalence in Koinadugu District (3.9/10,000). The total number of cases on the national register at the end of 2003 was 487. 20% of the total cases were amongst children. Late detection of cases is resulting in a high percentage of patients with MB have Grade 2 disabilities (19%).

Leprosy detection and care is also provided through the TB diagnosis centres, complimented by an outreach programme that assists with the social welfare needs of people disabled by leprosy.

Onchocerciasis: Sierra Leone has always been an Onchocerciasis endemic country and received support from the Onchocerciasis Control Programme based in Ouagadougou. The most affected areas of the country were the northern and eastern provinces, which during the civil war were the rebel held areas. As a result the Oncho control programme could not operate there for ten years, and the country has now seen an expansion of Oncho into formerly non-endemic areas. Sierra Leone has now been designated a 'Special Intervention Zone' (SIZ) and as such receives priority funding from APOC, through the WHO. We were not able to collect data on either the burden of disease represented by Oncho, nor the scope of the control programme in country.

⁸ Sierra Leone National Commission for Social Action (NaCSA 2002)

⁹ United Nations High Commission for Refugees (UNHCR) reports

¹⁰ This excludes Kailahun District, which has a notification rate of 0/100,000 due to the fact there is no TB diagnostic centre in the district. Estimated TB incidence in the district is 275/100,000.

Childhood illness: The infant mortality rate in Sierra Leone is 170/1000 while the child mortality rate is 286/1000, leaving Sierra Leone far from achieving the MDG child health targets. Poor diagnostic facilities and information systems make it impossible to estimate the prevalence of childhood diseases such as polio, diphtheria and pertussis. The MoHS believes polio has been eradicated from Sierra Leone. Measles remain problematic through periodic epidemics, though the risk of these episodes should decline as immunisation coverage increases. The number of cases of measles reported in 2001 was 649, compared to 3,575 in 2000.¹¹

The prevalence of main childhood illnesses is shown in Table 2:

<i>9.6.1.1 Disease or Condition</i>	Prevalence (%)
Underweight prevalence	27%
Stunting prevalence	34%
Wasting prevalence	10%
	Incidence (%)
Diarrhoeal Disease	25%
Acute Respiratory Infection	9%
Ill with fever (potential malaria)	46%

Source: GoSL (2000) Survey Report on the Status of Women and Children at the end of the Decade. November 2000

Higher percentages of children in the North and East are underweight than in the West and South. Levels of wasting are relatively constant across all regions in the country.

Immunisation rates are relatively high for a country that has suffered severe health service disruption. Table 3 provides information on immunisation rates nationally.

Antigen	% immunised
BCG	73%
OPV3	61%
DPT3	46%
Measles	62%
Fully immunised	39%

The Minister of Health recently received an award for achieving the 46% DPT3 rate. However, UNICEF in Sierra Leone estimate that the real percentage is somewhere in the low 30s, the variance due to problems with calculating the denominator in many areas of the country.

2. Health Policy and System

- σ Ranked 183rd (/191) in health system performance WHO Health Systems Review 2000 ranking comparable to other war-torn countries e.g. Angola and DRC
- σ National Health Policy 1993 recently revised and basis for rolling plan of MoHS. Much of it apparently unchanged from original document.
- σ Consultation processes with key stakeholders and communities are encouraged.
- σ The emphasis is set on the primary and secondary levels of care. No increase in beds at the tertiary level is envisaged in the short term.

¹¹ GAVI (2002) Sierra Leone December 2002. from GAVI Website

- σ Health care delivery is based on the following principles: the development of an integrated health system; the strengthening of the referral system; the involvement of the communities; the reinforcement of preventive strategies and the collaboration between sectors.
- σ a shift by the MOHS away from the current involvement in direct management of health services. It defines the role of the Ministry as a leader in policy and planning, both strategic and technical, for the whole sector. It is also envisaged that a number of services may be contracted out to institutions in the NGO or private sectors.
- σ The Ministry acknowledges the critical shortage of staff and will draw up a human resource plan. It will review the terms and conditions of the public sector health workers.
- σ As regard to finance, it is expected that the HIPC (Highly Indebted Poor Countries) initiative will allow an increase in the level of funding to the sector. The different user fee schemes that have been developed will be unified with a view to equity.

3. Health Services

The health services are based on a three tier model of care.

- peripheral health units delivering basic primary care services (417)
- district hospitals and private hospitals in districts providing secondary care (23)
- tertiary, referral hospitals, based in Freetown and provincial level (9)

There is no formal referral system between these different levels, so that hospitals are also the main primary care provider for communities living near them.

There is a highly uneven distribution of care facilities across the country. For example of the 9 tertiary care facilities functional in Sierra Leone, 7 are in Western Province, 1 each in Southern and Eastern Provinces and none in Northern province. Per capital expenditure on health shows marked variation between districts, ranging from Le 9,135/capita in Western Area (which includes Freetown) to Le 2,666 in Moyamba district.

Health service utilisation is estimated at 0.5 contacts per year, considered low by international standards. Reasons given for not using formal health services include cost, quality and geographic accessibility.

Quality: Health service quality has been substantially affected by a decade of civil war and poor resource base of the government. Health staff are paid low wages and seldom receive payment on time. Staff lists date from several years ago and are open to abuse. As a result, there are newly qualified staff working in health facilities who are not paid at all, because the facility payroll list shows there is full compliment of staff. Low pay and poor working conditions have forced many health personnel to either leave the service altogether or to take on supplementary private patients.

There is an absolute lack of materials, equipment and drugs in health facilities. Information systems are only just beginning to be developed to quantify both disease patterns within sierra leone as well as infrastructure and staffing issues.

Geographic accessibility: as noted above, there are distinct geographical differences of expenditure in the health services, corresponding as well to geographical coverage. Eastern and northern provinces are least well served, primarily due to having been the zones hardest hit by conflict with frequent change of hands between government and rebel control. Much has been done in the last two years to try and rectify the situation, particularly due to ngo efforts using emergency funding.

Besides formal health services, traditional medicine and private medicine are both widely practiced in Sierra Leone. While traditional medicine is practiced much as it has always been done, through healers, traditional birth attendants and spiritual healers, private practice takes place either through qualified practitioners who have left the health service or who are supplementing their incomes while still in the health service, and through Pepper doctors, who are unqualified, dispense medicine (and sometimes practice surgery!) but are also community based and affordable.

4. Health Financing

All health units charge a 'registration fee' for users, and the national health plan supports cost recovery through Bamako Initiative type policy. The registration fee quoted to us was usually Le 500 for children and Le 1000 for adults. Costs for consultations and drugs are charged separately. The costs of health services constitute a formidable barrier to their use, especially by poor people. As at least 60% of the population are estimated to be poor using the international standard of living at less than \$1per day, the impact of even the stated charges are clear. This is compounded by the fact that the real cost to service users is much higher than those stated officially, due to 'under the table' payments. The situation is exacerbated by the fact that the government has not set out a national standard for user charges, nor issued a directive to service providers about exemptions, despite a number of speeches having been made indicating that pregnant women, children under 5 and the destitute should all be exempt from cost recovery programmes. There is a lack of transparency around fees at all levels of service provision and policy making.

Service users have also had to make an adjustment from having services provided for free by NGO providers during the emergency phase to having to pay for services under the now government controlled units.

The impact of the opaque nature of user charges is discussed further in the section on individual GHPs.

5. Donor support to the Health Sector

DFID operating policy in SL, is not to work in direct support of the social sectors but to concentrate on the areas of the agreement. As such, the working agreement with its donor partners is not to have any specific projects in health. Some health specific inputs are provided through UN agencies or INGOs, but not directly to MoHS.

The EU and the WB both have large programmes with MoHS. Both are set up to work in an integrated fashion with the MoHS, in recognition of the need to be flexible and not overload the managers at policy level. They work directly to line managers as programme counterparts. The EU has recruited a management firm to provide the technical oversight and support needed for implementation. the following table summarises the donor support to the health sector, as of 2003:

Donor	Budget for 2003	Activities	Location / Partner
9.6.1.1.1 European Union			
Health Sector Support Project (8th European Development Fund)	<ul style="list-style-type: none"> ■ 28,000,000 € for 5 years. ■ Expected budget for 2003: 3 to 5,000,000 € 	<ul style="list-style-type: none"> ■ District Support and decentralisation. ■ Institutional reinforcement: <ul style="list-style-type: none"> ▶ Reinforcement at central level (Human Resources and Finance); ▶ Paramedical training; ▶ Support to the pharmaceutical sector. 	<ul style="list-style-type: none"> ■ Kailahun, Kambia, Pujehun ■ Freetown, Bo. ■ Partner: Sofreco
European Commission Humanitarian Office (ECHO)	<ul style="list-style-type: none"> ■ 3,774,600 € 	<ul style="list-style-type: none"> ■ Support to the Primary Health Care structures and to the referral system; ■ Health education; ■ Training of local health staff; ■ Nutritional management and integration into paediatrics; ■ Support to primary and secondary services for refugees. 	<ul style="list-style-type: none"> ■ Kambia, Bombali, Koinadugu, Kono, Kailahun, Kenema, Port Loko. ■ Partners: MSF, Merlin, ACF, Goal, IRC, COOPI, HI, Concern.
Sierra Leone Rehabilitation and Resettlement Programme (SLRRP)	<ul style="list-style-type: none"> ■ 1,700,000 € 	<ul style="list-style-type: none"> ■ Rehabilitation of health infrastructures; ■ Support to paramedical and TBAs training; ■ Water and sanitation. 	<ul style="list-style-type: none"> ■ Nation-wide ■ Partner: Agriconsulting
Budget Support to the Ministry of Finance for health and education	<ul style="list-style-type: none"> ■ 16,000,000 € for 2003. 	<ul style="list-style-type: none"> ■ Allocation to individual sectors not yet decided upon 	

Donor	Budget for 2003	Activities	Location / Partner
<u>World Bank</u>			
Health Sector Reconstruction and Development Project (HSRD)	<ul style="list-style-type: none"> ■ 20,000,000 US\$ Grant 	<ul style="list-style-type: none"> ■ Restoration of basic health services in 4 priority districts; ■ Support to priority technical programmes; ■ Strengthening of public and private sector capacity: <ul style="list-style-type: none"> ▶ Promotion of decentralisation and support to District Health Teams; ▶ Strengthening of key MOHS services: Human Resources Development, Financial Management, Planning Monitoring and Statistics, Procurement and Donor/NGO co-ordination. 	<ul style="list-style-type: none"> ■ Bombali, Koinadugu, Kono, Moyamba ■ Central level
National AIDS Secretariat	<ul style="list-style-type: none"> ■ 15,000,000 US\$ loan 	<ul style="list-style-type: none"> ■ capacity building, policy, advocacy ■ line ministry involvement ■ health sector response ■ community/CSO initiatives 	<ul style="list-style-type: none"> ■ National
<u>African Development Bank (ADB)</u>			
Health Services Rehabilitation Project	<ul style="list-style-type: none"> ■ Loan amount: 13,551,930 US\$ ■ GOSL: 1,574,605 US\$ ■ Total: 15,126,535 US\$ 	<ul style="list-style-type: none"> ■ Rehabilitation of 3 hospitals and 5 health centres (64%); ■ National essential drugs programme (26%); ■ Health management support (1%); ■ Project management (9% including audit). 	<ul style="list-style-type: none"> ■ Western Area ■ Partner: WHO for the essential drugs programme

Donor	Budget for 2003	Activities	Location / Partner
9.6.2 Islamic Development Bank			
Reconstruction and Construction of Kissy Mental Hospital	<ul style="list-style-type: none"> ■ 2,835,000 US\$ loan for two years (started in January 2003) 	<ul style="list-style-type: none"> ■ Rehabilitation and construction of infrastructures; ■ Medical equipment; ■ Drugs. 	<ul style="list-style-type: none"> ■ Kissy Mental Hospital (Freetown) ■ Implemented by MOHS
Integrated Rural Development Programme	<ul style="list-style-type: none"> ■ 1,450,000 US\$ loan for two years (2002 - 2003) 	<ul style="list-style-type: none"> ■ Rehabilitation of 20 PHUs; ■ Medical equipment; ■ Drugs. 	<ul style="list-style-type: none"> ■ Bo (3), Moyamba (2), Bonthe (1), Pujehun (3), Kenema (3), Koinadugu (1), Tonkolili (1), Port Loko (5), Western Area (1) ■ Implemented by NaCSA
<u>Other Donors</u>			
<u>UNICEF</u>	<ul style="list-style-type: none"> ■ 2,000,000 US\$ 	<ul style="list-style-type: none"> ■ Child protection; ■ Health (including EPI); ■ Water and sanitation. 	<ul style="list-style-type: none"> ■ Bombali, Koinadugu, Kono, Kailahun
<u>WHO</u>	<ul style="list-style-type: none"> ■ 2,491,800 US\$ for 2002 - 2003 ■ Regular budget 	<ul style="list-style-type: none"> ■ Technical support to 20 different programmes. 	<ul style="list-style-type: none"> ■ Country-wide
<u>USAID (OFDA)</u>	<ul style="list-style-type: none"> ■ No information on Fiscal Year 2003 was provided. In Fiscal Year 2002, the amount allocated to the health sector was: 5,540,218 USD. Number of the programmes initiated in 2002 will be continued in 2003. 		
Source:	EU	Project	Inception Report 2003

6. The PRSP Process

An interim PRSP (I-PRSP) has been in place since 2001. The Poverty Alleviation Strategy Coordination Office (PASCO) was established to lead the process for the completion of the PRSP in January 2002.

Governance and institutional arrangements

The PASCO is accountable to a PRSP Committee of Ministers under the chair of the Vice President. A Steering committee comprising of senior level government officials (PS and Directors) of key ministries, NGOs and Donors is in place to provide technical backstopping and resources for the process. Technical working groups for each sector are in place. A Technical committee is responsible for the drafting of the final document. The PASCO acts as overall coordinator and secretariat to the PRSP committees.

Participatory process

The process has been guided by 2 main principles of participation and consultation. Key elements of the process include:

- σ Household expenditure survey to provide profile of poverty in SL
 - Prelim results showing worse levels of poverty where 70% population below poverty line of US\$1/day
- σ Focus group discussions
- σ Participatory Poverty Assessment (PPA)
- σ Sector Review Studies (17)
- σ Sensitisation of public (Action AID awarded contract and used process of civil activation)
- σ Decentralization and empowerment of local councils (recent elections in May 2004)
- σ National consultation workshop (May 2004)
- σ Technical team to complete first draft by end July 2004 based on above outputs

Emerging Consensus

Pillars:

- I. good governance, security, peacebuilding
- II. pro poor growth and healthy macro economic environment
- III. human development and caring society for vulnerable
 - σ youth, education, health, social protection

Cross cutting issues

- ▶ HIV/AIDS
- ▶ Gender
- ▶ Youth
- ▶ Environment

The process by which this will feed into MTEF and ensure allocations to pillars has not yet been determined.

Financial management and systems strengthening is agreed to be a key enabler for public sector reform and modernization. While EU, WB, DFID are all supporting development in this area, from early 2005, this will be consolidated into a GoSL/SB Programme on strengthening financial management.

The Director of Planning of the MoH represents the MoH in the PRSP process.

Figure 2 illustrates the various levels in the PRSP and Health Planning processes and the relationship with DFID Sierra Leone Office.

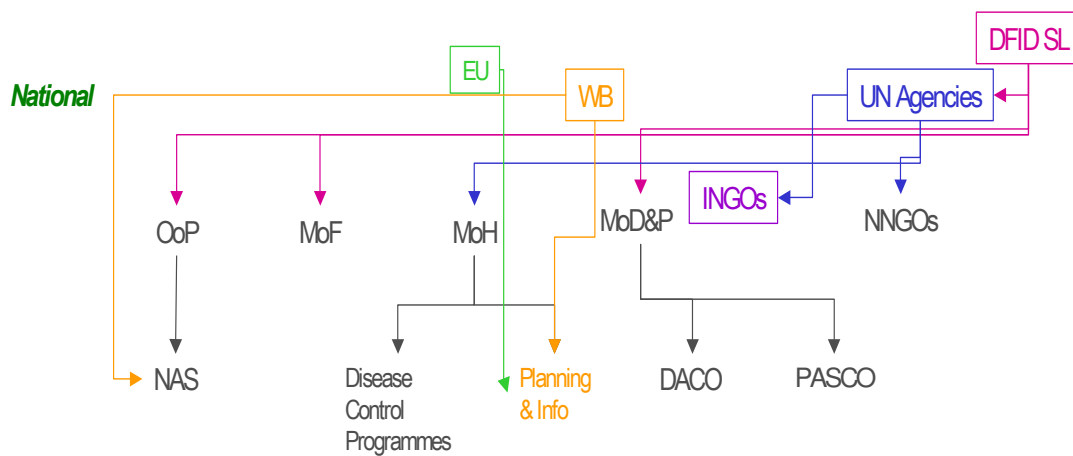


FIGURE 2: HEALTH AND PRSP PLANNING AND DFID SL

Appendix D:

UGANDA

This paper forms part of the 2004 DFID Study Global Health Partnerships - Assessing the Impact.

Rose-marie de Loor and Jennifer Sancho

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EXECUTIVE SUMMARY

This study is one of three country case studies for Sierra Leone, India, and Uganda. It was commissioned by DFID's Global Health Partnership Team as part of a broader assessment of the impact of Global Health Partnerships. The Uganda case study is representative of an environment with an operational Sector Wide Approach (SWAp) in the health sector.

Study findings are based on a literature review and interviews in Uganda with government officials, representatives of development partners and civil society (24th July – 5th August, 2004). The majority of the interviews took place at the national level with some interviews at district levels, i.e. Jingo and Mukono districts which are both relatively nearby Kampala.

The key questions addressed by the study concern the following aspects of GHP impact: their focus on neglected diseases; governance and co-ordination arrangements; mobilisation of additional financing; fit with the health system, extent to which needs of the poor and women are addressed; and their impact on prices and other aspects of commodity support. Given the short duration of the consultancy, the team was unable to interview stakeholders involved in all the 18 GHPs that are operational in Uganda. The study therefore focused on the three key diseases in Uganda, i.e. malaria, TB and HIV/AIDS, but also included a number of diseases targeted for eradication or elimination such as leprosy, lymphatic filariasis and sleeping sickness.

With regards to GHPs fit **with country priorities and systems effects**, the study showed that all GHPs assessed work towards the targets defined in the Uganda Health Sector Strategic Plan. With the exception of Haemophilus Influenza type B, all diseases addressed by the GHPs are part of the HSSP and included in the Minimum Health Care Package. With the exception of the Ugandan GFATM project, GHPs assessed were aligned to the national programmes and have helped implementation of the programmes through the provision of necessary inputs whether those be drugs, training, technical support or advocacy.

At the national level, interviewees did not think that the GHPs had skewed national priorities. However, at the district level, interviewees felt that the number of GHPs together with a high number of other major initiatives had considerably increased transaction costs and put a heavy burden on the already low numbers of existing staff.

With regards to the new HIV/AIDS initiatives in Uganda, including GHPs, there is a lack of apparent co-ordination between them at the national level.

With regards to **governance and accountability**, all but one of the GHPs is directly linked to the national disease control programmes of the MoH. Therefore, they are integrated into the SWAp and as such form part of MoH planning and review processes and regular reviews by all SWAp key stakeholders. The exception is the UGFATM, which potentially represents the biggest source of financing outside the budget.

With regards to the neglected diseases, the GHPs operating in Uganda address diseases that are included in the Minimum Health Care Package under the HSSP, or

are specified as district priorities. Uganda is participating in GHPs for guinea worm, leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis and sleeping sickness. The general view at country level is that these GHPs, and in particular the drug donations, are helping meet a real need. These GHPs are operating through district health systems rather than on a project basis. There appears scope, however, for closer co-ordination and integration of activities across GHP supported programmes with similar treatment strategies and modalities. The draft HSSP II is already reflecting this and working towards an integrated programme for all the hitherto neglected vector borne diseases.

With regards to **financial additionality**, the study showed that in general GHPs have provided additional financial and other resources. However, various MoH officials noted that the budgets of some disease control programmes had been considerably reduced in the last year. The extent to which additionality will continue in Uganda will depend on the process by which the MTEF ceiling is firmly fixed, as indicated by MOFPED, or can be raised to accommodate new funding sources. The main concern with the rigid enforcement of the fiscal policy to include projects and drug donations in the future is that it threatens the stability of the SWAp as the health sector risks losing the efficiency of budgetary support if it continues to accept projects. Further to this, since most projects and GHPs do not pay public sector salaries and certain operational costs of systems development, the imbalance between direct budget support and project support will seriously undermine the capacity of the MoH. If the sector ceiling remains at a fixed level, new projects will automatically displace health sector budgets under the control of MoH. Therefore, at an early stage GHPs should work in partnership with in-country development partners and GoU to negotiate the issue of additionality with the MOFPED.

With regards to **poverty and gender equity**, there is a lack of socio-economic data of the clients in the health sector. In the absence of these data, it is assumed that the GHPs that operate through the national disease control programmes and the HSSP (and by extension the PEAP) benefit the poor in particular because the health system in Uganda is pro-poor and drugs provided by GHPs are provided free of charge. Data from MoH also show that the poorest quintile of the population has benefited most from the abolition of user fees as health service utilization in this group has considerably increased.

With regards to the impact of GHPs on **commodity prices**, interviewees reported that GHPs have negotiated considerable reductions in cost of drugs on the international market. For example, the cost of TB DOTS treatment had been reduced from US\$30-40 to US\$10 per treatment. In addition, drugs for the so-called neglected diseases are provided free of charge under the various GHP programmes.

Recommendations

Harmonisation and integration - In the context of the SWAp in Uganda, GHPs should contribute as much as possible to in-country harmonization and systems strengthening efforts of the GoU and its development partners.

Financing, aid instruments and sustainability - In the context of the SWAp, GHPs should aim to:

- channel funds through preferred aid instruments;
- negotiate additionality of funds with MOFPED at an early stage;
- encourage open discussions on the sustainability issue.

Pro-poor and gender focus of GHPs – Development partners should encourage GHPs to adopt explicit pro-poor and gender focused goals.

GFATM - MOFPED, GoU and GFATM must discuss the option to fund at least MoH activities through (earmarked) sector support so as to integrate it into existing MoH systems. Transparency could also be increased by including CCM members in correspondence between the UGFATM PMU and the GFATM in Geneva.

International HIV/AIDS initiatives – Development partners should remain circumspect about creating too many new HIV/AIDS initiatives and especially ones that require separate governance arrangements. There is a need to for all stakeholders in Uganda to agree as soon as possible on how the bring about the 'Three Ones' to achieve the most effective and efficient use of resources and to ensure rapid action.

Future study - Given that the country studies largely focused on experiences with GHPs at the national level, it is recommended to invest in a similar study focused at the district level across different countries with decentralized health systems.

1. Introduction

1.1 Purpose of the country case studies:

The Aid Effectiveness group in DFID's Policy Division has commissioned the DFID Health Resource Centre to assess the impact of aid channelled through Global Funds and Partnerships in comparison with other aid instruments, at global and country levels. The country level assessments are being undertaken through a series of three case studies, in Uganda, Sierra Leone and India as examples of 3 distinctively different operating environments. The Uganda case study is representative of an environment with an operational sector wide approach plan (SWAp) in the health sector.

The TORs for the Assessment are comprehensive (see Appendix A) and the case studies have been undertaken as an integral part of these TORs in order to inform the Assessment in the following specific areas:

- whether GHPs have genuinely delivered additional funds for development within the case study countries, and whether the surge in support for GHPs has outstripped the decline in ODA.
- whether GHPs have addressed diseases that have been neglected by other forms of development assistance.
- governance arrangements of GHPs at country level
- how well GHPs are working with country programmes
- the extent to which GHPs address the needs of the poor and are gender-focused in practice, and the ways in which they operationalise a gender or poverty focus.
- whether GHPs have reduced commodity prices and improved commodity availability in countries

1.2 Methodology

The Uganda case study was undertaken through interviewing key stakeholders within Uganda. The majority of the interviews took place at the national level with some interviews at district levels, i.e. Jinja and Mukono districts which are both relatively nearby Kampala (1 – 2 hours travel by tarmac road).

The interviews were complemented by reviewing documents available on the web (mostly through individual GHP websites) and within Uganda. While the initial unit of analysis was the disease or health issue that the GHPs known to be in Uganda were covering, this report focuses on the operations of the GHPs themselves, setting their operation within the wider context of the Uganda health sector.

The list of stakeholders interviewed is available in Appendix 1 and the reference lists available in Appendix 2.

2 Country Context

This chapter provides a brief outline of the Ugandan context in which GHPs operate and provides, including a summary of key socio-economic indicators, the health situation, the national programming context for the health sector, funding for the health sector and SWAp mechanisms for decision making and Monitoring & Evaluation.

2.1. Summary Table

	1999	2002	2003
People			
Population, total	22.6 million	24.6 million	25.3 million
Population growth (annual %)	2.8	2.8	2.7
National poverty rate (% of population)	..	..	..
Life expectancy (years)	42.1	43.1	..
Fertility rate (births per woman)	..	6.0	..
Infant mortality rate (per 1,000 live births)	..	83.0	..
Under 5 mortality rate (per 1,000 children)	..	141.0	..
Births attended by skilled health staff (% of total)	..	..	..
Child malnutrition, weight for age (% of under 5)	..	..	..
Child immunization, measles (% of under 12 mos)	57.0	77.0	..
Prevalence of HIV (female, % ages 15-24)	..	..	..
Literacy total (% of ages 15 and above)	66.0	68.9	..
Literacy female (% of ages 15 and above)	55.6	59.2	..
Primary completion rate, total (% age group)	..	67.3	..
Primary completion rate, female (% age group)	..	61.7	..
Net primary enrolment (% relevant age group)	..	..	..
Environment			
Surface area (sq. km)	241.0 thousand	241.0 thousand	..
Forests (1,000 sq. km)	..	..	..
Deforestation (average annual % 1990-2000)	..	..	..
Freshwater resources per capita (cubic meters)	..	2,682.9	..
CO2 emissions (metric tons per capita)	0.1	..	..
Access to improved water source (% of total pop.)	..	..	..
Access to improved sanitation (% of urban pop.)	..	..	..
Economy			
GNI, Atlas method (current US\$)	6.5 billion	5.9 billion	6.2 billion
GNI per capita, Atlas method (current US\$)	300.0	240.0	240.0
GDP (current \$)	6.0 billion	5.8 billion	6.2 billion
GDP growth (annual %)	7.9	6.7	4.9
GDP implicit price deflator (annual % growth)	0.3	-4.0	9.2
Value added in agriculture (% of GDP)	38.4	31.6	33.1
Value added in industry (% of GDP)	19.9	22.0	21.8
Value added in services (% of GDP)	41.7	46.4	45.1
Exports of goods and services (% of GDP)	12.3	12.0	12.7
Imports of goods and services (% of GDP)	24.4	27.4	27.2
Gross capital formation (% of GDP)	19.4	21.7	22.7

Current revenue, excluding grants (% of GDP)	11.7	..	..
Overall budget balance, including grants (% of GDP)	-1.3	..	..
Technology and infrastructure			
Fixed lines and mobile telephones (per 1,000 people)	5.1	18.1	..
Telephone average cost of local call (US\$ per three minutes)	0.2	0.2	..
Personal computers (per 1,000 people)	2.5	3.3	..
Internet users	25,000.0	100,000.0	..
Paved roads (% of total)	6.7	..	..
Aircraft departures	3,000.0	300.0	..
Trade and finance			
Trade in goods as a share of GDP (%)	31.2	36.7	..
Trade in goods as a share of goods GDP (%)	..	..	..
High-technology exports (% of manufactured exports)	10.5	12.4	..
Net barter terms of trade (1995=100)	85.0	..	..
Foreign direct investment, net inflows in reporting country (current US\$)	140.2 million	149.9 million	..
Present value of debt (current US\$)	..	1.3 billion	..
Total debt service (% of exports of goods and services)	13.8	7.1	..
Short-term debt outstanding (current US\$)	132.1 million	153.4 million	..
Aid per capita (current US\$)	26.1	25.9	..
Source: World Development Indicators database, August 2004			

2.2 National Programming Context for the Health Sector

Based on the National Health Policy¹² and within the framework of the Poverty Eradication Action Plan (PEAP), the Health Sector Strategic Plan (HSSP) 2000/1 – 2004/5 was launched by the Ministry of Health following considerable consultation with related ministries, development partners and other stakeholders since 1997. Importantly, the National Health Policy and the Health Sector Strategic Plan were to be implemented through a sector-wide approach. The Policy Objective of the Sector-Wide Approach as stated in the National Health Policy is: “To provide an enabling environment that would allow for effective co-ordination of efforts among all partners in Uganda's national health development, increase efficiency in resource application, achieve equity in the distribution of available resources for health and effective access by all Ugandans to essential health care”.

In August 2000, the Government of Uganda (GoU) and its Development partners in the health sector signed a Memorandum of Understanding¹³ (MoU) to guide the implementation of the HSSP through a SWAp. Currently nine donors (UK, Ireland, EU, Norway, Sweden, Belgium, Netherlands, World Bank, DANIDA) in the health sector have moved to some degree of budget support through the Ministry of Finance, Planning and Economic Development (MoFPED). The GoU has taken a broad and flexible approach toward the SWAp and has allowed the inclusion of all stakeholders supporting the HSSP, including not only those donors who provide general budget support and sector support but also those development partners which support the health sector through traditional project support, e.g. USAID.

¹² MoH (1999) National Health policy.

¹³ Memorandum of Understanding between the Government of Uganda and Development Partners. Kampala: Ministry of Health, 2000

Among the more fundamental approaches introduced by the HSSP are the adoption of a sector-wide approach in health, introduction of the Uganda National Minimum Health Care Package for all (UNMHCP, see appendix 3), with emphasis on poor people, women and children, further decentralisation of health service delivery to the health sub-districts, and strengthened collaboration with the private sector.

The UNMHCP addresses the priority components of the national disease burden. The twelve elements of the UNMHCP constitute the most cost effective interventions considered to have the highest impact on decreasing population morbidity and mortality¹⁴¹⁵. It was designed to be implemented countrywide and delivered in an integrated manner at all levels of the health care system. For each element, there is a review of the annual targets, an assessment of the achievements made at the national and district levels and the challenges and constraints encountered. The package includes control of communicable diseases (such as HIV/AIDS, malaria and TB) and interventions against diseases targeted for elimination as a public health problem in Uganda. In the MoH Health Policy Statement 2004/2005, these were defined as follows: Polio, Measles, Neonatal Tetanus, Onchocerciasis, Leprosy, and Vitamin A deficiency, Iodine Deficiency Disorders, Filariasis, Sleeping Sickness and Guinea Worm.

Since the launch of the HSSP there has indeed been significant progress in the health sector. The Mid-term Review¹⁶ noted that the improved policy environment provided by the National Health Policy and HSSP, the increase in the health resource envelope and the abolition of user charges in March 2001 have all contributed to significant growth in the utilisation of primary care services, particularly by the poor. Figure 1 illustrates this trend.

▪ ¹⁴ Caines et al. (2003)) Impact of PPPs Addressing Accesss to Pharmaceuticals in Low Income countires: Uganda Pilot Study

▪ ¹⁵ Muhwezi J.K. Minister of Health (2004) Health Policy Statement. Kampala

▪ ¹⁶ MoH (2003) Health Sector Strategic Plan 2000/01 – 2004/05 Midterm Review Report

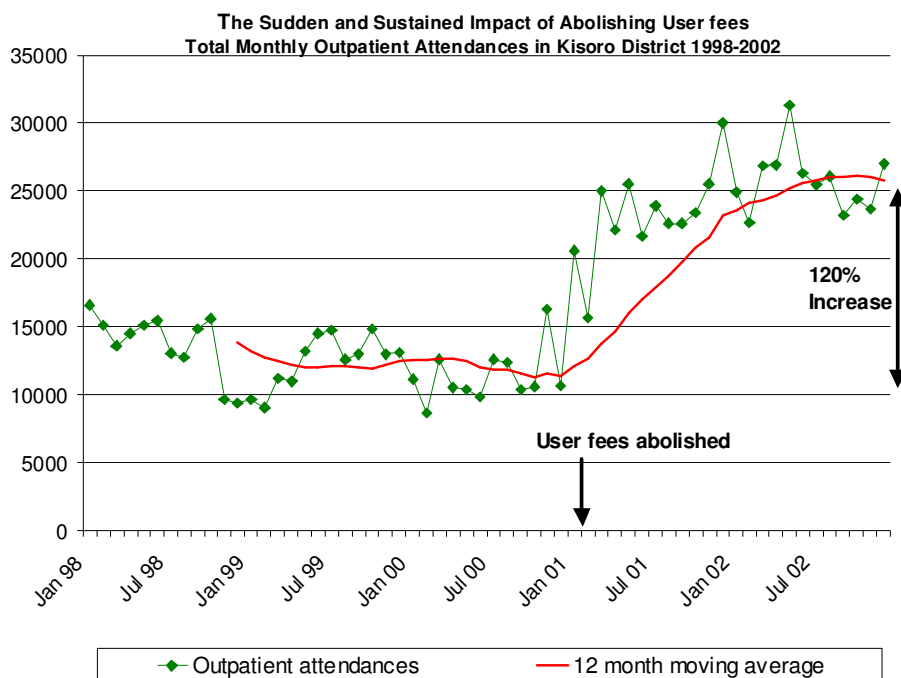


Figure 1: Impact of Abolition of user fees on outpatient attendances

However, the Midterm Review also identified the following issues as being the biggest challenges to the successful implementation of the HSSP:

- Inadequate funding
- Absence of clear prioritisation within the UNMHCP
- Shortage of trained health personnel
- Inadequate network of functional health infrastructure
- Serious shortages in drug supplies, and continued under-funding of drugs (at US\$1.2 per capita per year, it is 1/3rd of international targets for drug expenditure)
- Bottlenecks in implementation of HSSP activities, due to delays in central support systems (approval of release of funds, procurement, unclear lines of communication) and unclear linkages between district health systems and higher levels).

The MTR also raised an issue about assuring effective delivery of the minimum package, without reintroducing verticality. It described one constraint as that some MoH programmes were not able to separate the roles of facilitator (appropriate to the national level) and implementer (appropriate to the district level) and therefore continued to undertake activities that rightfully belonged to the district or health sub-district levels. Resources provided by the Global Fund to Fight AIDS, TB and Malaria (GFATM) and GAVI were seen as exacerbating the problem by encouraging the maintenance of vertical delivery systems. The disease programmes examined in this study have traditionally been managed in a vertical way.

The private sector (Private for Profit and Private Not for Profit Practitioners and Traditional Medical Practitioners) already plays a very significant role in health care in Uganda. Strengthening collaboration and partnership between the public and private sector in health to accelerate health care coverage is a key principle of the National Health Policy. Within this context, the Italian Cooperation (IC) supports an extension of the Department of Planning of the MoH in the facilitation of the development of

Public-Private Partnerships in Uganda. GoU financial support to this sub-sector increased from UG Shs. 1.0 billion in FY 1997/98 to UG Shs. 16.5 billion in FY 2002/03. A Policy on Private Public Partnerships in health has been formulated and is awaiting approval.

2.3 Health Situation

Main health indicators can be found in the table below.

Key health indices	Uganda	Source
% infants exclusively breast fed at 4 months old	74.8%	DHS 2000/01
Immunisation rate (% 12-23 month fully immunised against DPT)	83%	WHO/global Summary 2003 MOH AHSPR 2003/04***
Stunting prevalence	39.1%	DHS 2000/01
Underweight prevalence	22.8%	DHS 2000/01
Wasting prevalence	4.1%	DHS 2000/01
Child diarrhoeal disease incidence	53.1%	DHS 2000/01
Acute respiratory infection incidence	64.7%	DHS 2000/01
Malaria cases per 100,000 (incidence)	46/100,000	WHO/RBM 2004
Malaria as % of outpatient visits	52%	MoH 2003
Malaria – attributed contribution to U5 mortality	20-23%	MoH 2003
HIV prevalence (% of adults) – females 15-24	6-7%	MoH 2003
Tuberculosis estimated number of cases	77,853	WHO/TB Control Report 2003
Leprosy prevalence	0.42 / 10,000	MoH 2003
% deliveries attended by skilled personnel	39%**	DHS 2000/01
Access to safe water (% households)	46 % Rural 72% Urban	WB/WDI 2001
Health Services		
Health service utilisation rate	0.79contacts/year/person	MoH AHSPR 2003/04
Number of Peripheral Health Units *	250	MoH website, 2004
Number of District Hospitals *	104	MoH website, 2004
Number of Tertiary Hospitals *	2	MoH website, 2004

* Under the SWAp, these include government NGO and private facilities.

** However, there has been a consistent reduction in the number of mothers delivering in public and PNFP units, from 25 % in 1999/00 to 19% in 2001/02¹⁷

*** AHSPR: Annual Health Sector Performance Report

The Burden of Disease Study of 1995 indicated that communicable disease contributed more than 65% of the national disease burden. Among the numerous communicable diseases in Uganda, the HSSP focuses on malaria, HIV/AIDS and TB as indicated by their contribution to the national disease burden.

The government's goal is to reduce the HIV prevalence rate to 5% by 2005¹⁸. Reports from the MoH^{19 20}, state that HIV/AIDS prevalence in Uganda has been

¹⁷ MOFPED (2003) Uganda Poverty Status Report. Kampala: MOFPED

¹⁸ MOFPED (2001) Poverty Eradication Action Plan (2001-2003). Kampala: MFPEd

¹⁹ MoH (2003) Midterm review report on Health Sector Strategic Plan.

²⁰ MoH (2002) AIDS Control Programme

declining over the last decade and has been stabilised between 6-7 %. However, a study published recently by a Ugandan NGO²¹ shows that Uganda's prevalence rate is as high as 17%. It is estimated that there have been about 900,000 HIV/AIDS related deaths since the beginning of the epidemic in Uganda²².

Malaria is the most important public health problem in Uganda. Malaria is the leading cause of morbidity and mortality and is responsible for up to 40% of outpatient visits, 25% of inpatient visits and 14% of inpatient deaths²³. The burden of malaria is greatest among under 5 year olds and pregnant women due to their limited immunity to the disease.

Not much information is available with regards to diseases which have been targeted for eradication / elimination. The table below provides some basic information on these diseases in Uganda.

Disease	Incidence	Prevalence	
Leprosy	1,900 new cases during 2003/04	0.42/10,000	Elimination target achieved at national level in 1994 and maintained
Lymphatic Filariasis	Endemic in 20 districts		MOH mapping exercise 2003
Onchocerciasis			Estimated 2 million people concentrated in 22 districts at risk
Sleeping sickness		400 cases / year	In 2003, 90% of Soroti District health centre admissions are suspected sleeping sickness cases

2.4 Funding for the health sector

In 1998 the Government of Uganda was granted debt relief from donor countries and multilateral agencies under the Highly Indebted Poor Countries (HIPC) initiative, allowing a 20% reduction in its debt stock, which would save US\$120 million over the next three years²⁴. The Poverty Eradication Action Plan (PEAP), published in 1997, is the backbone of the government's poverty reduction policy. This is nested within the Medium Term Expenditure Framework (MTEF) and more recently also in the LTEF. The MTEF has enabled the government to redirect its resources toward the policy priorities specified in the PEAP, so that resources to the social sectors now account for around 35% of the budget.

In 1998, the Poverty Action Fund was set up to mobilize and channel additional funds towards the key sectors. Currently, an estimated 35% of total GoU budget is devoted to spending through the PAF, which is protected from budget cuts up to 90%. In 2001, 13% of PAF funds were used to finance the HSSP, which amounted to 24% of HSSP funding. Funding for the HSSP comes from a range of sources. Figure 2²⁵ provides an overview of the funding of the HSSP in the overall financial context.

²¹ BBC News, 21 September 2004; The Guardian, 23 September 2004

²² MoH (2004) Health Sector Strategic Plan II – 2005/6 – 2009/2020. 1st draft June 2004

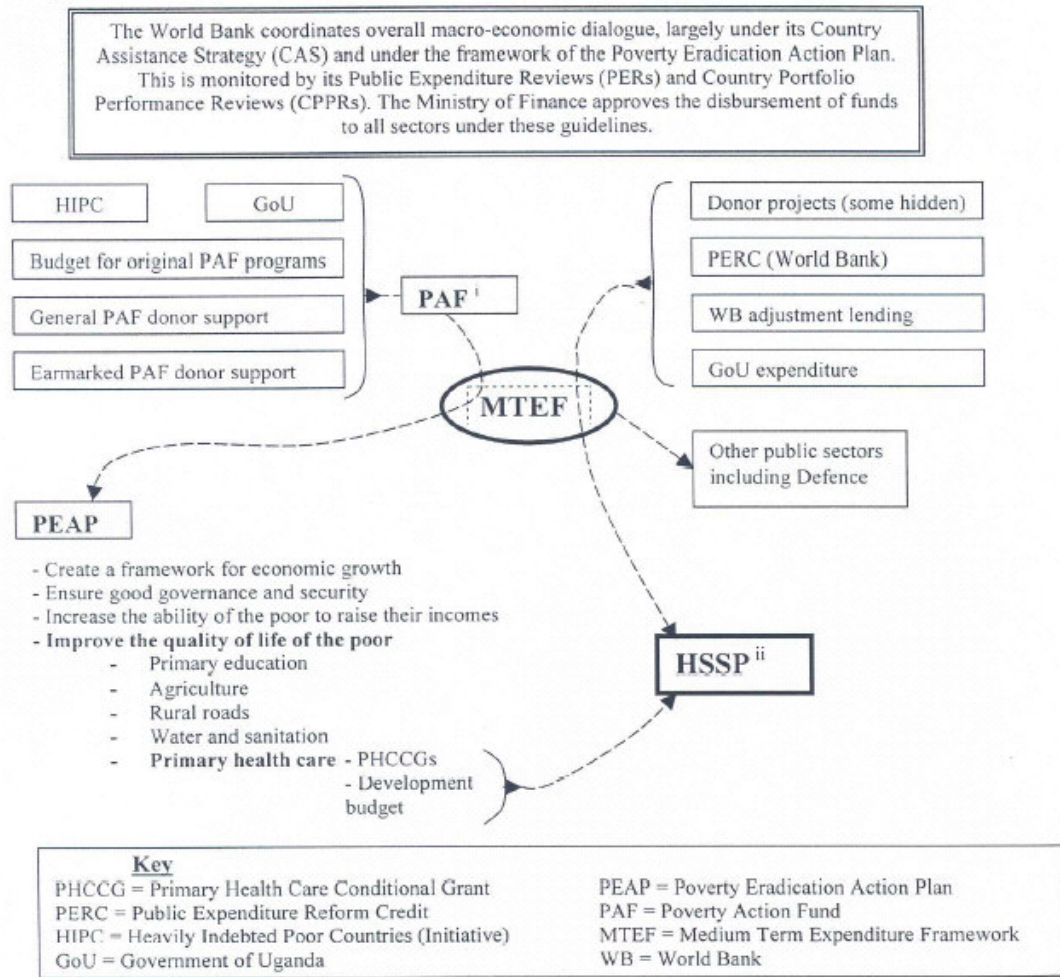
²³ Root et al. (2003) Roll Back Malaria Scoping Study (Malaria Consortium)

²⁴ Tumusiime-Mutebile, E. (1999) Making Partnerships work on the ground. Experience in Uganda.

Kampala: Ministry of Finance Planning and Economic Development

²⁵ Hamilton D (2001) Relationship between Global Health Initiatives and the sector-wide approach to health systems development in Uganda – a case study (MSc Thesis for Community Health, Dublin)

Figure 2. Funding of the HSSP in the overall financial context.

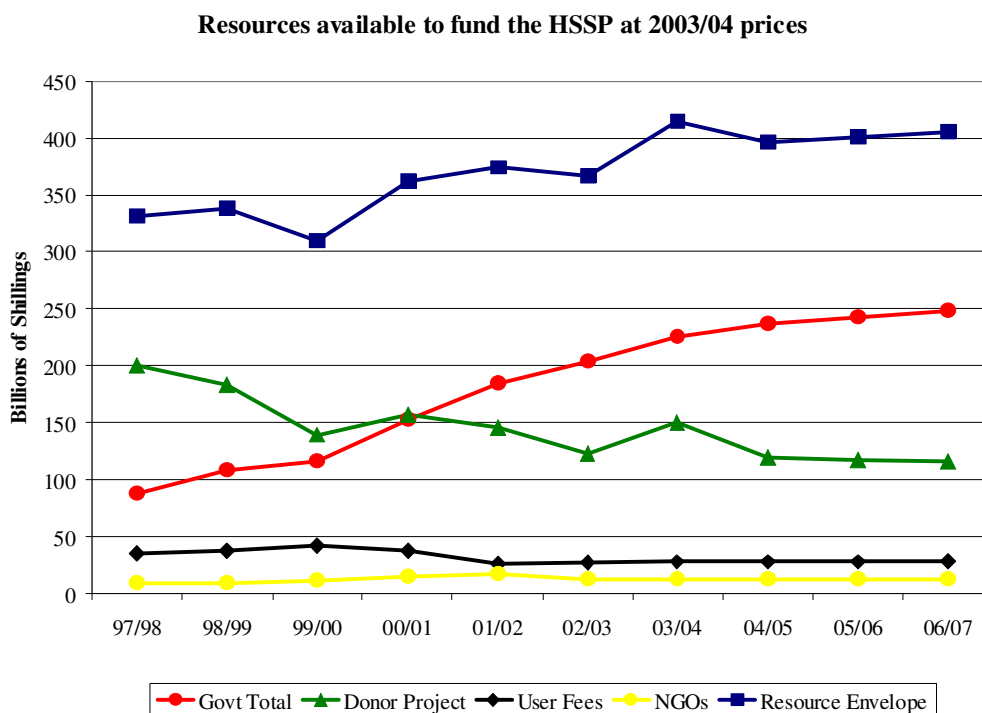


The National Health Policy was prepared within the framework of the PEAP, and its strategy is to shift health care resources in favour of rural areas, to emphasise primary health care and to bring services closer to the people. As a result, the proportion of the overall sector budget directly allocated for district services, (including not for profit providers), has increased from 32% in 1999/2000 to 54% in 2003/04 at the expense of the central MOH and referral hospitals.

Despite Health sector budget increase of an average of 9% per annum over the last three years, there is still a significant mismatch in the funding requirements of the HSSP (US\$28 per capita, excluding the cost of ARVs and the pentavalent vaccine) and the available resources (US\$9 per capita excluding donor projects and 12.6% including projects). However, an important feature of the SWAp is that alternative mechanisms of donor funding are accepted, including general budget support, earmarked sector support, Technical Assistance and projects funded directly by donors, thus ensuring continuing active participation of all the major Development Partners in the SWAp process.

Figure 3 illustrates this gap in total available resources in terms of the financing gap.

Figure 3: Comparison of finances available and estimated cost of HSSP at 2003/4 prices



While the Directorate of Planning and the Policy of the HSSP aims to actively encourage budget support over financing through project mechanisms as the more efficient financing mechanism, the Ministry of Finance’s explicit policy aims to keep public health expenditure within MTEF ceilings determined by macroeconomic stability considerations, which essentially leaves very limited ability to adjust the ceilings upwards. As new and additional funding became available (including the World Bank MAP, GAVI, GFATM and PEPFAR), this rigid fiscal policy has left little option, even if they could be allocated through PAF, other than for these initiatives to be established as projects, albeit within the SWAp and the HSSP.

However, funding through projects has now been brought into the MTEF ceilings for the current financial year 2004/5. The ceiling was adjusted upwards to accommodate current projects, including Rounds 1 and 2 of the GFATM, but the status of Rounds 3 and 4 awards are unknown. The issue of additionality of any new funding, whether that be GoU, GHP or bilateral or UN project support, is now the key issue to be negotiated. Similarly, it is unclear how the US President’s Emergency Plan for HIV/AIDS Relief (PEPFAR) will be accommodated. The MoFPED states as their main concern that of macroeconomic stability due to the effect of these relatively large amounts of funding passing through the Government budgetary process, leading to possible inflationary effects on the economy. There is also concern that insufficient attention is being paid by the new financing mechanisms to direct financing of the private sector.

2.5 SWAP mechanisms for decision making and monitoring and implementation

A series of committees guide the SWAp process and aim to ensure accountability and transparency. The Health Policy Advisory Committee (HPAC), that consists of representatives from the MoH and other Ministries, bilateral donor agencies, and medical bureaux, meets once monthly and acts as the steering committee for the health sector development process, and is the key structure for operationalising the SWAp. It generates consensus of stakeholders, reviews and endorses reports, and provides strategic support and guidance. There is a range of other groups and committees feeding into HPAC that are key to co-ordination, policy development, monitoring and evaluation (appendix 4 provides an overview).

Since the beginning of the sector-wide approach in the health sector, Joint Review Missions (JRMs) have proven to be important events in which donors and development partners come together, progress in the health sector is reported, key areas are reviewed, and undertakings agreed for the next 6 month period (until the next JRM). More recently, the JRM is held annually, in October, immediately following the National Health Assembly.

The HSSP is built on an extensive range of log frames, which detail targets, verifiable indicators and means of verification for each output. These were jointly developed by GoU and development partners. The MoU²⁶ stipulated that once a year an Annual Health Sector Performance Report be published summarizing progress made against the defined targets.

²⁶ Memorandum of Understanding (2000) between The Government of Uganda and the African Development Bank, Austrian Agency for International Development, The Belgian Directorate-General for International Cooperation, Danish International Development Assistance, The Commission of the European Union, Ireland Aid, Department for International Development of the United Kingdom, French Cooperation, German Development Cooperation, International development Association – World Bank, Italian Cooperation, Japanese International Cooperation, Netherlands Cooperation, Norwegian Agency for International Development.

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3. FINDINGS: GLOBAL HEALTH PARTNERSHIPS IN UGANDA

3.1 Introduction

This section will briefly clarify terminology and scope of the study. Section 3.2. will provide information about the GHPs whose primary purpose is financing and GHPs whose primary purpose is technical and services. Subsequently, section 3.3 will provide information about the proliferation of and interaction between major HIV/AIDS initiatives, including the GFATM, MAP 1+2 and PEPFAR.

Perceptions of Global Health Partnerships in Uganda

With the exception of some high officials in the central Ministry of Health in Kampala, most interviewees confused the concept of Global Health Partnerships with any big bi- or multilateral health initiative. This is perhaps understandable given that a GHP at the country level is different from that at the global level. At country level GHPs are more about implementation and technical assistance rather than global policy development, resourcing and/or product development.

Scope of the study

As can be observed from the table below, there are 17 GHPs in operation in Uganda. Given the short time frame of 11 days in-country, we were unable to interview stakeholders involved in all 18 GHPS. The study therefore focused on the three key diseases in Uganda, i.e. malaria, TB and HIV/AIDS, but also included a number of diseases targeted for eradication or elimination such as leprosy, lymphatic filariasis and sleeping sickness. However, the two GHPs in Uganda whose primary purpose is product discovery and development, IAVI and MIM, are not included in this study as we were unable to meet with the relevant stakeholders.

Given the proliferation of HIV/AIDS initiatives in Uganda, the study also looked into the relationship between these initiatives and their links with country based partners.

GHPs in Uganda according to typology

The table below lists the GHPs operating in Uganda and indicates the primary and secondary roles of the Partnership as found at country level. From the table below, it can be observed that the primary purpose of most GHPs operating in Uganda fall either in the 'Access, Systems strengthening and Donation' or the 'Financing' categories.

GHPs operating in Uganda

9.7 GHP	Research and development	National Advocacy	Financing	Technical service donations and discounted products	support, delivery, and
APOC		S	S		P
DPP					P
GAEL		S			P
GAELF		S			P
GAVI		S	P		S
GFATM			P		S
GPEI		S	S		P
GWEP		S	P		S
IAVI	P	S			
IPAAA		P			
MIM	P	S			
MTCTPlus		S			P
NETMARK-PLUS		S			P
RBM		P			S
SCI		S	P		S
Stop TB		S			P
VDP					P
WPSS		S			P

P=Primary Role S=Secondary Role

3.2 Financing Global Health Partnerships

In this section, the Global Fund for AIDS, TB and Malaria and GAVI will be discussed.

3.2.1 GFATM

Scope of the programme

Uganda has been successful in all four rounds of the GFATM, with an overall approval of US\$201m, of which only US\$18.6m have been disbursed. The table below summarises the current status^{27,28}.

²⁷ GFATM website summary

²⁸ Project Management Unit for the Uganda Global Fund to Fight AIDS, TB and Malaria Project (2004) Progress Report January – June 2004

Status of GFATM proposals

(US\$ millions)	HIV		Malaria		TB	Total
	R1	R3	R2	R4	R2	
Requested	51.9	118.6	35.8	158.0	5.7	370
Approved	36.3	70.4	23.2	66.4	4.7	201
signed grant agreement	6 Mar 03	Approved but not signed	27 Feb 04	Approved but not signed	15 Mar 04	
Disbursed	13.6	0	3.9	0	1.2	18.6

The proposals for rounds 1 and two were designed to support scaling up of the national responses to HIV/AIDS, Malaria and TB. The round 3 proposal is aimed at scaling up ART and support for Orphans and Vulnerable Children (OVCs). When funding was approved for this, Uganda became the first country to achieve funding for OVCs.

Fit with health sector

The various GFATM proposals are in line with the Government's PEAP and the National Health Sector Strategic Plan I (2000/01 -2004/5) (HSSP I) and the National Health Sector Plan II²⁹, which MoH started drafting with the assistance of all key stakeholders involved in the health SWAp at the end of 2003. The HSSP II clearly sets out that the reduction of the burden of HIV/AIDS, Malaria and Tuberculosis is one of its three Programme Areas. The OVC component of the second HIV/AIDS proposal to the GFATM (3rd round) fits with the social sector rather than the health sector. MOFPED / MoH will need to consider which agencies will be implementing this component.

Although the activities funded by the Global Fund are in line with the HSSP and the national disease control programmes, the way in which the Ugandan Global Fund Project has been set up within the MoH has meant that it runs as an independent entity rather than an integrated part of the MoH. This is mainly due to factors related to the GF 'additionality' clause. Firstly, during the first round of proposals, the Fund asked Uganda to resubmit its integrated programme for combating Malaria, TB and HIV/AIDS into three separate disease proposals for Malaria, TB and HIV/AIDS to be financed as projects³⁰. The Ugandan Government had originally submitted a proposal to fund these proposals using budgetary support for the health SWAp. Secondly, the Government opted for "projectising" GFATM support to complying with the additionality clause that was posed by the Fund, as up to then "projects" were not strictly displacing regular budget funds.

As a result, a separate Global Fund Project Management Unit (PMU) was created under MoH which has led to the creation of parallel structures which operate alongside the MoH disease control programme structures for these diseases. The Ugandan Global Fund for AIDS, TB and Malaria (UGFATM) as it is called, thus

²⁹ MoH (2004) Health Sector Strategic Plan II (June 2004 – 1st draft)

³⁰ Mokoya, P. and Sohani, S. (2002) Global Fund – Country Case Study: Uganda. London: DFID HSRC

appears to operate independently from MoH (see governance section for more information). For example, the PMU requires the MoH national disease programmes at both national and district levels to submit separate workplans to the Unit to be considered for funding. This leads to extra transaction costs both at central and district levels as they already have their own MoH workplans. The Unit's own progress report states that: "... it coordinates development of work plans to be funded by the (UGFATM) project and manages the activities of all recipients"³¹. The Unit has set up its own staffing (20 members of staff at present), Procurement Facility and a parallel transport system as opposed to using a more integrated approach and making use of existing MoH resources and structures. The PMU will also soon move out of the MoH buildings into separate rented accommodation.

The above indicates that particularly during the first round, the Global Fund was "reverticalising" the health system and forcing it to a disease specific approach as well as not taking into account Uganda's SWAp process and preference for budget support, that is currently used by eight bilateral Development Partners (as well as the WB), many of whom also provide financial support to the GFATM. This does not fit well with the overall policy objective of the Ugandan SWAp which is: "To provide an enabling environment that would allow for effective co-ordination of efforts among all partners in Uganda's national health development, increase efficiency in resource application, achieve equity in the distribution of available resources for health and effective access by all Ugandans to essential health care"³². Swaps have been strongly promoted as a mechanism for reducing fragmentation and duplication of assistance to developing countries through pooling of donor funds, strengthening country coordination of policy making and planning, and agreed systems for monitoring funds and health sector activities³³

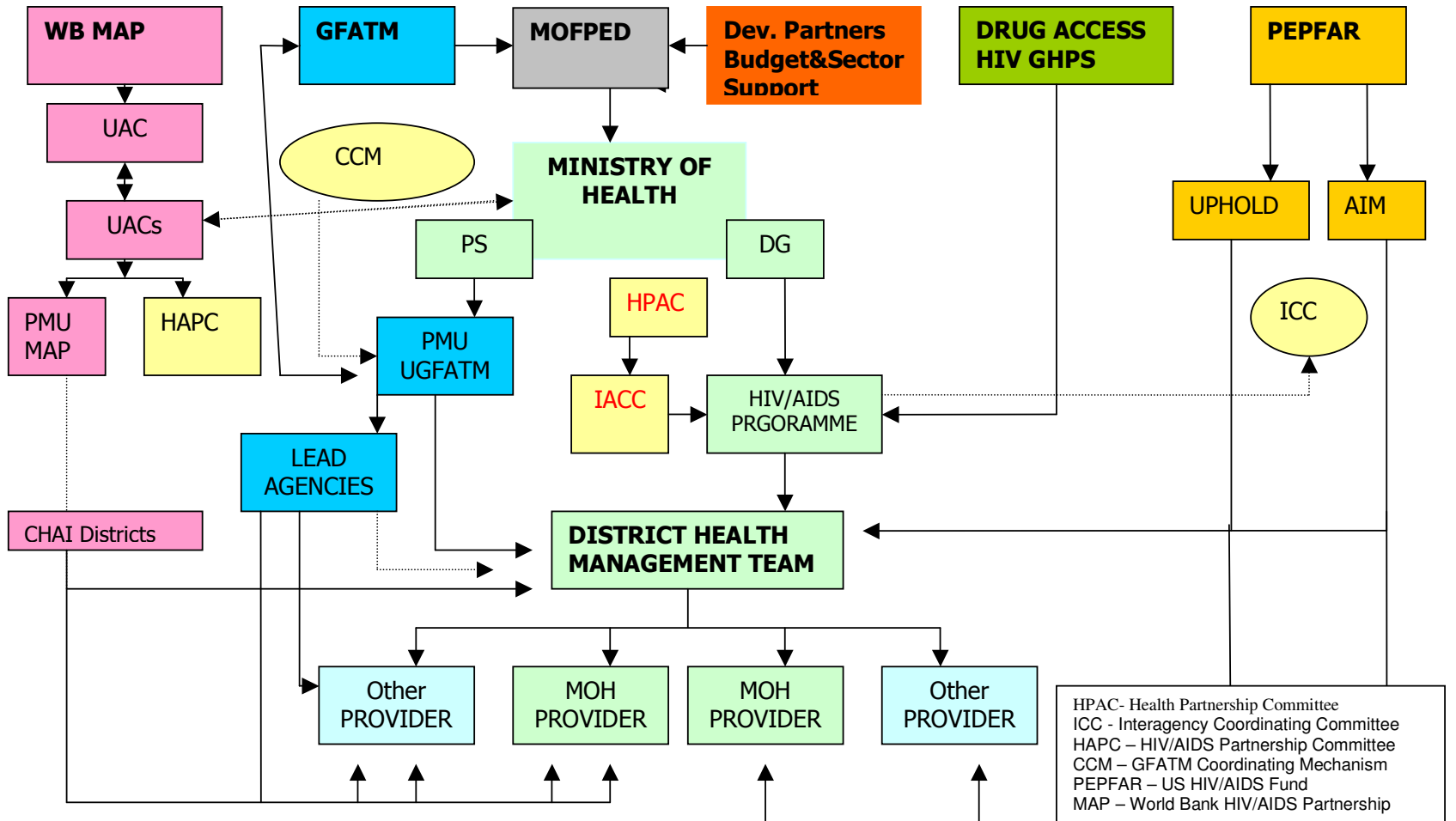
Various interviewees mentioned other new global HIV/AIDS financing initiatives, which they saw as overlapping with the Global Fund as creating coordination problems. These included the World Bank Multi-sectoral AIDS Programme (MAP) and the US President's Initiative (PEPFAR: US\$70m over the next 3 years). Interviewees not only reported the burden on government and other key stakeholders in negotiating with these initiatives but also the lack of co-ordination between the various initiatives, leading to a fragmented approach towards scaling up successful activities. The diagram on the page overleaf provides an overview of the various HIV/AIDS initiatives, where they are based and the (lack of) links between them.

▪ ³¹ UGFATM (2004) Progress Report: January – June 2004

▪ ³² MoH (1999) National Health Policy

▪ ³³ Cassels A and Janovsky K. Better health in developing countries: are sector wide approaches the way of the future. *Lancet* 1998; 352: 1777-79

Institutional arrangements of major HIV/AIDS Initiatives in Uganda



Governance

The Ministry of Finance Planning and Economic Development (MOFPED) is the Principal Recipient (PR) for all five proposals. The MOFPED has delegated the implementation functions to the Ministry of Health. In December 2003, a Project Management Unit (PMU) set up under MoH to provide overall co-ordination of project implementation. In its progress report, the PMU describes its remit as follows:

- Responsible for all aspects of project management and implementation;
- To coordinate development of work plans to be funded by the project and manage the activities of all recipients;
- To co-ordinate sub-awards to public and non-government implementers, including lead agencies, and to oversee their performance.

The LFA is Price Waterhouse Coopers (PWC).

The Country Coordinating Mechanism (CCM) was established in 2002 in order to develop the round 1 proposal. Since the CCM was meant to represent the 3 focal diseases, none of the existing programme Interagency Coordinating Committees (ICC) or the Uganda AIDS Commission (UAC) were considered appropriate for the role, although the guidelines for the CCM stated a preference for the CCM to be 'an already existing body'. The Chair of the CCM is the Director General of the MoH.

However, the links between the PMU and the CCM are unclear as both parties hold different views. The PMU sees itself as reporting directly to the MoH PS and MOFPED, the latter as the Principal Recipient with the CCM having links with the Inter-Ministerial Council (IMC) and the MOFPED. Conversely, CCM members interviewed see their role as overseeing implementation of programmes / projects funded by GFATM, overseeing the PMU, ensuring transparency and being part of strategic decisions such as selection of lead agencies, revisions of existing proposals, procurement procedures etc.³⁴ CCM members expressed deep concern about the apparent autonomy of the PMU and the lack of transparent governance. There appears to be disagreement about the frequency of CCM meetings, with CCM members aiming for one meeting per month and the PMU finding this much too frequent.

As a result of the lack of apparent links, CCM members interviewed said they had little idea about what the PMU was up to and what the status was of some of the proposals submitted to the GF. They were concerned about a number of issues which had come to their attention, including:

- Significant revisions in the latest malaria proposal;
- Change in lead agency mechanism, whereby PMU had apparently appointed direct implementers;
- Change in procurement procedures, such as abolition of third party procurement agency.

It appears that the PMU has on its own initiative changed some of the key elements of the GFATM proposal as submitted to the GFATM. Most interviewees agreed that the proposals submitted to the GFATM were written in a participatory way. This is confirmed by a country case study conducted in Uganda on GFATM proposals³⁵. The proposals in Uganda are based on funding gaps in the HSSP and scaling up of existing successful activities by the various SWAp stakeholders, including non-state providers. Various CCM members interviewed stated that GFATM proposals were

▪ ³⁴ CCM Uganda (2004) Revised Draft of the CCM / GFATM Operating Procedures Manual

▪ ³⁵ Mokaya P and Sohani S (2002) Global Fund – Country Case Study: Uganda. London: DFID HSRC

based on concrete proposals submitted to the CCM by various stakeholders and that lead agencies were selected for the co-ordination and implementation of the various components of the GFATM proposals for when funding would be received from the Global Fund.

However, it was reported that the PMU has decided to start the proposal process again, particularly for non-state providers. A call for Expressions of Interest from candidate organizations wishing to enlist as Lead Agencies was issued in February 2004. A number of organizations were 'pre-qualified' by the PMU as Lead Agencies and subsequently approved by the Contracts Committee (of the MoH)³⁶. Subsequently, lead agencies were asked to submit proposals for funding to the PMU by May 3rd, 2004. Organisations who did not meet the deadline were excluded; these were UNASO, GOAL and ACTION AID. A Technical Review Panel was set up by PMU and approved by MoH Contracts Committee, to evaluate the Lead Agencies' proposals. The PMU argues that it had to go through the above described process as the GFATM did not approve all of the funds requested. However, the CCM has not been aware of most of the above, as can be noted from their concerns outlined above. It also appears that the PMU does a fair bit of negotiating with the Secretariat of the GFATM in Geneva without informing the CCM and vice versa.

There is also lack of clarity about the links between the PMU and the MoH decision making and monitoring bodies operational under the health SWAp, such as the Health Policy Advisory Committee (HPAC) and the MoH Working Groups. On the operational level, it is also unclear what the links are between the CCM Technical Working Groups and MoH Working Groups. It appears that the same people are participating in the various working groups, which leads to increased transaction costs.

Financing

Although the GFATM has approved five proposals from Uganda totalling US\$201 million, there has been a significant lag between approval, signing of the grant agreements and disbursement of approved funding. In July 2004, only US\$18 million had been received by Uganda. This is distributed as follows: US\$13.6 million for HIV/AIDS; US\$ 3.8 million for Malaria and US\$1.2 million for TB. Interviewees reported frustration as expectations had been raised that funding would be in place quickly after the establishment of the Global Fund. The proposals submitted by Uganda have focused on funding gaps in the existing national plans for HIV/AIDS, Malaria and TB, and therefore have not directly caused any major impact on existing services for these diseases. However, in a recent Technical Working Group meeting, the PHA Forum expressed their concern that: "the Global Fund was not implemented in a timely manner in Uganda, hence people are continuing to die when treatment could be made available to many more than currently the case".

The severe delays in disbursements of GFATM funds appear to be linked with the issue of 'additionality'. GFATM funds are intended to be additional to existing levels of financing, particularly that of the GoU and not merely replace current flows.

As described in section 2.4., funding through projects has been brought into the MTEF ceilings for the current financial year 2004/5. According to the MOFPED, the ceiling was adjusted upwards to accommodate current projects, including Rounds 1 and 2 of the GFATM, but the status of the Round 3 and 4 awards are unknown. The

▪ ³⁶ UGFATM PMU (2004) Progress report: January – July 2004.

issue of additionality of any new funding, including GFATM funds for Rounds 3 and 4, will need to be negotiated.

However, the issue of additionality remains unclear. Various MoH interviewees said independently from one another that the overall MoH operational budgets for disease control had been cut for 2004/05 (fiscal year runs from July 1st to June 30th) in comparison with 2003/05 due to the arrival of GFATM funds within the MTEF ceiling. This contradicts MOFPED statements that the ceiling had been raised to allow the GFATM funds. One MoH interviewee went as far as to say that his/her department's budget had been reduced by 23% for 2004/05. The team was unable to confirm these statements by MoH officials from the financial department or in any written documentation.

At the operational level, various CCM members expressed their concern about the disconnect between CCM and the PMU. This included concerns about adjustments made by PMU on lead agencies and appointment of direct implementers. CCM members explained that they had little insight in UGFATM finances and disbursements made to lead agencies and beneficiaries. At district level, MoH keeps separate account for UGFATM funds and reports according to project activities and expenditure to the UFGATM. District Health Teams also stated that not all activities in the workplans submitted to the UGFATM are funded, without much explanation given for this.

Two other large HIV/AIDS funding initiatives set up as projects are PEPFAR and the WB MAP projects. The WB MAP project is linked to the Ugandan Aids Commission but with funding for the MoH Districts. MAP I funding totalled US\$50 million (2000/1 – 2005/6), which includes a GoU counterpart contribution of about US\$1.39 million³⁷. PEPFAR operates as a project under the auspices of the US Ambassador. Although the total amount is estimated to be around US\$70 million over three years, the implementation strategy has been to scale up existing USAID projects in the first instance, which makes it less clear how much additional funding has been made available and the time period involved.

Poverty and Gender

We found no evidence that Poverty and Gender are specifically addressed by GFATM projects. However, MoH and non-state providers work jointly under the SWAp and by extension the PEAP. The National Health Policy puts emphasis on special consideration for the welfare of the poor and vulnerable and on mainstreaming gender considerations. The new (draft) Health Sector Strategic Plan II lists this as one of its Guiding Principles. Central MoH has also provided guidance for the Districts on how to mainstream gender into all MoH programmes and requested the districts to design activities to address gaps in gender disparities.

The MoH has also increased funding to facilities owned/managed by Faith Based PNFPs, with the particular objective to improving access to the poor. In addition, MoH has increased funding to the Districts in poorer parts of Uganda. For example for the year 2004-05, it is projected that Pader district in northern Uganda will receive 50% more per capita funding than Kampala district in central Uganda³⁸. The second Participatory Poverty Assessment found that the abolition of cost-sharing had

▪ ³⁷ Adupa et al. (2004) Draft synthesis report on midterm review of Uganda HIV/AIDS control project

▪ ³⁸ MoH (2004) Financing Health Services in Uganda 1998 – 2001- National health Accounts

significantly increased utilization of government health services, particularly by the poor³⁹.

Commodities

It is too early to assess the impact of additional finance on commodity prices. As stated above, according to its latest progress report, the UGFATM has received US\$18 million so far. It is understood that no drugs have yet been procured by the project as its Procurement Plan has not yet been approved by the Global Fund.

3.2.2 GAVI

Scope of the programme

GAVI support to Uganda is US\$ 87,445,500 for the period 2001 – 2005⁴⁰. The project includes the following components:

- Support Funds to strengthen the system and increase coverage
- Injection safety materials: auto-disable syringes
- Addition of two antigens:
 - Hepatitis B (Hep B)
 - Haemophilus Influenza type B (Hib)
 - Using Pentavalent presentation (DPT-HepB + Hib)

The proposals were submitted to GAVI by the Interagency Coordinating Committee for Immunisation (monitored by HPAC and MoH), which includes 17 representatives from development partners, UN organizations, Religious Medical Bureaus and other agencies such as the Ugandan Red Cross. Besides providing immunization services in its own health facilities, MoH also contracts not for profit providers to undertake immunization in areas where MoH does not have infrastructure in place.

Since the inception of the SWAp and the decentralization of health services, coverage with all the antigens has increased, with DPT3 coverage rate of 70% (2002) exceeding the revised national target of 60% set for the end of the entire HSSP period⁴¹. The new vaccines Hep B and Hib were successfully introduced together with the autodestruct syringes. However, stockout of the pentavalent vaccine happened in 2003 for a period of several months and the country had to revert to its traditional vaccination scheme. This was partly due to the fact that improved performance was exceeding the planned targets and the actual wastage rate being higher than the pre-set 5% but also due to reduced availability on the global market.

UNICEF handles the procurement of vaccines and safety injection related materials for EPI and GAVI. WHO / UNICEF and MoH have monthly planning meetings to forecast the vaccines needed.

▪ ³⁹ MOFPED (2002) Deepening the understanding of poverty – Ugandan Participatory Poverty Assessment Report.

▪ ⁴⁰ GAVI website http://www.vaccinealliance.org/home/Support_to_Country/Country_Status/index.php

▪ ⁴¹ MoH (2003) Midterm Review Report on the Health Sector Strategic Plan

Fit with the health sector

The Health Sector Strategic Plan I (2000/01-2004/05) outlines that the Uganda National Expanded Programme on Immunisation (UNEPI) will provide immunization against the following 6 diseases: measles, poliomyelitis, whooping cough, tetanus, tuberculosis and diphtheria. These will be delivered as part of the Essential Health Care Package. Although the HSS Plan states additional vaccines such as Yellow Fever and Hepatitis B may be introduced, there is no mention of the Hib vaccine. Two interviewees external to MoH queried the appropriateness of the Hib vaccine in Uganda, particularly in view of the large funding deficit of activities that *are* part of the Minimum Health Care Package. In addition, various interviewees mentioned that the pentavalent vaccine is too expensive for MoH to sustain coverage beyond GAVI funding. The funding issue is further discussed under the finance section below.

However, overall, MoH officials are happy with GAVI, both at national and district level, as the programme has brought much needed extra resources for EPI training, vaccines and injection safety related materials.

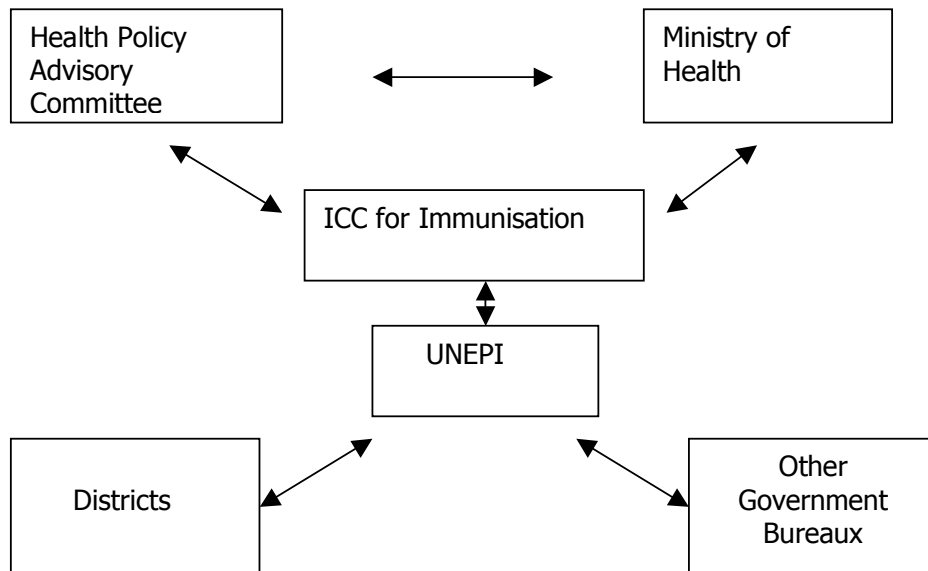
MoH needs to provide separate reports to GAVI on expenditure and coverage. At district level, the District Health Teams interviewed also explained that they have separate bank accounts for GAVI money and they are required to submit separate reports on activities funded under GAVI.

Governance

The MoH is responsible for implementation of the GAVI project in Uganda. As such the GAVI programme is under direct control of central MoH and is part of the SWAp. As such it is monitored by the Health Policy Advisory Committee (with representation from UN organisations, DPs and religious medical bureau) and the ICC for Immunisation which reports to HPAC. During the 12th GAVI Board meeting it was noted that the SWAp mechanism had increased transparency and trust among stakeholders⁴².

▪ ⁴² GAVI (2003) Addressing Health Systems Barriers to Immunization. 12th GAVI Board Meeting, Geneva

Please see diagram below for the governance and functional relationships of the ICC.



Financing

As stated above, GAVI has committed US\$87,445,500 for a period of five years. Funding is distributed over the key programme components as follows:

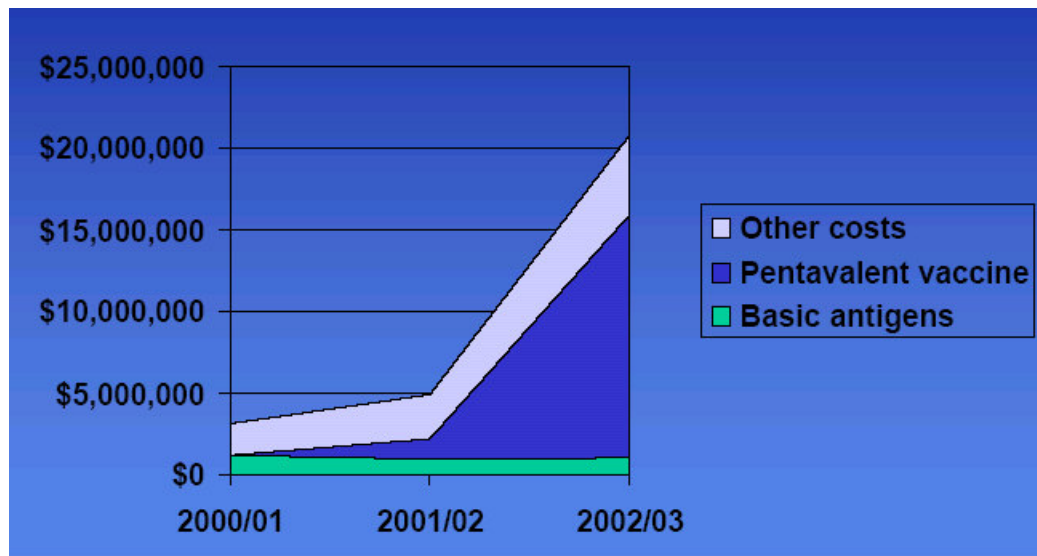
5 year immunisation services support:	\$11,974,500
3 year injection safety support	\$ 1,338,000
5 year new & underused vaccine support	\$74,213,000
Other support	\$ 100,000

GAVI provides financial awards to countries for extra immunized children (higher than the established targets). In this context Uganda has received \$4.2 million of which 80% was spent in the districts for maintenance on cold chain, outreach etc. It was reported that these funds had not been captured in the ceiling as they were directly deposited in the district accounts for GAVI.

Before GAVI funding the total cost of the national routine immunization programme amounted to US\$4.5 million for the fiscal year 2000/01. In the first year of GAVI funding (fiscal year 2001-02), which included 1 month of pentavalent vaccine, the cost for the immunization programme was \$6.4 million. In the following fiscal year, the first full year with pentavalent vaccine, the cost of the programme had risen to \$21.2 million⁴³. The Government contribution only slightly increased between 2000/01 and 2002/03 and funding from other sources slightly decreased during the same period. However, the Government has continued to meeting the full cost of the traditional vaccines. Figure 4 demonstrates the cost of the immunization programme over the period 2001-2003.

⁴³ Natasha His / PHRplus (2003) Financial impact of new vaccine introduction in Uganda

Figure 4 Cost of immunisation programme 2001 – 2003



Source: PHRplus 2003

A PHRplus study on the financial impact of the new vaccine introduction in Uganda showed that in 2003 the cost of the pentavalent vaccine as a proportion of GoU health budget was around 17%, but only 2% of the health budget was allocated to this.

The study identified three reasons for the \$15 million funding gap for the current immunization programme in Uganda:

1. Cost of pentavalent vaccine formulation:
 - DPT: 0.09/dose
 - DPT-Hep B: \$1.00/dose
 - DPT-Hep B-Hib: 3.45/dose
2. Population growth of 3.4%
3. Increase in immunization coverage, whereby DPT3 rose from 58% in 2000 to 84% in 2003/04

It should be noted that the increase in immunization coverage should be contributed to a number of factors, including the introduction of the health SWAp and the decentralization of health services with increased immunization points both through expansion of static and outreach service points combined with improved operational funding for health facilities.

The PHRplus study confirms, however, the views of many interviewees that MoH is not able to sustain the cost of the pentavalent vaccine when GAVI funding ends. Uganda will need to assess what is realistic for financial feasibility in Uganda, taking into account the disease burden of Hepatitis B and Hib..

Poverty and gender

As described in the GFATM section of Poverty and Gender, the Ugandan Health System is pro-poor; it undertakes specific efforts to reach the very poor and to address gender inequity. The HSSP places immunisation as a priority of priorities. In 2003/04, DPT3 coverage was 84% and a recent survey in Busoga has established

that the rate of fully immunized children (by card and history) aged 12-23 months to be 71%⁴⁴. MoH is committed to strengthening its outreach programme in order to serve the hard to reach populations.

Commodities

As mentioned above commodities for GAVI are procured and supplied by UNICEF. Other vaccine initiatives such as the Measles Partnership, Neonatal Tetanus and PEI are hosted by WHO. UNICEF receives a 6% overhead fee for its procurement service. Prices for various vaccines and the issues of sustainability have been discussed above.

3.3 National Advocacy Global Health Partnerships

3.3.1 Roll Back Malaria

Scope of the programme and fit with national programme

With the signing of the Abuja Declaration by 44 representatives of the 50 malaria afflicted African countries in 2000, RBM gained a mandate from the highest political level. Among the signatories was HE Yoweri Museveni who made the commitment on behalf of Uganda⁴⁵. The signatories also committed their countries to increase health sector spending to 15% of the overall budget⁴⁶. In addition, a resolution was made to ensure appropriate and sustainable action to strengthen health care systems to ensure that by 2005 intermediary targets were met. The goals and general objectives of RBM- Africa Region are similar to the global ones.

At national level, the Malaria Control Programme, which falls within the Department for National Disease Control of the MoH, provided technical support and policy guidance to the operational level. Guiding principles articulated in the malaria strategic plan derive from both international (RBM) and national (PEAP, HSSP) agenda, and include: equity of access, a poverty and gender awareness; emphasis on country ownership of the entire process; building an strengthening partnerships; contribution to sectoral reform; integration of malaria control activities into primary health care, and other socio-economic development activities⁴⁷

In Uganda there appears to be disappointment with the RBM partnership. Interviewees from the MoH felt the RBM partnership at country level had only recently started to function properly. Various interviewees stated that RBM had not done much at country level and that RBM priorities did not coincide with country priorities. For example with regards to vector control RBM promotes ITNs whereas the national malaria control programme emphasises environmental control measures. It was felt that RBM was a talk shop with little action. The WHO RBM lead in country confirmed that when founded RBM had raised a lot of expectations in Uganda. MoH officials had hoped that RBM would bring extra resources rather than it being limited to its advocacy and technical support roles. Various interviewees also expressed their disappointment about the low level of funding for malaria control

▪ ⁴⁴ Minister of Health (2004) Health Policy Statement 2004/2005.

▪ ⁴⁵ WHO/CDS/RBM (2000) The African Summit on Roll Back Malaria. Abuga 2000

▪ ⁴⁶ quoted in MoH, Budget Framework Paper for the Health sector 2002/3 to 2004/5, p.8

▪ ⁴⁷ MoH (2001) Malaria Control Strategic Plan

measures from Development Partners in comparison with those provided for HIV/AIDS.

On the other hand, however, interviewees external to MoH said that MoH had not seen the value of the ICCM and had therefore not taken a leading role. Various ICCM Working groups were also reported not to be functioning properly and not to be capitalising on the RBM Partnership.

Governance

The RBM partners external to MoH, include 7 bilaterals, 5 multi-laterals and 12 NGOs. The primary mechanism for the co-ordination of RBM partners is that of the Inter Agency Co-ordination Committee on Malaria (ICCM), which in turn is supported by four Working groups for respectively: Case Management/Drug Policy; Vector Control / ITNs; Advocacy / IEC; and Research. As the ICCM is part of the health SWAp, it is overseen by MoH and the Health Policy Advisory Committee in which Development Partners and other key SWAp stakeholders are represented.

It is understood that currently the ICCM meets up once a quarter and that meetings are held at RBM partners' offices by rotation.

Financing

In addition to finance and budget support, there are various projects / programmes that support the National Malaria Control Programme. These include: Technical Assistance by WHO, USAID and Malaria Consortium; National ITN Voucher Scheme by USAID; some system strengthening activities by USAID funded UPHOLD programme; ADB support for home-based malaria treatment in 10 districts; and the GFATM funds of round 2 (see GFATM section).

There was consensus among the interviewees that the National Malaria programme is still under resourced and that drastic measures are needed for Uganda to reach the Abuja targets. GFATM funds will certainly contribute to the National Malaria Control Programme but due to the set up of the UGFATM as a project funds are outside the direct control of MoH and the NMCP. A WHO representative stated that WHO funding for Malaria Control in Uganda had dramatically fallen. Whereas WHO had a budget of US\$2.4 million for the period 2002 – 2004, it will not have a funded workplan any longer since development partners do only provide limited funding.

A Roll Back Malaria Scoping Study⁴⁸ identified four additional initiatives and funding sources that are considered necessary to scale up malaria control in Uganda and accelerate progress towards the Abuja targets. These initiatives cover the provision of direct support to the NMCP, Home-based Management of Fever and ITN interventions, and Emergency measures in support for IDPs encamped in Northern Uganda. The paper suggests that the very nature of the initiatives and the requirement for implementation at the earliest possible time, suggest that a project format and additionality of project funds should be allowed to expedite their progress. The paper continues, however, to say that such funding is seen as a short-term measure and in the medium to longer term, external DPs should be encouraged to both join and finance the SWAp through general budget support to the GoU.

▪ ⁴⁸ Root et al. (2003) Uganda Roll Back Malaria Scoping Study

Commodities

The cost of ITNs are still too high for the poorest. In the beginning of 2004, PSI undertook a UGFATM funded pilot study on an ITN voucher systems to assess the purchasing power of the poor. The voucher system was established in two districts whereby vouchers were distributed through MoH systems (<5 clinics, EPI etc) for a period of three months. The cost of long lasting ITNs on the local market is approximately Ush 10,000 and of Permanets Ush15,000. The pilot sold the nets in the two districts at Ush 4,000 and 6,000 respectively. The outcome was that the district with the higher subsidy had higher purchasing power. However, the study also demonstrated that the poorest were unable to buy the subsidized nets. As a result the UGFATM has decided to distribute 5.6 million ITNs to the under fives and pregnant women.

The home-based management of fever (HBM) strategy using prepacked Chloroquine and SP (Homapak) is an intervention that was developed by WHO in Uganda. Homapak was piloted by WHO in 10 districts and ADB supports an additional 10 districts) within a period of 18 months. Under new guidelines from WHO, Homapak will need to be redeveloped in order to change towards the much more expensive ACTs. This does not only put an additional strain on MoH financial resources, but WHO also will need funding to develop the new Homapak.

Poverty and Gender

Malaria mainly affects poor and marginalized communities. As stated above the NMCP is guided by the PEAP agenda and includes equity of access principles as well as a poverty focus and gender awareness. The abolition of user fees has resulted in increased use of health services, particularly by the poorest quintile of the population.

3.4 Global Health Partnerships providing Technical Support, service delivery, donations and discounted products

In this section the various GHPs falling within this category are not separately discussed given the similarities of their modus operandi in country. However, information is provided where they differ from one another. With the exception of Stop TB, all GHPs in this category aim to eradicate and/or eliminate the diseases targeted.

Scope of Programmes and fit with health sector

The GHPs in this category are all straight forward drug donation programmes. Four of these GHPs aim to eradicate or eliminate the following diseases: Leprosy, Lymphatic Filariasis, Onchocerciasis and Sleeping Sickness. The Government of Uganda is a signatory to the international resolutions committed to the elimination and eradication of these diseases. Whilst HIV/AIDS, TB, Onchocerciasis and Leprosy are included in the National Minimum Health Care package, sleeping sickness and filariasis are designated district specific priorities because of their localized endemicity.

MoH interviewees expressed the view that the GHPs in this category are aligned to the national disease control programmes and operate within the HSSP.

The table on the page overleaf provides an overview of the various aspects of the drug donation programmes, including country host, agency responsible for transport, storage and implementation. As can be observed from the table, at the national level

all the GHPs in this category are working in partnership with MoH and non-providers within the framework of the HSSP. Drugs are donated to country and enter the national health system at the national level and are then distributed through the vertically organized control disease programmes to the districts and from there to the lower levels of the health systems. The major, widely appreciated benefit is the assurance of a sustained and consistent supply of free, high quality drugs with without unreasonable conditionalities. A Ugandan case study on the impact of PPPs addressing Access to Pharmaceuticals in Low Income Countries found that there was no evidence of any skewing of national or district priorities, not of unhelpful diversion of human and financial resources at central, district or community levels⁴⁹.

Governance

As mentioned above, all the GHPs in this category work at country level, mostly through WHO, in partnership with MoH. This is mainly through the Directorate of Clinical and Community Health Services which is organized into three Departments. The Department of National Disease Control is responsible for the oversight of the UMHCP which cover Malaria, HIV/AIDS/STIs, Tuberculosis and Leprosy programmes and those diseases targeted for elimination and eradication. Although each partnership at the national level may have a different make-up of partners, they all operate within the SWAp and in the framework of the HSSP. Therefore, they are all governed by the Health Policy Advisory Committee as well as the various working groups and Inter Agency Co-ordinating Committees (see appendix 4).

▪ ⁴⁹ Caines K. et al. (2003) Impact of PPPs Addressing Access to Pharmaceuticals in Low Income countries: Uganda Pilot Study

GHP	Host in Country	Procurement / donation by	Transport	Storage	Implementation	Districts of distribution
Stop TB	WHO , but based at MoH TB control programme	On proposal basis, Stop TB provides free drugs to fill gaps	The WHO country office clears and collects the shipment from the airport	Stored in the office of TB/Leprosy MoH Programme Manager.	National TB Control Programme under HSSP	
GAEL (Leprosy)	WHO	Donation of MDT Drugs to national MoH national leprosy Control programme	The WHO country office clears and collects the shipment from the airport	Stored in the office of TB/Leprosy MoH Programme Manager.	MoH (with assistance from the German Leprosy Relief Association under HSSP	Distributed to the seven zonal districts
GAELF (Lymphatic Filariasis)	WHO	GlaxoSmith Klein and Merck & Co	The WHO country office clears and collects the shipment from the airport	Drugs delivered to the MOH programme manager	National Programme to Eliminate Lymphatic Filariasis under HSSP	The programme covered two districts in 2002 and scaled up to 10 districts in 2003
APOC (Onchocerciasis Control programme)	National Onchocerciasis Task Force (NOTF) based at MoH	Merck and Co donate Mectizan free of charge	The WHO country office clears and collects the shipment from the airport	MoH secretariat delivers each district consignment to the Medical Stores of the respective districts	Implemented by National Oncho Control programme under the HSSP, including non state providers	Total coverage of the communities at risk was achieved in 2001 and has been sustained since. Funding will cease soon.
WPESS (Sleeping sickness)	WHO	Aventis and Bayer AG supply various drugs free of charge	The WHO country office clears and collects the shipment from the airport	Delivered to the Programme managers office at the MOH headquarters	MoH&Ministry of Agriculture and Animal Industry MoH National Sleeping Sickness Control Programme	The MoH National sleeping sickness control programme is providing services to all 14 districts with reported cases
Viramune Donation Programme	Drug procurement, importing and handling by Surgipharm, a national rep of Boehringer	Boehringer Ingelheim donates Viramune (nevirapine) free of charge	External agencies collaborate to supply the drugs to the office of the PMTCT officer in the MoH NACP	Health stores receive store and dispense Diflucan	MoH National Aids Control programme, PMTCT co-ordinator under the HSSP	22 Districts
Diflucan Partnership Programme	Axios International manages the drug application process and distribution	Pfizer provides Diflucan free of charge	MoH orders drugs from Pfizer South Africa, which delivers to the NMS.	NMS delivers consignments to the district / health facilities	MoH, health facilities at all levels	National coverage

Financing

As described in chapter 2, the disease control for diseases targeted for eradication and elimination are all included in Uganda's National Minimum health Care Package. In view of the large shortfall in funding for delivering the total package, all interviewees stated they highly appreciated the additional resources brought in by these GHPs. This was also found by the Uganda case study on the Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low Income Countries by Caines et al. (2003) that concluded that there was an open acknowledgement of the high value of the additional resources for those drug donation programmes reviewed in the study. MoH officials also noted, however, that the national strategies for disease control were vital as "Uganda did not wish to be led by outsiders".

However, it is difficult to access estimates of the dollar value of the donations and of the technical and operational support that these GHPs in this category provide. Since the drug donations are provided in kind, their value has not yet come under the scrutiny of the budgetary processes although this may change in the future. The MoFPED has indicated that in the medium term, value of drug donations will also be included in the budgetary and MTEF processes.

Although the onchocerciasis and leprosy programmes are making encouraging moves towards sustainability⁵⁰, the ability of Uganda to take on the burden of these programmes has to be seen in the shortfall in funding for delivering the NMHCP.

Poverty and Gender

In the absence of routine socio-economic data on the clients, it is assumed in Uganda that these programmes benefit the poor particularly, because the drugs are provided free in unlimited amounts and because the diseases targeted by the GHPs in this category, mostly affect the poor. In particular those working and living in areas where the disease vectors are part of the habitat and where susceptibility is exacerbated by poor sanitary and environmental conditions, overcrowded housing, and poor access to social services including health.

▪ ⁵⁰ Caines et al. (2003) Impact of PPPs Addressing Access to Pharmaceuticals in Low Income countries: Uganda Pilot Study

4 KEY FINDINGS AND CONCLUSIONS

In this chapter the main findings around the key topics will be discussed as well as the experiences of key stakeholders in country with the proliferation of the GHPs.

4.7 Scope and fit with the health sector

All GHPs active in Uganda work towards HSSP targets. With the exception of Haemophilus Influenza type B, all diseases addressed by the GHPs are considered a priority by MoH and as such are part of the HSSP and included in the Minimum Health Care Package..

With the exception of the Ugandan GFATM project, interviewees expressed the view that the GHPs present in Uganda are aligned to the national programmes and have helped implementation of the programmes through the provision of necessary inputs whether those be drugs, training, technical support or advocacy.

At the national level, interviewees did not think that the GHPs had skewed national priorities. The two District Health Teams interviewed, however, felt that the number of GHPs and other major initiatives, such as WB MAP projects, PEPFAR, UNFPA projects, UNICEF and WHO supported EPI , Child Survival programmes, USAID funded PMTCT, WB Health Infra-structure Programme, had considerably increased transaction costs and put a heavy burden on the already low number of existing staff. One of the districts explained that it had 15 of these programmes with many requiring workplans, budgets, M&E and reporting as well as separate accounts for a large number of them. In addition the teams receive regular M&E visits from various of these initiatives as well as the MoH teams of the various national control programmes.

With regards to the new HIV/AIDS initiatives in Uganda, including the UGFATM project, many interviewees regretted the lack of apparent co-ordination between these initiatives at the national level. Whilst the team was in country the UAC proposed to put into place an HIV/AIDS supra coordination structure. It was understood that it was not well received. This is related to the fact that the various co-ordinating and technical bodies for the various initiatives have considerably increased the workload of key stakeholders, especially as the same people from both the MoHS, development partners and NGOs attend the various coordination meetings.

4.8 Governance and accountability issues

All but one of the GHPs are directly linked to the national disease control programmes of the MoH. Therefore, they are integrated into the SWAp and as such form part of MoH planning and review processes, which is highly appreciated by all key stakeholders. The exception is the GFATM, which potentially represents the single biggest source of financing outside the government budget.

Some of the governance issues with respect to the GFATM are due to:

- The request of the GFATM to resubmit the first integrated proposal for all three diseases whereby Uganda proposed that budget support be used.
- Uganda's acceptance of GFATM's suggestion to undertake the GFATM proposal submitted to the Fund as a project to address the concerns of additionality.

- Uganda's decision to establish an autonomous operating PMU that is the result of reporting lines within MoH. The head of the UGFATM reports directly to the PS MoH without linkages to any other structures in MoH. In addition, the PMU considers that it has no official linkage with the CCM but that instead the CCM is linked to the MOFPED, which is the official Principal Recipient.
- UGFATM and GFATM appear to be corresponding and reaching decisions without CCM being aware and/or involved/
- Separate planning, procurement and contracting mechanisms are being established by the PMU for all components of the GFATM.

As mentioned above, with regards to HIV/AIDS the GFATM PMU and the CCM work independently of the Uganda AIDS Commission and the World Bank MAP project which is implemented through the UAC.

4.3 GHP focus on neglected diseases

All GHPs operating in Uganda address diseases that are included in the Minimum Health Package under the HSSP, or are specified as district priorities. Therefore, they have been recognized as serious public health problems and prioritized by MoH and its partners. Whereas it is generally agreed that GHPs are providing 'additional' resources, and have improved the funding and delivery of priority disease programmes at national and district levels, it would be unfair to say in the Uganda context, that these diseases have been 'neglected' by other forms of development, rather than the processes have not been successful at raising the level of financing required to deliver the basic package – including funding from Government. The package has been costed at US\$28 per capita, not including ARVs, ACTs or the pentavalent vaccine, and the funding available for the package is about US\$8-10 per capita.

Uganda is participating in GHPs for guinea worm, leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis and sleeping sickness (human African trypanosomiasis), among what are commonly termed the 'neglected diseases'. The general view at country level is that these GHPs, and in particular the drug donations, are helping meet a real need. There has, for example, been a dramatic resurgence in sleeping sickness in the country.

In general, the GHPs are operating through district health systems rather than on a project basis. The vital need for this is demonstrated by the example of an MSF project on sleeping sickness. An earlier study⁵¹ noted that the Ugandan national plan to revitalise sleeping sickness control, using donated drugs, achieved such success in the West Nile District that, in October 2002, MSF France — who had run the programme there as a project with its own staff — was able to withdraw support in that area. However, 750 new cases were reported in the district in 2003. This suggests that, whatever the transitional arrangements, the districts concerned were not in a position to maintain the required level of activity in both surveillance and mopping up of early cases, and highlights the desirability of integrating project effort with the district health system from the outset.

▪ ⁵¹ Caines K. and Lush L., et al. *Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries: A Synthesis Report from Studies in Botswana, Sri Lanka, Uganda and Zambia*, Initiative on Public-Private Partnerships for Health, Switzerland, 2004. ISBN 2-940286-21-3

There also appears scope for closer coordination and integration of activities across GHP-supported programmes with similar treatment strategies and modalities, for example mass drug administration. A study in Uganda in mid-2003⁵² noted that discussions were underway between the National Onchocerciasis Control Programme, the Programme to Eliminate LF and the Schistosomiasis Control Initiative on how best to integrate activities such as training, supervision, advocacy, registration and drug distribution. Integrated community-directed treatment for onchocerciasis, schistosomiasis and intestinal helminths was planned in 6 districts, with potential for considerable benefit and increased efficiency. It should be noted that the draft HSSP II sets out to integrate the control of these vector borne disease.

4.4 Financing and additionality

It is worth reiterating that interviewees when asked about their experiences with GHPs tended to include all sources of international funding regardless of whether this was budget, project, financial or non financial inputs. For example inputs from World Bank, EU, UN projects, USAID and PEPFAR and other donor or international are perceived as examples of global (international) partnerships.

Until now GHPs have, in general, provided additional financial and other resources. However, various MoH officials noted that the budgets of some disease control programmes had been considerably reduced in the last year.

The extent to which additionality will continue in Uganda will depend of the process by which the MTEF ceiling is firmly fixed, as indicated by the MOFPED, or can be raised to accommodate new funding sources. For example, third round GFATM allocations have not been considered in the new ceilings for health as these were not yet in the system. As such, the grant agreement has not yet been signed for the third round disbursement as the MOFPED has not agreed that these funds will in fact be additional. It is also intended that in the medium term, the cost of drug donations will also be considered as a project input and be included within the sector ceilings for budgetary purposes.

The main concern with the rigid enforcement of this fiscal policy to include projects, and drug donations in the future, is that it threatens the stability of the SWAp as the health sector risks losing the efficiency of budgetary support if it continues to accept projects. Further to this, since most projects do not pay public sector salaries and certain operational costs of systems development, the imbalance between direct budget support and project support will seriously undermine the capacity of the MoH. If the sector ceiling remains at a fixed level, new projects will automatically displace health sector budgets under the control of MoH.

The option of including project support within the SWAp was seen as a mechanism for those Development Partners whose policies or procedures did not allow them to give direct budget support but who were willing to work within the framework of the HSRP and therefore the SWAp. It was not envisioned that there would be an explosion of essentially new 'donors' or financing mechanisms to be accommodated in this way. There is a real risk of distorting the balance of national priorities,

▪ ⁵² Caines K., et al., Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low Income Countries: Uganda Pilot Study, Initiative on Public-Private Partnerships for Health, Switzerland, 2003. ISBN: 2-94 0286-10-8.

particularly with regards to the massive injection of funds for ART in the current environment of fixed and rigid budget ceilings.

Regarding the financing GHPs, and in particular the GFATM, the case is also being made by the Directorate of Planning and the MOFPED that direct budget support is the more cost effective and efficient financing mechanism, as compared to project funding, which has allowed abolition of cost sharing in public facilities, increased allocation to primary care and the basic package, increased public sector salaries and a more predictable and manageable planning environment for Districts. It should be noted that as far as MOFPED is concerned, the GFATM is just one the many initiatives that operate as projects.

4.5 Poverty and gender equity

There is a lack of socio-economic data on clients in the health sector. The GHPs do not have any specific mechanisms to be either pro-poor or gender focused.

In the absence of routine socio-economic data on the clients, it is assumed that the GHPS that operate through the national disease control programmes and the HSSP (and by extension the PEAP) benefit the poor in particular because the health system in Uganda is pro-poor and drugs provided by GHPS are provided free of charge. Data from MoH also show that the poorest quintile of the population has benefited most from the abolition of user fees as health service utilization in this group has considerably increased.

Free ITNs will be provided under the UGFATM project as a result of a pilot project that showed that the poorest do not have the purchasing power to buy subsidized nets.

4.6 Commodities

Various interviewees mentioned that GHPs have indeed negotiated considerable reduction in cost of drugs on the international market. For example, the cost of TB DOTS treatment had been reduced from US\$30-40 to US\$10 per treatment. The GDF provides approximately 50% of Uganda's TB drugs.

Social Marketing is used in Uganda for a range of products, including ITNs and Family Planning materials.

Drugs for the so-called 'neglected diseases' are provided free of charge under the various GHP programmes described above.

The UGFATM procurement plan has not yet been approved by Geneva and therefore ARVs have not yet been procured by the project.

5. RECOMMENDATIONS

Harmonisation and integration

In the context of the SWAp in Uganda, GHPs should contribute as much as possible to in-country harmonization and systems strengthening efforts of the GoU and its development partners. SWAp mechanisms for decision making, governance, M&E, reporting, accounting, procurement, transport etc. should be used as much as possible as bypassing existing structures to ensure short term gains will weaken the health system in the long term.

Regarding the GHPs providing Technical Support, service delivery, donations and discounted products, there is a need for better coordination across neglected programmes, and greater integration within the district health systems is desirable. The draft HSSP II is already reflecting this and working towards an integrated programme for all the hitherto neglected vector borne diseases. Further synergy of GHPs, and indeed other major initiatives, would be achieved if the GHPs were well integrated into the HSSP district health services as well.

Financing, aid instruments and sustainability

In the context of Uganda, as well as other countries with a SWAp, when supporting Ministries of Health, financing GHPs should aim to channel funds through the preferred aid instrument of the government and in-country development partners, i.e. in Uganda direct budget or sector support. This will strengthen the SWAp, reduce transaction cost and ensure transparency.

With regards to the fixed health sector ceiling in Uganda, at an early stage GHPs should work in partnership with in-country development partners and GoU to negotiate the issue of 'additionality' of funds with the MOFPED. Increasing the number of projects on the one hand and decreasing MoH budgets will undermine the SWAp in general and the MoH in particular.

At the international and national levels, the issue of financial sustainability of some of the new global initiatives should be discussed openly by all parties involved. Given the current financing gap of the UNMHCP, It is unlikely that Uganda will be able to sustain the Pentavalent vaccine and provision of ARVs in the medium term. This should also be seen in the context of the increasing cost for treating malaria⁵³, the number one cause of morbidity and mortality in Uganda.

Pro-poor and gender focus of GHPs

In the absence of GHPs' specific pro-poor or gender related goals, the GHPs are only as pro-poor / gender focused as the environment of the health system they operate in. If GHPs aim to be pro-poor and gender focused, they will need to assess utilization of GHP related services by the poor and vulnerable groups.

GFATM

Given the problems with the GFATM project in Uganda, it is recommended that MOFPED, GoU and GFATM discuss the option to fund at least MoH activities through (earmarked) sector support so as to integrate it into existing MoH systems, thus preventing the creation of parallel structures, reducing transaction costs and increasing transparency. Together with in-country development partners and non-

▪ ⁵³ First line of treatment change from SP/Chloroquin to ACTs due to resistance problems in many African Countries.

state providers, they may also wish to discuss using this aid instrument to fund non-state providers by MoH contracting out as it already does under the SWAp.

In addition, it is recommended that in the short term correspondence between the UGFATM Programme Management Unit and GFATM in Geneva be copied to CCM members. In Uganda, the CCM will need to discuss and agree its role with the MOFPED as the official Principal Recipient and MoH as the delegated Principal Recipient.

International HIV/AIDS initiatives

Although GHPs with a focus on HIV/AIDS are a useful and complementary addition, the international community ought to be cautious in developing too many of these initiatives in rapid succession.

Although at the international level and the national level, the “Three Ones” principle has been endorsed, GHPs and other major initiatives that focus on HIV/AIDS appear to require, and in fact insist on, different co-ordinating and governance mechanisms on the ground in country. There is a history of cooperation and collaboration between the relevant stakeholders in Uganda. They need to agree as soon as possible on how to bring about the “Three Ones” to achieve the most effective and efficient use of resources and to ensure rapid action.

Future study

This study, and indeed the other GHP country studies, focused largely on the national level. It is therefore recommended to undertake a similar study that focuses on experiences with GHPs at the the district level across countries with decentralized health systems.

APPENDIX 1

List of people interviewed

Prof Omaswa	DG MoH
Dr Lwamafa	Commissioner NDC
Dr Kwakimari	MoH Manager National Malaria Control Programme
Dr Bakambesi	MoH PPP & Financial Department
Dr Okware	MoH Commissioner Community Health
Dr Madraa	MoH, Director HIV/AIDS Control Programme
Dr Imoko	TB Control Programme
Christine Kirunga	MoH Directorate Planning
Grace Murindwa	MoH Directorate of Planning
Rob Yates	MoH Directorate of Planning
Dr Kitimbo	Director Health - Jinja District
Dr Tumushabe	Director Health - Mukono District

Tiberius Muhebwa, UGFATM PMU

Enyaku Rogers MOFPED
Kenneth Mugambe MOFPED,, Poverty Monitoring Analysis Unit

Stephen Talugende PHA Forum
Charles Akora PSI
Alex Courtinho TASO
Millie Kitana Health Rights Action Group
Graham Root Malaria Consortium
Andrew Collins Malaria Consortium

Ros Cooper DFID
Susan McQueen USAID
Mary Oduka, DCI
Peter Okwero World Bank

Dr Robert Azairwe, WHO Malaria
Dr Walker Oladapo WHO Representative
Juliet Nabyonga WHO
Dr Vincent Orinda UNICEF
Eva Kabuongera UNICEF
Ruben del Prado UNAIDS

The consultants also attended an UN and Bilats HIV/AIDS Meeting on the second day of their consultancy in Uganda.

APPENDIX 2

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APPENDIX 3

Elements of the Uganda National Minimum Care Package (UNMHCP) as outlined in HSSP I

1. Control of Communicable Disease
 - Malaria
 - STI / HIV/AIDS
 - Tuberculosis
2. Integrated Management of Childhood Illness (IMCI)
 - Promotion and use of IMCI approach at all health facilities, and at the community and household levels.
3. Sexual and Reproductive Health and rights
 - Essential Ante – natal and Obstetric Care
 - Family Planning
 - Adolescent reproductive health
 - Violence against women
4. Other Public Health Interventions
 - Immunisation
 - Environmental Health
 - School Health
 - Epidemics and Disaster Prevention, Preparedness and Response
 - Improving Nutrition
 - Interventions against diseases targeted for eradication
5. Strengthening Mental Health Services
6. Essential Clinical Care
 - Care of injuries and other common conditions including non-communicable diseases
 - Disabilities and Rehabilitative Health
 - Palliative Care
 - Oral / Dental Health

Please note that various changes to the UNMHCP are currently proposed in the draft HSSP II.

APPENDIX 4

SWAp mechanisms for decision making and M&E

