

**Review of Irish Aid-Clinton Foundation Partnership
May 2010**

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Executive Summary

President Clinton and Taoiseach Bertie Ahern signed an agreement in 2003 that paved the way for a five year joint venture of support to the Government of Mozambique's fight against HIV and AIDS. As the result of a positive mid-term review in 2006 it was decided to include the Government of Lesotho in the Clinton Foundation/ Irish Aid partnership and to extend it until the end of 2010. This document provides an internal review of the progress to date whose objective it is to provide recommendations as to the need for a formal continuation of this partnership.

The goals of the partnership are to provide financial and technical support to Government in its fight against HIV and AIDS and to help strengthen national health systems, in particular human resources for health, in keeping with national strategies and plans.

The review concludes that these goals and the fight against HIV and AIDS remain highly relevant in both countries. A recent shift in focus from a specific disease orientation to broader development goals in both partner organisations is conducive to improved development impact for resources invested and is particularly suited to the fight against HIV and AIDS. This broader development approach encompasses efforts to eradicate extreme poverty and hunger, reduce child mortality and improve maternal mortality. This also entails, in keeping with Ireland's principle of locally owned and led development, better alignment with Governments' priorities as set out in their respective poverty reduction strategies, which ultimately augurs well for future synergies within the partnership and between the partnership and respective Governments.

The partnership has played a major role in the achievement of very impressive results in both countries. For example:

- the number of HIV positive mothers who received prevention of mother-to-child infection increased nearly a hundred fold in Mozambique between 2003 and 2009,
- national coverage of HIV counselling and testing increased from less than 10% in 2007 to almost two thirds of the population of Lesotho in 2009.
- in 2003 there were only just over 3,000 people actively on treatment in Mozambique. By the end of 2009, there were over 170,000
- by end 2009 220 sites were offering antiretroviral treatment in Mozambique, up from 12 in 2003

These crucial services provide proven high value for money and their dramatic roll-out has occurred in tandem with capacity building and sustainable systems strengthening.

The Partnership has showcased how a Global Health Initiative and a bilateral donor can work successfully together in support of Government achieving its own development goals. Perhaps the most important aspect of the Partnership is that it incorporates crucial and high quality technical support within a sector-wide approach to health sector development. The Partnership thus effectively accelerates sustainable progress and has become a flagship for the aid effectiveness agenda. Government ownership, donor alignment and mutual accountability are inherent to its model of support. As a result the partnership has been highly influential in drawing other donors and Global Health Initiatives into working more effectively together under Government led coordination mechanisms.

This successful formula has not only benefited the respective Governments significantly but the high profile and positive visibility it has created for the Partnership has been clearly beneficial to the reputation of both Irish Aid and the Foundation, not only in Lesotho and Mozambique but also internationally.

The review recommends that the Partnership should be formally extended until 2015 with a view to at least maintaining current levels of funding. Over the next five years the Partnership will work towards the seamless transition of key activities to Government, as well as on the considerable challenge of influencing key partners in the respective health sectors to follow the example of the

Partnership by aligning their support with Government plans and cycles. In the interim, there is an inherent public health obligation to continue funding treatment for all those who have been put on it since treatment itself must be life long for every patient.

Critically, the HIV prevalence amongst adults is 15% in Mozambique and 23.2% in Lesotho. HIV is recognised as the biggest challenge to socio-economic development in both countries, with significant losses already being seen on previous gains made. If overall Irish Aid programmes in these countries are to have a long-term sustainable impact HIV and AIDS must be addressed as a core priority. Furthermore, Irish Aid's commitment to Division of Labour, and consequent decisions to remain active in the health sector in both countries, imply that resources will be released from other sectors which will help insure that current levels of funding in the health sector can be maintained.

The Clinton Foundation possesses the capacity to broker additional funds, rally significant technical resources, negotiate for lowest prices for drugs, diagnostics and other commodities, and above all to support countries and build their confidence in the fight against HIV and AIDS. Irish Aid, because of its strong and established experience in development, its comprehensive approach to harmonised, coordinated and aligned support to developing-country governments, and the Irish Government's commitment to HIV and AIDS as a priority issue, has made it an ideal partner to maximise the approach of the Clinton Foundation, and to ensure the sustainability of HIV and AIDS services in the long run. Any further funding beyond this continued phase will be dependent upon a review in 2014.

Part A

General

The partnership agreement between the Clinton Foundation and Irish Aid began in July 2003 with the signing of a Memorandum of Understanding (1) between the Clinton HIV&AIDS Initiative (CHAI) and the Irish Government, as represented by Irish Aid. The original agreement focused primarily on Mozambique and was updated in 2006 to include Lesotho and to extend the period of funding to end 2010. The Clinton Health HIV&AIDS Initiative has recently changed its name to the Clinton Health Access Initiative to reflect that it has expanded its mandate from HIV and AIDS alone to providing high-quality technical assistance and support to the Government for broader health systems-strengthening, focusing in particular on critical areas such as human resources for health (HRH), laboratory capacity development, drug logistics and management, and nutrition.

Goals of the Partnership

The three goals of the partnership as outlined in the 2006 agreement are:

- i) To provide financial and technical support to assist in the implementation of national plans for the prevention, treatment, care and support of people affected by, or living with, HIV and AIDS
- ii) To contribute towards the strengthening of the health system in a manner consistent with national strategies and plans for the delivery of equitable health services
- iii) To respond in particular to the crisis in human resources which is weakening the capacity of the public sector to improve health services and to implement national responses to HIV and AIDS

Objective of this Review

The objective of the review is to document progress towards attaining these goals and in doing so should:

- **Document results and progress** to date, including benefits to systems-strengthening of the health sector and progress towards achieving broader development goals
- **Document lessons learnt** from engagement between a Foundation and a bilateral donor with specific mandates and different ways of working
- **Summarise relevant findings** from relevant existing reports
- **Identify the achievements and 'value-added'** of the partnership from the perspective of Irish Aid, the Clinton Foundation, and that of the respective HIV efforts in the health sectors as a whole
- **Outline recommendations** on the merits of continuing the partnership

Methodology

The ToRs of this review were drafted jointly by the Mozambique and Lesotho IA/CHAI partnerships with input from respective HQs (see Annex 2). The first section of the review consists of Mozambique and Lesotho country specific reports drafted by the respective country partnerships, followed by summary conclusions and recommendations of the partnership as a whole drafted by IA HQ through continued consultation with country partnerships.

Part B

Country Specific Reviews

B1 Mozambique

M1. Background to the Partnership

M1.1 Introduction

The Government of Ireland through its Development Programme (Irish Aid) is committed to supporting the Government of Mozambique to reduce poverty through its poverty reduction strategy (PARPA II) and to strengthen health systems in line with the Ministry of Health's health sector strategic plan (PESS II) and the National Strategic Plan to combat HIV&AIDS (PEN III). The Irish Aid Country Strategy Paper (CSP) Mozambique, 2007 to 2010, has as its overall goal 'to contribute to poverty reduction by supporting the development, implementation and monitoring of pro-poor policies within Mozambique'.

The nature of this partnership is such that the additional funding from Irish Aid is channelled in the form of sector budget support to the Ministry of Health in Mozambique together with the remainder of Irish Aid funding to the health sector. There is no direct funding relationship between Irish Aid and the Foundation and monitoring of the impact of the partnership is commensurate with monitoring of implementation of the health sector response to HIV&AIDS and progress in general in the health sector.

M1.2 Evolution of the Partnership 2003-2010

Mid Term Review of the Partnership: A mid term review (2) of the Mozambique Irish Aid-Clinton Foundation Partnership undertaken in early 2006 provided both parties with information on progress to date, value-added of the partnership, and recommendations for continued collaboration. The review validated the approach undertaken to date and recommended that both organisations continue with this approach for future resource commitments. It highlighted the fact that the partnership has played a positive role in strongly supporting the Ministry of Health in its leadership position, encouraging the buy-in of other stakeholders to the sector harmonisation and partnership structures, thereby ensuring that HIV&AIDS has been dealt with as a core priority within and across the health sector, and not as a vertical issue. Most importantly, it demonstrated the contribution that has been made to the significant scaling-up of access to services in the period of 2003-2006 and the establishment of the building blocks for a sound health sector response to HIV&AIDS.

Extension of the Partnership to 2010: With the subsequent updating of the agreement in 2006 (3), both organisations were able to commit to ongoing technical resources from the Foundation and significant financial resources from Irish Aid until the end of 2010. By the end of 2010 a total of €76 million will have been allocated by Irish Aid to Mozambique. The Mid Term Review of the Irish Aid CSP 2007-2010 (4) noted that the Clinton Foundation additional funding accounts for a major portion of the country programme's budget (25-30% 2007-2010). As such early appreciation of future funding levels beyond 2010 will be important for planning, commitments and will have serious implications for the programme's overall budget.

Clinton Foundation Mandate: In the last number of years the mandate of the Foundation has evolved beyond focusing primarily on the provision of HIV treatment, and it has expanded its role as a key technical partner to the Ministry. The Foundation's programmes in Mozambique were reviewed in 2008 leading to a more integrated systems-based programmatic approach rather than gap-filling projects as in previous years. The Foundation supports all areas of the patient continuum in an effort to improve quality of care through system-strengthening, including major programmes such as multi-disciplinary mentoring, human resources for health, new technology evaluations, paediatric HIV&AIDS and access (lab and commodities). This focus

reflects that of the health sector in maturing beyond the provision of acute and emergency medical services to now care for and integrate a very complex and demanding 'chronic' health care problem such as HIV&AIDS.

Irish Aid in the Health Sector: By 2006, as a result of the significant funding due to the partnership, Irish Aid had become the largest bilateral donor to PROSAÚDE, the then common funding mechanism of the health sector, providing an additional €12 million per year from 2006-2010 (inclusive). Irish Aid has been able to leverage this position by assuming a central role in many of the key processes which have led to the firm establishment of a functioning SWAp with strong leadership from the Ministry and aligned and harmonised support from 15 PROSAÚDE donors and 26 partners in total, while using its technical expertise to specifically monitor the scaling-up of the health sector response to HIV&AIDS and the improvement in health outcomes more generally. (See Annex 1 for more background on the Partnership).

M2. Health Sector Progress against the three goals of the Partnership (3)

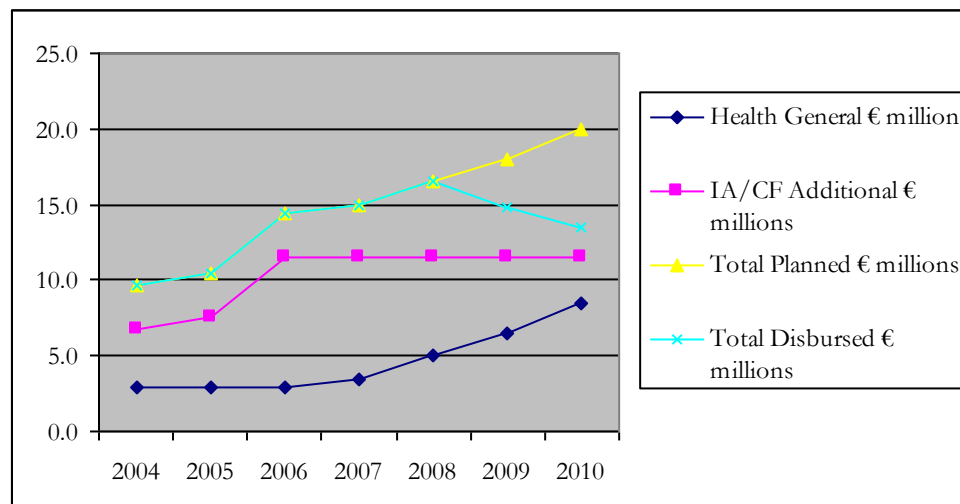
M2.1 Financial and Technical Support to HIV Programme Implementation

M2.1.1 Financial Support

The approach adopted by the Ministry of Health and Development Partners is the Sector Wide Approach for Policy Dialogue and Programming – SWAp. The Code of Conduct, which was reviewed and signed in 2003, and the SWAp Terms of Reference are the key instruments guiding dialogue and coordination within the sector. The new PROSAÚDE Memorandum of Understanding II (MOU), including annexes, was signed by 15 donors in July 2008 and facilitates and guides effective financial support to the sector plan (PES) in the form of sector budget support (5).

Irish Aid funding in the health sector continues to be committed on the basis of the SWAp to support the annual plan (PES). Irish Aid funds, including the additional funding as a result of the partnership, are channelled through PROSAÚDE II. Graph M1 indicates the trends in Irish Aid funding through PROSAÚDE from 2004-2010.

Graph M1. Trends in Irish Aid PROSAÚDE funding 2004-2010

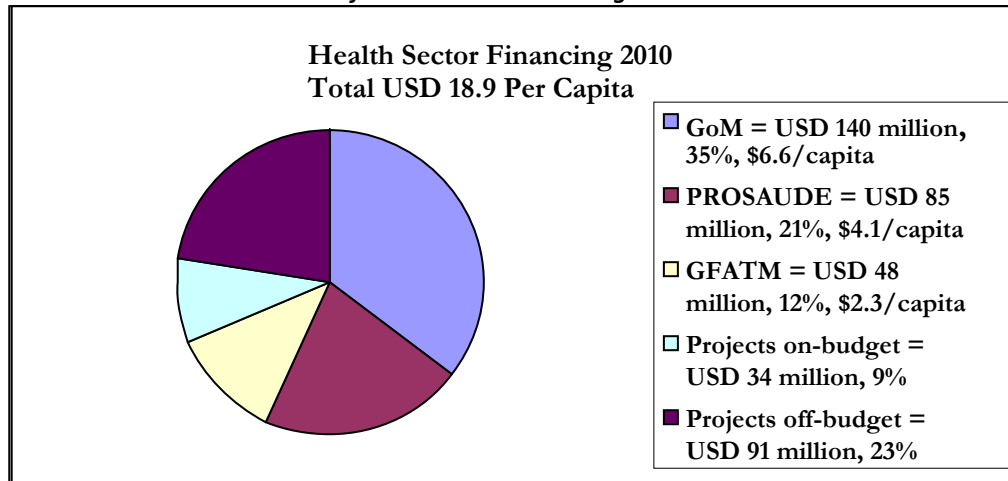


Source: Irish Aid, March 2010

Irish Aid support to the health sector from 2008-2010 represented between 17-23% of PROSAÚDE funding. PROSAÚDE itself has decreased in terms of the overall proportion of funding to the sector from 30% in 2008 to 20% in 2010. This proportional decrease is due in part to the exit of a number of PROSAÚDE donors as a result of division of labour exercises and in part to the ongoing increases in vertical funding outside of PROSAÚDE, in particular PEPFAR funding (approximately USD250 million/year). See Chart M1 for 2010 funding proportions.

Progress within the health sector has been made with remarkably limited resources. The Government's budget for health represents less than \$7 per capita, and has fluctuated between 10% and 12% of the total budget over the last 3 years. With PROSAUDE funding this rises to about \$11 per capita and \$13 per capita with Global Fund monies. With other project funding the total is still only \$19 per capita (See Chart M1.). This is insufficient to provide comprehensive health services – normally estimated at around \$50 per capita – and it therefore highlights the importance of prioritising and focusing on those elements of the health services that will have the biggest health impact.

Chart M1. Source and Volume of Health Sector Financing 2010



Source: Health Partners Group, March 2010

Budget execution of the budget over which the Ministry has direct control – the government budget and PROSAUDE funding - was good in 2009, over 90% (6). However, overall budget execution was recorded at 68%. The Ministry claims that there are serious problems with project reporting and that this reduces the overall budget execution rating. While reporting is an issue, it seems that low implementation is also a problem. In particular, there remain ongoing problems with Global Fund disbursements to the health sector with none of the funding foreseen for 2009 being disbursed. A unit to help manage the GFATM is being established within the Ministry, and partners stand ready to support this unit.

The Ministry and Partners have invested significantly in the development of several key strategic and operational plans for disease and program specific responses as well as the cross cutting health systems elements, e.g. Accelerated Plan to Reach MDG 4&5, Malaria Business plan etc. These plans have been costed and reflected in a projected MTEF. In addition disease specific MTEFs for HIV&AIDS, TB and Malaria have been developed.

Irish Aid's modality of channelling the additional funding to the sector was chosen with the aim of providing untied, unearmarked funding to the Ministry of Health to be used for implementation of a jointly agreed

plan for the sector as a whole. Given that there is a rigorous process of jointly agreeing on the annual plan, and the fact that HIV has always been prioritised within this, Irish Aid was able to have confidence that the additional funding would indeed be contributing towards joint priorities of the sector, with a strong focus on HIV&AIDS, but would also go towards addressing broader systems issues such as human resource constraints, drug logistics and management, integrated planning, financial management, and monitoring and evaluation. The channelling of this volume of additional funding in this manner was a significant boost for the Ministry of Health in allowing this 'HIV&AIDS' funding to be directly under the control of the Ministry and to be used for the overall sectoral priorities.

Challenges:

- Since the signing of the PROSAUDE II MOU in 2008, four of the original fifteen signatories have announced their intention to exit based on their internal Division of Labour decisions. Norway, previously a significant donor to the sector, exited at the end of 2009. Both France and Finland will exit by end 2010 and DFID will exit by the end of 2012. The exit of France, Finland and DFID would represent a 23% reduction in available funding based on the 2010 commitments. To date, there has been very little discussion on the potential impact of these decisions on the future funding of the sector, with little heed being paid to 'responsible exit'. In fact, the only current commitments for 2013 are \$9m from Canada and \$1.2m from UNICEF
- The channelling of enormous volumes of vertical funds (PEPFAR \$250 million/year) outside of PROSAUDE continues to present significant challenges to the credibility of SWAp given that funding is increasingly being dominated by the proportionality of these funds. Given that the current PEPFAR Partnership Framework only extends up to 2013 there remains the big question over continuation of funding beyond this and the subsequent implications for sustainability.
- Similar uncertainties remain over the future of World Bank funding to the health sector and indeed future funding for HIV&AIDS after the closure of the Multi-country AIDS Project (MAP) (officially ended in 2009 but no-cost extension to mid 2011). The Health Service Delivery Programme (HSDP) has been approved but has yet to become effective and as yet there are no definitive plans to design a follow-on project to the MAP (which also provided funding to the health sector). Both the US Government and the World Bank continue to reiterate their commitment to the health sector and HIV&AIDS in Mozambique so it is clear that advocacy and demonstration of results will continue to play important roles in continuing to engage these important donors.

M2.1.2 Technical Support

Clinton Foundation Mozambique has a strong team of clinical/technical experts who all have significant experience in the field. In the area of technical and programmatic support to health systems strengthening, over the last few years the Clinton Foundation has supported a number of key areas as part of the Government of Mozambique's plan to improve quality of care and increase access, including **supply chain management, procurement and logistics; paediatrics; laboratory capacity development; and human resources for health; and nutrition.**

Through a partnership with **UNITAID**¹, the Foundation has been providing direct support to the Ministry of Health for the procurement of paediatric commodities, second line antiretrovirals and other HIV medicines, diagnostics, and ready to use therapeutic food (e.g. plumpy nut) for malnutrition at lowest available prices. In addition, in 2010 CHAI-UNITAID will support CD4 Point of Care Technology devices and reagents/commodities for 25,000 patients as part of the evaluation of the new devices.

CHAI's **Paediatric Initiative** for 2009 and 2010 focuses on increasing the testing of children through better linkages with the PMTCT program and other entry points at health facilities through the mentoring and retention program.

In the areas of **laboratory capacity development** CHAI supports:

¹ UNITAID is the International Drug Purchase Facility being established by Brazil, France, Chile, Norway and the United Kingdom as an innovative funding mechanism to accelerate access to high-quality drugs and diagnostics for HIV/AIDS, malaria and tuberculosis in countries with a high burden of disease.

- DNA PCR diagnostics rolled out nationwide including infant testing.
- Real time results substantially reducing waiting times for health staff and patients. Mozambique will be the first sub-Saharan country to realize a national scale roll out.
- The National Reference Institute for roll-out of Point of Care devices in diagnostics that will improve quality of care.
- Global Fund proposal writing resulting in successful grants of \$192 million over 5 years for Health Systems Strengthening and HIV.
- Operational research to aid the Ministry in managing and adopting new WHO guidelines.

Irish Aid has significant technical expertise within the health sector with designated health and HIV&AIDS advisors. This expertise has positioned Irish Aid to engage effectively and prominently in many of the processes pivotal to the scaling-up of access to care and treatment services and in strengthening the structures and mechanisms of the SWAp. For example, Irish Aid created the HIV/TB working group and has chaired this twice in its existence of five years. Irish Aid has also co-chaired and participated actively in some of the key working groups with the Ministry which have led to considerable progress in key process and service delivery related issues, e.g. Monitoring and Evaluation, Audit and Finance, and Human Resources for Health, in addition to Community Health, PMTCT and Paediatric Decentralisation task forces. Moreover, part of the Irish Aid Clinton Foundation support is set aside as the Process Fund which targets strategically important technical interventions to ensure effective annual implementation of the Government's HIV and Health Strategies.

Irish Aid is acknowledged as being one of the few bilateral agencies within the health sector that maintains strong technical expertise and support, using this capacity to complement the systems-strengthening approach of a broader development agency. Similar technical capacity is usually only seen within the UN technical agencies or USAID and CDC, who have enormous direct technical engagement. These are agencies playing a pivotal role within the sector but which are not always deeply engaged in the broader SWAp agenda.

M2.2 Health Systems Strengthening

M2.2.1 Health Sector Response to HIV&AIDS

- **Policy Environment for HIV&AIDS**

The third **National Multisectoral Strategy for HIV and AIDS (PEN III)** was developed in 2009 and again prioritizes HIV&AIDS care and treatment as one of the four key components of the national response (7). HIV is also prioritized in other government documents elaborated by the Government of Mozambique. For example, HIV indicators are included as components of the second Poverty Reduction Strategy (PARPA II) with specific targets, and make up three of the 54 key monitoring indicators which are reviewed twice a year as a part of the Performance Assessment Framework monitored by the Government and the Programme Aid Partners (the G19 donors providing direct budget support to Government). This performance assessment framework is intended to jointly evaluate progress made in the implementation of PARPA II. As such, these areas are considered crucial for monitoring the progress of the HIV&AIDS response.

The **Health Sector Strategic Plan for STIs and HIV&AIDS (PEN Saúde)** provided the context for the Ministry and Development Partners to begin scaling up access to services in 2004 (8). The approach in the strategy at that time was to ensure that issues such as long-term sustainability would begin to be addressed together with the broader needs of the health sector, using the focus on antiretroviral treatment as the impetus to ensure a balanced approach to HIV&AIDS in the health sector. The result was a comprehensive and balanced strategy that covered the whole spectrum from prevention through diagnosis to care, treatment, and impact mitigation. It also undertook to ensure that issues of capacity at all levels are addressed as prerequisites to treatment and other complex service expansion. This strategy will be updated in 2010 under the umbrella of the above mentioned PEN III.

Strategy to Accelerate HIV Prevention: This strategy was developed in 2008 by a multisectoral Prevention Reference Group led by the Minister of Health (9). It represented a reinvigoration of HIV prevention efforts in Mozambique with a commitment from the highest levels of Government. The Strategy prioritised ten areas as being central to a comprehensive prevention response, including care and treatment, and was one of the key documents to inform the development of the PEN III.

- **Results**

Since implementation of the health sector response began in earnest in 2004, significant progress has been made in the provision of services. In 2003 there were only 3,314 people actively on treatment in Mozambique. By the end of 2009, there were a total of 170,198 (156,688 adults; 13,510 children 2009 target – 158,000). Approximately 8% of the total is children less than 15 years old and 63% are females. In addition, by end 2009 220 sites were offering antiretroviral treatment, up from 12 in 2003, with every district in the country having at least one health facility offering treatment; 200 health facilities are now linked to Home Based Care services with over 100,000 beneficiaries of care; 832 sites are offering services for the prevention of mother to child transmission (PMTCT), up from 9 in 2003; and the number of HIV positive pregnant women receiving antiretroviral prophylaxis for PMTCT was 66,615, up from 877 in 2003. In total over one and a quarter million people were counselled and tested in 2009, up from 240,000 in 2004.

Table M2. Compiled results 2004-2009

	2003	2004	2009	Increase by factor of
Antiretroviral treatment				
# Health Units providing ARV treatment	12	12	220	18
# on ARV treatment	3,314	10,494	170,198	51
Prevention of Mother To Child Transmission				
# Health Units with PMTCT	9	51	832	92
# Women counselled & tested	-	46,583	649 820	14
# Women who received prophylaxis	877	3,182	66,615	76
Counselling and Testing				
# C&T Centres	-	113	359	3
# people receiving C&T	-	194,000	602,171	3
Home Based Care				
# Health Units linked to HBC services	-	79	200	2.5

beneficiaries

- 17,790 108,626 6

All of these achievements are at or above targets set for 2009. See Table

M2 for compiled results in some key programmatic areas 2003-2009.

Other 'cross-sectoral' areas have also seen significant progress, e.g. laboratory capacity development; training of personnel; integration of services; monitoring and evaluation capacity development; rehabilitation of health facilities, etc.

- **Integration and Decentralisation of Services:**

In 2008, the Ministry of Health made the decision to integrate and decentralize many HIV services, including adult and paediatric treatment services, from the former "day hospitals" or larger health facilities at the quaternary and tertiary level to peripheral health facilities at the secondary and primary level. The decentralization process began in early 2009 with the decentralization of adult patients from the Maputo Central Hospital. The decentralization process for adult patients at these larger health facilities is underway in most of the 11 provinces; however, a slower and more phased approach has been adopted in relation to paediatric services given the additional complexities regarding clinical management and paucity of trained personnel.

While decentralization of services is necessary to ensure equity of access to services, strengthen referral systems and leverage existing resources to improve the overall health system, it also carries the risk of diminishing the quality of care provided if carried out without adequate training, supervision or ongoing quality improvement. To address this concern, the Strategy for the Acceleration of HIV Prevention (9) calls for a shift in focus on geographic expansion to improvements in the quality of services provided. In particular, this approach involves the scale up of HIV quality improvement activities, clinical mentoring, integrated site supervision, and the updating of guidelines (to reflect recent WHO developments, etc.) and operational manuals to further facilitate the integration of HIV services into primary health care.

The Prevention Strategy also recommends improved collaboration between the Ministry of Health and Civil Society organizations working in communities in order to improve adherence to treatment, establish early warning systems for the detection of illness in HIV-infected patients not yet eligible for treatment, and implement simple screening programmes to detect people at high risk for malnutrition, TB, and other common illnesses.

- **Other Policy Developments:**

Target Setting: In 2009, the 2010-2012 national paediatric and adult HIV targets were revised to reflect changes in the indicator definitions and relevant policy changes. For the first time, long-term targets were defined for 2013-2014. The key policy changes that drove this revision process were the revised WHO adult and paediatric treatment guidelines, together with planned changes in the quantity and quality of available human resources due to various applications of task-shifting, prolonged working hours and overall implementation of the Human Resource Development Plan 2010-2014 (11).

Home Based Care: The Home Based Care (HBC) programme in Mozambique has created a national policy that defines what constitutes HBC, monitoring and supervision tools, and a management and coordination structure consisting of provincial and district level Focal Points. All provinces currently have HBC services in place. The programme emphasizes clinically related services such as adherence support, basic home nursing care, treatment/prophylaxis or referral for key symptoms, and medication side effects. Many programs serve as a link to nutritional supplements for malnourished patients, and to support medication adherence. Volunteers also refer individuals and vulnerable family members (including OVC) to existing formal or

informal services related to socioeconomic needs such as food support or cash grants through the Ministry of Women and Social Action, legal support for issues related to protection against violence and succession planning, educational access, prevention and psychological needs including to Associations of PLWHIV for adherence, disclosure and bereavement support. Volunteers are also trained to promote respect for human rights and to address community stigma.

Nutrition: The Ministry of Health has also approved national guidelines for nutritional support for HIV-infected patients, in particular the provision of a basic food basket (*cesta básica*) to patients on antiretroviral treatment with low body mass index. This is aimed at improving the nutritional status of the HIV positive patients and improving adherence to treatment. The out-patient treatment for severe acute malnutrition with the use of Ready-to-Use Therapeutic Food (provided by UNICEF and the Clinton Foundation) has already been introduced throughout the country for children. Of the 216 health units that offer antiretroviral treatment for children, 146 provide out-patient treatment for severe acute malnutrition with Ready-to-Use Therapeutic Food. Community involvement is being developed and expanded.

Prevention of Mother to Child Transmission (PMTCT): While progress in PMTCT was initially slow, implementation has improved in recent years with an estimated 45% of women in need of PMTCT accessing it in 2009. The Ministry and partners have reacted promptly to international changes in protocols, etc and have followed through on these in so far as has been possible keeping in mind resources constraints, etc. Efforts have been made to improve links between the necessary components of the health services, and to ensure that children born to HIV positive mothers are retained in the system and do not get lost to follow-up.

Counselling and Testing: The national counselling and testing strategy has undergone major changes since 2005, which aside from greater emphasis on expansion of Provider Initiated CT (PICT) in clinical settings, includes the “Counselling and Testing in Health” (CTH) approach being introduced to include health promotion and prevention activities aimed at increasing the number of people who access health services. This health promotion package proposes continuation and expansion of HIV counselling and testing as well as the inclusion of Tuberculosis (TB), Sexually Transmitted Infections (STIs) and hypertension screening and referrals where necessary, counselling on malaria prevention, environmental health education, and sexual reproductive health orientation – especially in relation to early pregnancy diagnosis and promotion of institutional delivery. With the support of partners, the MOH has released National Guidelines on CTH. Since 2008, the Ministry has started to expand community-based testing and counselling.

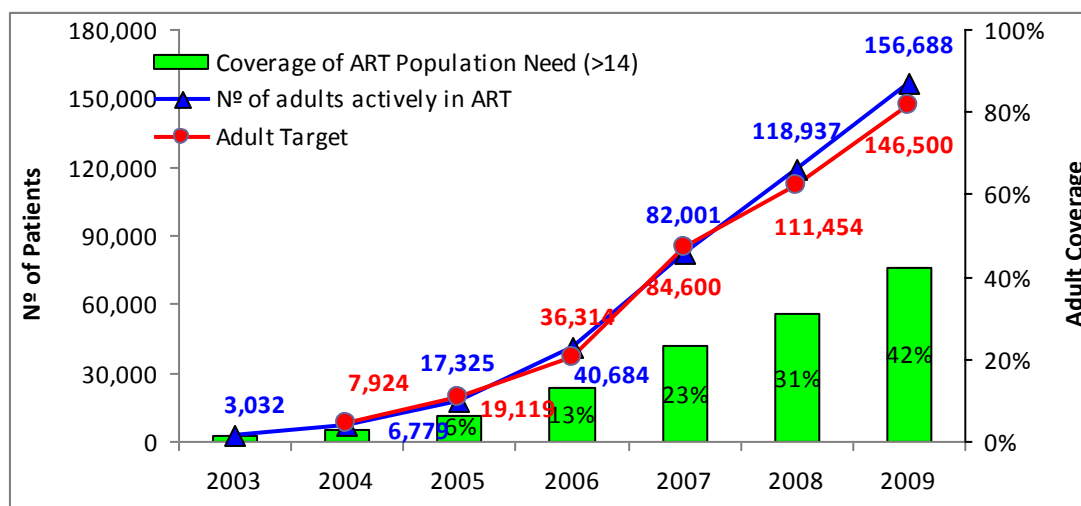
TB/HIV Collaboration: A National Strategic Plan for TB (2008-2012) is now in place and focuses on further expanding TB and HIV collaborative activities as well as implementing a quality monitoring and evaluation system allowing impact measurement of programme activities. This has been a very welcome development considering that in 2008 more than 60% of TB patients tested for HIV were HIV-positive. As a part of the effort to strengthen TB/HIV collaborative activities, the Ministry began the process of updating the HIV care and treatment patient monitoring and reporting tools in 2009.

Ongoing Challenges:

- With the decentralization of services in recent years many primary level health facilities have begun to saturate their capacity to absorb additional patients, weakening their ability to monitor and follow up patients both in care and treatment. This has ongoing implications for quality and supervision of the treatment programme. To address this constraint the Ministry has authorized the expansion of antiretroviral treatment services to an additional 82 health facilities.
- The 2006 WHO HIV treatment guidelines for both adults and children, adopted by Mozambique in 2009, have had implications in relation to the need to train increased numbers of staff, transfer of responsibilities (increased need for task shifting), forecasting and procurement of drugs, and demand on facilities with already limited resources.
- Weaknesses continue in monitoring nutritional status (in particular anthropometric parameters) in HIV positive patients. However, monitoring of the nutritional status has been incorporated into the new health information system tools to be piloted and implemented in 2010

- Even with this significant expansion of access to ART services, treatment coverage in Mozambique remains low and still has some way to go to reach universal access. By the end of 2009, with an estimated 372,943 adults and 77,031 children in the advanced stages of AIDS, approximately 42% of adults and 18% of children of those in need of antiretroviral treatment were receiving it (See Graph M2.).
- Access to treatment estimates show that approximately 60% of those (adults and children) in need of treatment have access in the southern region, 26% in the centre, and only 27% in the north (See Chart M2.)

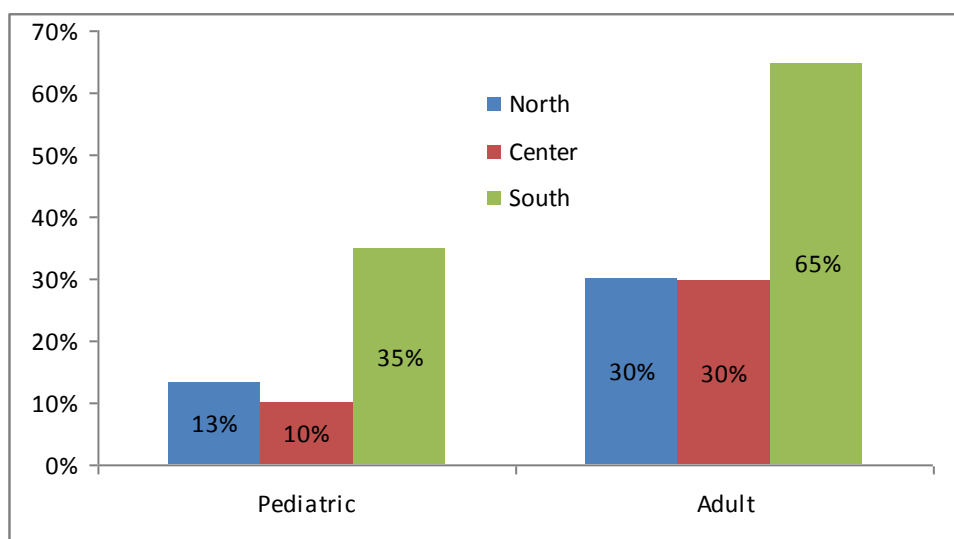
Graph M2: Trend in Adult Antiretroviral Treatment Coverage, 2003-2009



Source: Draft UNGASS report, Mozambique, March 2010

- Collaboration between the Ministry and Community Based Organizations/NGOs in the area of home-based care (HBC) continues to be pivotal to an appropriate treatment programme given the role HBC plays in monitoring adherence and nutritional status, and in providing essential psychosocial and other support to both patients and families. With the increasing number of patients in treatment, and the growing incidence of complicated cases (treatment failure, progression to more complex second line regimens, poor adherence, etc) the expanded provision of adjunctive HBC services will be imperative.
- The renewed emphasis on Community Health as shown by the approval of a new strategy and operational plan, a revised training curriculum for Community Health Workers and the definition of a long-awaited Essential Health Services Package calls for support in rolling out this important service successfully.
- Effective management of TB-HIV co-infection remains a critical priority for Mozambique but practical and logistical challenges remain in relation to the linkages between HIV/AIDS treatment services and those of the TB programme. Collaboration between the two programmes has improved, but referral systems remain weak and implementation of key policies such as the 3 I's (Infection control, Intensive case finding, and Isoniazid Preventive Therapy) has not yet been taken to scale.

Chart M2: Antiretroviral Treatment Coverage by Region for Adult and Paediatric patients in 2009



Source: Draft UNGASS report, Mozambique, March 2010

M2.2.2 Health Outcomes: Mozambique continues to show positive trends in decreasing Maternal and Infant Mortality. Infant Mortality Rate has dropped from an estimated 135 death per 1,000 live births in 1997 (12) to 93 per 1,000 live births in 2008 (13). In relation to maternal health, that there has been an increase in the number of health facilities able to provide emergency obstetric care, and in the number of health centres that have a waiting home for expectant mothers. Childhood malnutrition has shown some improvements but remains a great concern with 43.7% of children under five having moderate to severe stunting due to malnutrition (down from 47.7% % in 2003). In 2008, Mozambique successfully achieved the Leprosy elimination target. Malaria continues to be one of the major causes of death, the first cause of admissions and consultations in the health services. Below are some of the selected health performance assessment framework indicators (other than HIV), measuring progress against annual targets.

Table M3. Compiled key non-HIV health results 2004-2009

Indicator	MDG	2004	2006	2009	Increase by factor of
Immunisation Coverage (DPT/HepB3)	4	92.6%	99.4%	94%	1.02
Child birth by skilled staff	5	44.4%	48.3%	55%	1.25
Consultation per capita	4,5,6	0.9	1.0	1.261	1.4

Source: Draft Annual Review Report 2009, Mozambique, March 2010

Ongoing Challenges:

- Effective delivery on maternal health requires a functioning health system and therefore progress in this area is a demonstration of the extent to which we are making progress in strengthening the health system. More efforts are needed to reach the target set for institutional deliveries if the MDG target is to be reached.
- Despite the existence of an extensive network of health facilities and continuous increases in the use of health services since the end of the war in 1992, more than 50% of the population are still not covered by basic health services.

M2.2.3 Process Improvements: The sector has given much attention to building mechanisms for quality review processes, annual operational plans and systems necessary for delivery of core services, including HIV services. Overall in this area good progress and achievements have been made in strengthening overall government systems and mechanisms: a single country health plan (PES) and budget; a results framework and joint monitoring process; a country-based validation process; and a fiduciary framework.

There have been major policy and programmatic achievements during the last number of years, such as the completion of the first sectoral Public Expenditure and Financial Accountability (PEFA) in 2009. In addition to providing insight into the current situation, the assessment brought together key government, donor and other non-governmental partners to agree on priority actions to improve public financial management. At the request of the Minister of Health, these recommendations were consolidated with recommendations from other audits and assessments into one single Action Plan for Public Financial Management. This single Action Plan was formally endorsed in July 2009, and is a useful tool for focussing discussions and support in this area. Implementation of the Action Plan has begun, although due to a number of other government priorities in 2009 there was limited time to make significant progress in most areas leaving the vast majority of actions to be completed by late 2010 and in 2011. Irish Aid, as a key member of the Audit & Finance working group, continues to actively advocate and address key milestones in relation to public financial management activities in the 2010 action plan.

At a national level, major progress has been with adoption and use of a performance assessment framework (Health PAF) to monitor annual progress against agreed targets. Additionally, progress was made by the revised five indicators for the general PAF. The Ministry and health development partners are confident that the Health PAF is an excellent tool and an opportunity to move towards Performance Based Monitoring. IA has played a role as chair and active member of the Monitoring and Evaluation working group and was instrumental to facilitating the adoption of this important tool for use in policy dialogue.

Implementation of the PROSAUDE MOU will now be monitored on a routine basis. A draft analysis of MOU implementation in 2009 has already been produced and a tool for monitoring MOU implementation will be developed.

The current Minister has taken a very strong stance on corruption and there is evidence that corruption within the sector is decreasing. There is now an anti-corruption strategy in place.

Ongoing Challenges:

- Implementation of the PFM Action Plan needs to happen in a timely fashion in 2010 in order for donors to have confidence moving into the next phase of support to PROSAUDE.
- Better monitoring of PAF performance and of MOU implementation are also key for maintaining confidence and for ensuring better accountability and managing for results.

M2.3 Response to Human Resource Crisis

Mozambique ranks as one of the top countries affected by the Human Resource for Health Crisis. A lack of Health Care Workers is the greatest challenge to delivery of services and quality of care. In addition, the majority of the current health care workers represent a lower tier of cadre of workers providing treatment and care outside of larger health facilities. Poor conditions, low salaries, overburdening of existing staff at sites has led to a lack of motivation and high attrition rates of Health Care Workers. The current ratio of Doctors per patients is 0.03/1000. This remains extremely low compared to neighbouring countries such as South Africa (0.77) and Zambia (0.12). The ratio of Nurses is 0.21/1000, compared to SA (4.08) and Zambia (1.74).

Since the MTR of the IA-CF partnership in 2006, an in-depth analysis of the Human Resource situation was completed as well as the development and approval of the National Human Resource Development Plan (PNDRHS) for 2009-2015. This plan estimates the cost of increasing the number of health care workers from the current level of approximately 26,000 to 46,000 by 2015 as an additional \$28m in 2009, \$45m in 2010, and \$79m in 2011.

The National Human Resource Development Plan includes a series of interventions to overcome the serious absolute and relative shortage of HRH in the country. To achieve the health sector's objectives included in the Millennium Development Goals for the year 2015, Mozambique urgently needs a greater number of well-trained and supported health workers who are highly motivated and equitably distributed.

National Human Resource Development Plan

It is expected that the plan will allow:

- A qualitative leap in the Mozambican health services system associated with significant improvements in the Ministry's training system and management capacity by 2015
- A rapid expansion of all secondary and higher level professional resources by 2025

The implementation of the plan is expected to directly result in:

An increase in the total number of health workers from 25,683 (1.26 per 1,000 population) to 45,904 (1.87 per 1,000 population) by 2015. This will still be below the ratio of 2.3 per 1,000 population proposed by the World Health Organization (WHO) in the World Health Report 2006, but it can still bring major improvements for the attainment of the health MDGs. Mozambique expects to need another decade to achieve the ratio of 2.3 per 1,000

Source: "Resource requirements for HRH in Mozambique", Global Health Workforce Alliance

Implementation of the plan got off to a slow start in 2009 but significant progress is expected in 2010, including the development of new curricula and training for superior cadres, expansion of three training centres, roll out of the community health workers cadre to improve coverage of primary services, creation of an observatory, improved incentives package and long distance learning.

Both Irish Aid and the Clinton Foundation have supported the National Human Resource Development Plan in various areas. At the National Level, both organizations have been ongoing active members in the HRH technical working group (TWG) that is providing technical assistance and leveraging resources for the plan. The HRH TWG includes most major donors acknowledging the priority of this area such as WHO, DFID, CIDA, USAID, EC, MSF, GTZ, Italian Cooperation and Flanders.

In terms of financing, PROSAÚDE funds support areas such as salaries, incentives, subsidies, retention (gap year), trainings etc and in 2009 amounted to \$22 million dollars. The Clinton Foundation also provided technical assistance for the Global Fund proposal Round 8 resulting in additional funding of \$30 million dollars over 5 years specifically for HRH.

In addition to its support at central level, Irish Aid addresses issues of accelerated training of health workforce within the provincial engagement in Inhambane and Niassa. With Irish Aid funds, Nurses and other basic health workers are trained by health training centres in both provinces. In addition, Irish Aid's support and focus on rolling-out the recently approved community health strategy in Niassa will significantly improve access to services.

The Foundation has supported in-service training of 384 clinical health care workers in Paediatrics; 50 in Laboratory and 40 in Pharmacy. In addition a multi-disciplinary team is now in place providing mentoring support in 3 provinces that account for 25% of total patients in the national treatment programme. Mentoring teams are comprised of Ministry of Health staff in collaboration with the CHAI mentoring team, and are comprised of a Doctor, Nurse, Pharmacist and Psychologist with the aim of enhancing health care worker productivity and quality of services at the site through on-site clinical training. Five day visits are carried out to Ministry prioritised sites once every three months. The programme, approved by the Ministry in 2008, includes chart reviews of all paediatric patients in care and treatment and includes a component of tracking children lost to follow-up. The mentoring team also review the needs of each health facility and identify the gaps in staffing levels, basic lab equipment, and other clinical tools.

The chart reviews and support of activists have increased the number of children back into care and treatment, with the objective of reducing the loss to follow up and mortality rates. CHAI is supporting local organizations which train activists (recruiting HIV+ mothers where possible) to support the health centre in

tracking patients and ensuring that patients on an ongoing basis return for care and treatment appointments. In addition they undertake monitoring of families identified as high risk for loss to follow up.

Ongoing Challenges:

- Although the National Human Resource Development Plan has been prioritised and is very ambitious, only 30% of the activities were realized in 2009 due to the lack of capacity within the Government. As a result, five technical advisors have been seconded to the Department of Human Resources to support the implementation of the plan.
- A new Director of the Human Resources for Health (HRH) Department was also appointed in 2010 so there has been a period of downtime while the Department was re-organized. An operational plan has been developed and better progress is expected (though reduced from initial plan) in 2010.
- Global Fund support to the plan has been identified as a priority to ensure future funding based on performance of Round 8. However, there are many ongoing issues with the Global Fund in the health sector (reporting, M&E requirements, etc) leading to difficulties in disbursements of previously allocated and approved funds.
- In addition to changes in the HRH Department, challenges have been identified in trying to achieve the results in certain areas of the plan due to the involvement of multiple stakeholders and insufficient coordination. For example, pre-service training curriculum development has proven to be difficult in coordinating the various departments involved, including the Faculty of Medicine, Ministry of Education and Ministry of Health, notwithstanding the capacity and expertise required. The ability to coordinate the expansion of training centres with adequate teachers and soft components between the various stakeholders and ministries is already presenting challenges. Additional activities have been delayed, such as teacher certification and the Community Health Care worker initiative due to incomplete plans requiring an overhaul of some of the areas.
- Commitment from both Government and Partners needs to remain high to ensure that the plan moves forward at an achievable rate to support the objective of improved health services and access. Predictable funding to the sector in general will be crucial to guarantee implementation.

M3. Lessons Learnt from the Partnership (2, 14, 15)

The mid-term review of the Irish Aid-Clinton Foundation partnership in Mozambique highlighted the fact that, under the leadership of the Ministry of Health, this relationship has developed into a strong and effective partnership, with considerable influence and much to offer. Although the focus of the partnership was originally on the provision of care and treatment services for HIV&AIDS through the health sector, it has chosen to work through the existing SWAp mechanisms, channelling funds through common funding mechanisms, with a focus on systems-strengthening across the sector.

At an operational level this partnership drew from past experience and comparative advantages. The Clinton Foundation possesses the capacity to broker additional funds, rally significant technical resources, negotiate for lowest prices for drugs, diagnostics and other commodities, and above all to encourage and support countries in the fight against HIV&AIDS. Irish Aid, because of its strong and established experience in development, its comprehensive approach to harmonised, coordinated and aligned support to developing-country governments, and the Irish Government commitment to HIV&AIDS as a priority issue, has made it an ideal partner to maximise the approach of the Clinton Foundation, and to ensure the sustainability of HIV&AIDS care and treatment in the long run.

M3.1 National Context

Harmonisation and Alignment: Led by the Ministry of Health and with intense effort by all partners, solid foundations and mechanisms for harmonisation of external assistance and alignment of work in the sector have been built upon and strengthened. This impressive commitment and evidence of progress continues

to ensure the engagement of a broad group of donors/partners in the SWAp process. Even those partners who cannot channel their funds through the common funds now try to ensure that their resources are 'on plan' and thereby contribute to the capacity of the Ministry to have a full picture of financing to the sector.

Vertical initiatives such as the GFATM, US Government's Presidential Emergency Plan for AIDS Relief (PEPFAR), and the World Bank Multicountry AIDS Programme (MAP) and Treatment Acceleration Programme (TAP) also followed suit in supporting the Ministry plans, M&E systems, and procurement regulations and agreed to utilise the health SWAp coordination mechanisms rather than engaging in primarily bilateral meetings within the sector. This has allowed the Ministry to plan accordingly in terms of what is available, where it is directed, and therefore where/what the funding and activity gaps are in relation to available resources and priorities set for the sector as a whole, although considerable challenges remain in guaranteeing the sustainability and predictability of these funds.

Overall, SWAp partners and the Clinton Foundation agree that this harmonised arrangement makes for more effective external assistance with more enduring gains. This has been an excellent example of harmonisation in practice and how it can multiply to involve others, albeit with different approaches.

However, many challenges remain in ensuring that the SWAp continues to deliver in terms of improvement in performance of the sector and in key health indicators. Financial management issues and human resource capacity are amongst two of the key areas of concern for partners, and will need to be dealt with in a manner that will ensure that partners continue to have faith in the rigour of the existing structures in guaranteeing accountability, transparency, and improved performance.

Ownership: Consistent, coordinated support for the Ministry-led strategic plan has ensured that the Ministry has been firmly in the driving seat, while ensuring the engagement of all relevant stakeholders. Decision-making around HIV&AIDS is taken in the SWAp, therefore increasingly being integrated into the broader health system, not only in terms of planning and budgeting but also in terms of service delivery. All partners implementing activities in Mozambique can only do so in coordination with the national health system and under the framework of the national strategy. A Code of Conduct is in place, having been signed by donors and technical agencies adhering to jointly agreed principles of engagement in the sector. A more recent Code of Conduct has been put in place for non-governmental organisations working in the sector and an NGO unit has been established in the Ministry managing direct contracts and monitoring engagement.

Mutual Accountability and Managing for Results: As well as providing a unique opportunity for systems-strengthening this approach has unquestionably contributed towards the capacity of the sector to demonstrate mutual accountability and to manage for results. A performance framework for the health sector in Mozambique, monitored on an annual basis, includes an indicator tracking development partners' responsibilities and behaviour, and in general provides the basis for joint monitoring and reporting by all partners with a focus on service delivery and improved health outcomes. A yearly joint evaluation by the Ministry and Partners is now firmly established as the 'one' evaluation and continues to evolve in terms of quality and inclusiveness. As already mentioned, key health related HIV&AIDS indicators have also been included in the 54 key performance assessment framework indicators which are reviewed twice a year by the Government and the Programme Aid Partners (including Civil Society) in the context of monitoring progress made in the implementation of the Poverty Reduction Strategy (PARPA II). As such this process is considered central to monitoring the progress of Government and Partners in combating poverty.

M3.2 Broader Implications

Irish Aid has learnt much from this partnership and the experience in working with a global entity under the auspices of a more structured coordination with other role players under Government leadership has been acknowledged as a successful approach that ought to be documented and shared with other countries and stakeholders more widely. Indeed this experience has been presented in various international conferences and published as a case study as an example of how agencies with differing agendas and mandates can work together in support of a government-led system.

Based on the experience to date, it is felt that Irish Aid can point to this partnership experience to more confidently advocate for global entities supported by Irish Aid to seriously explore options to work within existing country level harmonisation and coordination structures. In addition, this affords a positive experience on which to explore similar modus operandi in engaging with other Foundations with specific mandates/ways of working.

As a result of this initiative Irish Aid is now the single biggest bilateral donor to Ministry of Health managed funding mechanisms in Mozambique. This partnership demonstrates how a bilateral, like Irish Aid, can engage with such global initiatives at country level and can allocate considerably enlarged resources to one sector on the basis of jointly agreed objectives, maximisation of synergies, and respecting of institutional differences. The significantly enlarged funding envelope has brought a further benefit of this partnership to Irish Aid in the political and technical influence it now has at the highest levels.

The Foundation is fulfilling a critical role of technical support to the Ministry which significantly helps to ensure that Irish Aid support to the Ministry of Health provides best possible value for money. Moreover, the close relationships it maintains within critical directorates in the Ministry helps to provide Irish Aid with improved oversight of critical areas.

This partnership experience has been positively reflected on the way the Foundation has continued to engage in Mozambique and other countries in a harmonised way through existing partnership structures at country level. Indeed the Clinton HIV&AIDS Initiative (CHAI) has recently changed its name to Clinton Health Access Initiative (CHAI) to reflect the fact that they have moved beyond focusing on scaling up access to treatment, to a broader systems-strengthening approach, as evidenced in their increasing focus on human resources for health, laboratory capacity-building and logistics, nutrition, etc.

By partnering with system-focused bilateral donors such as Irish Aid and jointly committing to Government-led harmonisation and alignment, Clinton Foundation has earned substantial credibility within Mozambique as a partner who is willing to adapt to country specificities and support broader systems-strengthening approaches.

M4. Conclusions and Recommendations for the Future Partnership

The impact of this partnership within the health sector in Mozambique has been considerable from both a technical and financial perspective. There is little doubt that the approach adopted at its inception was in many ways catalytic in setting the stage for future engagement of other HIV&AIDS initiatives and in the Ministry of Health assuming a strong lead in the context of the SWAp. Both Irish Aid and the Clinton Foundation are cited as critical partners within the health sector and have demonstrated the ability to maximise comparative advantages for the benefit of the sector in line with the PARPA, Irish Aid's CSP, the Foundation's mandate and the broader context of MDGs 4, 5, and 6. The health sector itself has continued to demonstrate progress, not only in the process and structural areas of the SWAp, but also in service delivery and attainment of better health outcomes.

However, considerable challenges remain for the health sector and concerns are now arising around the future of HIV&AIDS funding and health sector funding in general, given the ongoing exit of bilateral donors from PROSAÚDE and the proportional increase in vertical funding. The exit of four of the original fifteen bilateral donors from PROSAÚDE by 2012 will leave PROSAÚDE with considerably less influence, both financially and substantively, with much less engagement from like-minded donors. Ongoing difficulties in securing Global Fund monies, together with the very vertical nature of PEPFAR, and uncertainties around the future of World Bank funding to the sector, present an enormous challenge in guaranteeing predictability and sustainability of its financing. In the five years prior to the MDG target of 2015 a concerted effort is needed to continue to support the health sector in Mozambique to reach not only MDG 6, but also MDGs 4 & 5.

The long-term engagement of Irish Aid in the sector and the proportion and influence of its funding (17-23% of PROSAÚDE, 2008-2010) has led to an implicit assumption on the part of the Ministry and partners of Irish Aid's continued commitment to the sector. A non-continuation of a comparable level of funding to

the sector beyond 2010 would impact on the capacity of the sector to deliver on its strategy. The credibility of the SWAp in general would also be undermined, with what would essentially be viewed as another 'exit' from PROSAÚDE (without the additional partnership monies Irish Aid funding would be in the region of smaller PROSAÚDE donors such as UNICEF, UNFPA, Catalonia rather than the like-minded donors remaining). Any impact on the credibility of the SWAp will also be reflected on Irish Aid as one of the most active proponents of the SWAp in recent years and a consistent advocate for better predictability and sustainability of funding and clearer accountability. In the context of recent budget cuts to the sector a further considerable reduction (85% based on 2010 levels) would no doubt be perceived as failing to deliver on implicit commitments.

Another reputational risk exists for Irish Aid in relation to sustaining commitment. There has always been an inherent understanding of the need to maintain a long-term financial commitment to HIV care and treatment, given its chronic and long-term nature and the potential dangers of treatment failure, drug resistance, etc. if treatment is not continued. Irish Aid was cognisant of this at the initiation of the partnership and of the extreme need to be able to guarantee continued provision of treatment through the public sector.

Given these findings, this review concludes that the health sector in Mozambique would benefit from a continuation of this partnership and has the following recommendations:

- i)** A funding commitment is made to the sector beyond 2010 with a view to at least maintaining current levels and to avoid undermining the gains of the sector to date
- ii)** In line with the requirements of the Division of Labour exercise under the EU Code of Conduct, Irish Aid and the Clinton Foundation should engage in dialogue with the Ministry and other partners around the implications of this partnership and other donor decisions on the future funding to the sector
- iii)** Irish Aid should align this with its new country strategy 2012-2015, demonstrating the continued commitment to the health sector and to the mainstreaming of HIV&AIDS as a priority within the sector
- iv)** Irish Aid and the Clinton Foundation should separately and jointly consider the findings and implications of this review with a view to identifying additional areas for leverage of respective resources and maximising of efforts and influence at the international and national levels

B2 Lesotho

L1 Background to the Partnership

L1.1 Background to Lesotho

One of Lesotho's biggest challenges is its inaccessibility, being a mountainous, landlocked nation completely surrounded by South Africa. The population of Lesotho is approximately 1,880,800 people with 76% of the population living in rural areas. The greatest health problem the Basotho face is HIV and AIDS. The current HIV prevalence rate in Lesotho among the age group 15-49 stands at 23.2%, the third highest national rate in the world. The high HIV prevalence points to an increased burden on health and other vital services, decline in life expectancy (48.7 years for men and 56.3 for women) and set back on economic development gains that were made by Lesotho in the past.

AIDS is a leading cause of morbidity and mortality in Lesotho. The AIDS epidemic is regarded as a major threat to Lesotho's attainment of the Millennium Development Goals, combating poverty and promoting sustainable human development. HIV and AIDS has long-term impact on development, for instance, in 2007 Lesotho was ranked 156 on the Human Development Index as opposed to 149 in 2005 and 137 in 2003. This decline is attributable to a number of factors inclusive of drastic cuts in life expectancies and high mortality rates as a result of AIDS. There are estimates that the impact of HIV and AIDS epidemic will reduce GDP in Lesotho by almost one third by 2015.

Drivers of the HIV/AIDS epidemic that have been identified in Lesotho include:

- **Marriage trends are changing towards older age of first marriage for men and women.** This, combined with earlier sexual debut of men, leads to increased years of pre-marital sex.
- **Long term trends in median age at first sex suggest a decrease for men and a stable level for women.** In young women, low education level, low wealth quintile, and rural residence are strongly related to younger age at first sex.
- **"Male circumcision" (MC) as practiced in Lesotho is part of the male initiation process and does not seem to confer the level of protection against HIV expected from MC.** This may be because traditional MC does not fully remove the foreskin, and there is evidence of unhygienic conditions during the MC procedure, as well as riskier behaviour upon MC.
- **Sexual concurrency is exceptionally high in Lesotho with an overall prevalence of multiple concurrent partners (MCP) of 24% in 2007, compared to 10% in the region.** The number of sexual partners is a strong predictor of HIV sero-status. Survey results over the last 15 years suggest that MCP frequency may be declining but remains at a very high level.
- **MCPs are part of the 'way of life' of many Basotho.** MCPs are facilitated by labour migration which separates couples and steady partners, by multiple needs and wants of women, and perceptions that MCPs verify a man's wealth, standing and manhood. There is evidence that the food crisis and basic needs as well as the availability of modern consumer goods affect risk taking by women.
- **Key sub-populations at risk of HIV are mobile populations such as apparel workers and their migrating partners, miners, transport workers and plantation workers.** Sexual networks among mobile sub-populations involve both transactional and commercial sex.
- **Community level analysis of the epidemiology of HIV in Lesotho** found that gender roles and discrimination, social norms around age-disparate relationships and transactional sex, and alcohol use are important co-factors. At the **structural level**, labour and migration, sexual and physical violence and income inequality are key determinants of the epidemic but largely outside individuals' control.²

²March 2009 – NAC - Lesotho – HIV Prevention Responses and Modes of Transmission Analysis

L1.2 Clinton Health Access Initiative in Lesotho

The Clinton Foundation in Lesotho started work as the Clinton HIV and AIDS Initiative (CHAI) upon the invitation of the Government of Lesotho in 2005. Operations began in-country in 2005 with assisting the Government in their submission to Global Fund Round 5. The Government's submission was successful and resulted in the allocation of a grant of US\$40,000,000 for the scale up of Anti-Retroviral Therapy (ART). Initial in-country operations by CHAI focused on the scale up of paediatric ART (demonstrated by President William J. Clinton's visit in 2005 to open the paediatric wing of the Bopehelong ART clinic at Queen Elizabeth the II Hospital – the central hospital in the country), the donation and supply chain management of paediatric ARVs (which has continued to this date), and the strengthening of laboratory systems.

At the time of the signing of the memorandum of understanding between CHAI and the Government of Lesotho in 2005, the CHAI team consisted of five permanent staff members. It has since grown to a team of 25 covering seven different programmes, namely: Rural Initiative, Human Resources, Mentoring (Clinical and laboratory), Supply chain management, Paediatrics HIV care and treatment and Prevention of Mother to Child Transmission of HIV (PMTCT). In 2010 the name of the Clinton HIV and AIDS Initiative was changed to the Clinton Health Access Initiative (the acronym remains CHAI), and was established as a separate entity to carry on, and expand the projects previously conducted under the Clinton HIV and AIDS Initiative. This was done as the scope of CHAI's work has expanded from HIV and AIDS alone, to important work in health systems and malaria.

L1.3 Irish Aid Lesotho

Ireland as one of the longest standing development partners in Lesotho, has in the last thirty years developed a reputation for being responsive to Government needs and priorities, and has been committed to Government-led processes. It has had a particularly long engagement in the **health, education and water sectors**.

Irish Aid in Lesotho has developed a new Country Strategy Programme (CSP) for 2008 – 2012, and its goal is to **contribute to improved social development outcomes in Lesotho**. This Country Strategy which is fully in line with the Government of Lesotho's priorities will assist the people and Government of Lesotho to realise the Millennium Development Goals. One of the desired final outcomes for this new CSP, is to **have more effective delivery of quality basic services for citizens, as it is only through improving the availability and quality of services to both women and men**, that the social development indicators can be improved.

In order to achieve the stated goals, Irish Aid adopts a 'whole of Government' approach and works in collaboration with other Development Partners to deal more effectively with bottlenecks that are often outside the scope of a sector. The aim of Irish Aid has always been to assist the Government of Lesotho to achieve its own development goals. Irish Aid regards bilateral programme activities as an investment in people – human capital – which is very much in line with Lesotho's own Vision 2020 goal of ensuring that appropriate education and training and excellent health services are accessible to all.

L1.4 Evolution of the Partnership 2006-2010

Irish Aid and CHAI entered into a Cooperation Framework with the Ministry of Health and Social Welfare (MOHSW) signed on 27th November 2006 that reflected a commitment to collaborate in a tri-partite partnership and are implementing four main programs aimed at strengthening health systems and increasing access to comprehensive prevention, care and treatment for people living with HIV and AIDS in the most remote rural areas of Lesotho.

Significant progress was made during the initial agreement which expired on 31st December 2007. It was subsequently extended to the end of June 2008. A revised agreement was subsequently signed

by the partnership contributing to the Irish Aid new CSP for 2008- 2012 and is aligned with the five year commitment. It is envisaged that the programme will become fully integrated within the Government led National Response as articulated in the MOHSW HIV and AIDS Revised Strategic Plan (2008-2011) and the vision of CHAI to promote ownership by Government of the interventions.

Over the course of the five years CHAI will ensure that all components are transitioned to the MOHSW providing for their exit strategy at the completion of the newly approved Irish Aid CSP.

L2 Health Sector Progress in the three goals of the Partnership

Although there are four programmes implemented by the partnership, discussions on the progress will be based on the three goals as outlined in the Global MoU. While Irish Aid remains the main donor of all four programs, the three programs are being implemented by CHAI and MOHSW and the fourth, rural access program CHAI has sub-granted to Partners In Health (PIH).

L2.1 Financial and technical support to HIV Programme Implementation

Table L1 Expenditure to date

<i>Summary by year</i>	
2006	€ 1.3 million
2007	€ 3.7 million
2008	€ 4 million
2009	€ 3.75 million
2010	€ 3.65 million
TOTAL	€ 16.40 million

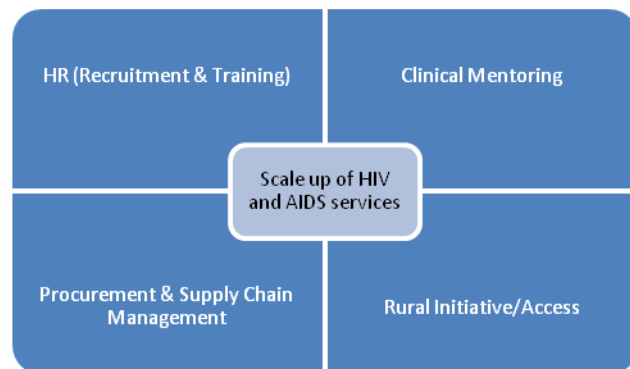


Figure L1 Programmes under the partnership

L2.2 Health Systems Strengthening

L2.2.1 ARV Procurement and supply management

ARV procurement and supply chain management: the overall objective of the program is to support the MOHSW through the provision of technical assistance and training for departments within MOHSW. The partnership supports the strengthening of reliable systems, builds competencies, and improves overall supply chain management.

CHAI supports the National Drug Service Organisation (NDSO) at the MOHSW in all aspects of supply chain management as well as providing assistance in the procurement of ARVs.

- Through CHAI's access pool of preferred suppliers the MOHSW is able to purchase ARVs at discounted prices – with an emphasis being placed on paediatric and maternal drugs. This has resulted in a substantial increase in access of drugs for paediatric patients and pregnant HIV positive mothers than would be the case without access to preferential pricing.
- The partnership assists in the strengthening of NDSO's internal systems. A countrywide ARV stock assessment was conducted between 20th July and 10th August 2009. Data captured helped provide a clear picture on stock movement and to help identify problem areas for improvement. Data used from the survey helped create a tool that was used in the training of health centres in forecasting and quantification.

- An emphasis has been placed on providing assistance at all levels of the MOHSW in addressing the capacity to conduct accurate and timely quantification of ARVs. By supporting the capacity of MOHSW to carry out quantification, future shortages of drugs will be avoided.
- Pharmacy training has been conducted at a central level, bringing in pharmacy technicians from around the country to Maseru for training, in addition early rounds of mentoring were held at hospital and health centre level.
- A new round of pharmacy mentoring was conducted between September 2009 and March 2010. MOHSW handled the recruitment of five temporary pharmacy mentors, CHAI assisted with on-boarding arrangements – funding for the positions was supported by Irish Aid. Pharmacy mentors are currently providing mentoring on storage, dispensary, inventory management, requisitioning ARVs/other medicines, receiving stocks, pre-packing, dispensing, and adherence assessments.

L2.2.2 Rural Access

Rural access: the overall objective of the partnership is to support the MOHSW in the decentralization of HIV and AIDS care and treatment services and primary health care in remote rural areas. The programme is in the process of rolling out to nine sites under the Lesotho Flying Doctors Services (LFDS). Partners In Health Lesotho (PIHL) is a sub-grantee that acts as an implementing partner managing many of the day-to-day aspects of clinic operations.

- The rural access programme is designed to roll out decentralised care and treatment at nine Lesotho Flying Doctor Services (LFDS) sites in some of the most remote areas of the Lesotho highlands. Some of these clinics are inaccessible by road and are many hours walk from the nearest road.
- Partners In Health-Lesotho (PIHL) is providing treatment services in seven of the nine target remote clinics.
- Under the partnership, construction of clinics has been completed at five of the sites, and is nearing completion at an additional site. The partnership is in the process of moving forward in identifying suitable contractors for construction at the remaining three sites.
- As of the end of December 2009, a total of 33,091 people had received counselling and testing for HIV at the seven clinics under PIHL management since the programme began in 2006, a total of **7,552** patients were enrolled in HIV care and treatment, and **4,791** were started on ART.
- The partnership, in conjunction with the World Food Programme (WFP) provides nutrition support to almost 2,500 households with family members meeting a clinical criterion. Patients who receive nutrition support are provided with enough food for themselves and family members for an extended period of time, before being phased out of treatment when deemed able.
- The services offered at the rural initiative sites are unique amongst health centres in Lesotho and anecdotal reports from patients suggest that many people travel long distances, in some cases over two days, in order to access the care and treatment services offered at these sites.

L2.3 Response to Human Resource Crisis

L2.3.1 Mentoring

Clinical Mentoring

The overall objective of the program is to use health care providers with high levels of HIV treatment experience are recruited to mentor health service providers through in-service and on-site training and coaching at ART facilities throughout the country. Mentoring has been transitioned from an internationally led intervention to a local team mentoring.

- The programme began in November 2005, Phase I relied on ~60 international HIV and AIDS health care providers volunteering their services at health facilities. Phase II shifted from an international model to local mentors with extensive rapid scale up experience of quality HIV treatment and care. Greater management and ownership is being shifted to MOHSW.
- 34 new ART sites opened with the support of clinical mentors since the programme started. Decentralization of health centres has allowed increased access, equity, and better support of adherence to care and treatment by providing HIV and AIDS care close to the patient's home.
- Confidence levels among clinicians increased by 56% after six weeks of mentoring.
- Clinic operations are streamlined to maximize productivity and effectively manage patient flow and continuity of care. Mentors support local workers to set up systems including effective management of ARV supply through pharmacy system support, laboratory sample transport, development of appointment systems to follow up defaulters, community linkages, etc.
- Over 85 out of the 190 facilities in the country have benefited from the clinical mentorship programme, and over 300 local healthcare professionals have been recipients of the mentoring at both hospitals and health centres since the inception of the programme. Clinical mentees reported satisfaction rates of close to 100% at site level. Additional benefits of the programme include the informal network of primary health care providers that is created through contact and phone mentoring during off site support.

Laboratory Mentoring

The objective of laboratory mentorship program is to strengthen laboratory operations and services, safety, quality, and management to match the increasing demand in diagnosis, monitoring and surveillance of disease.

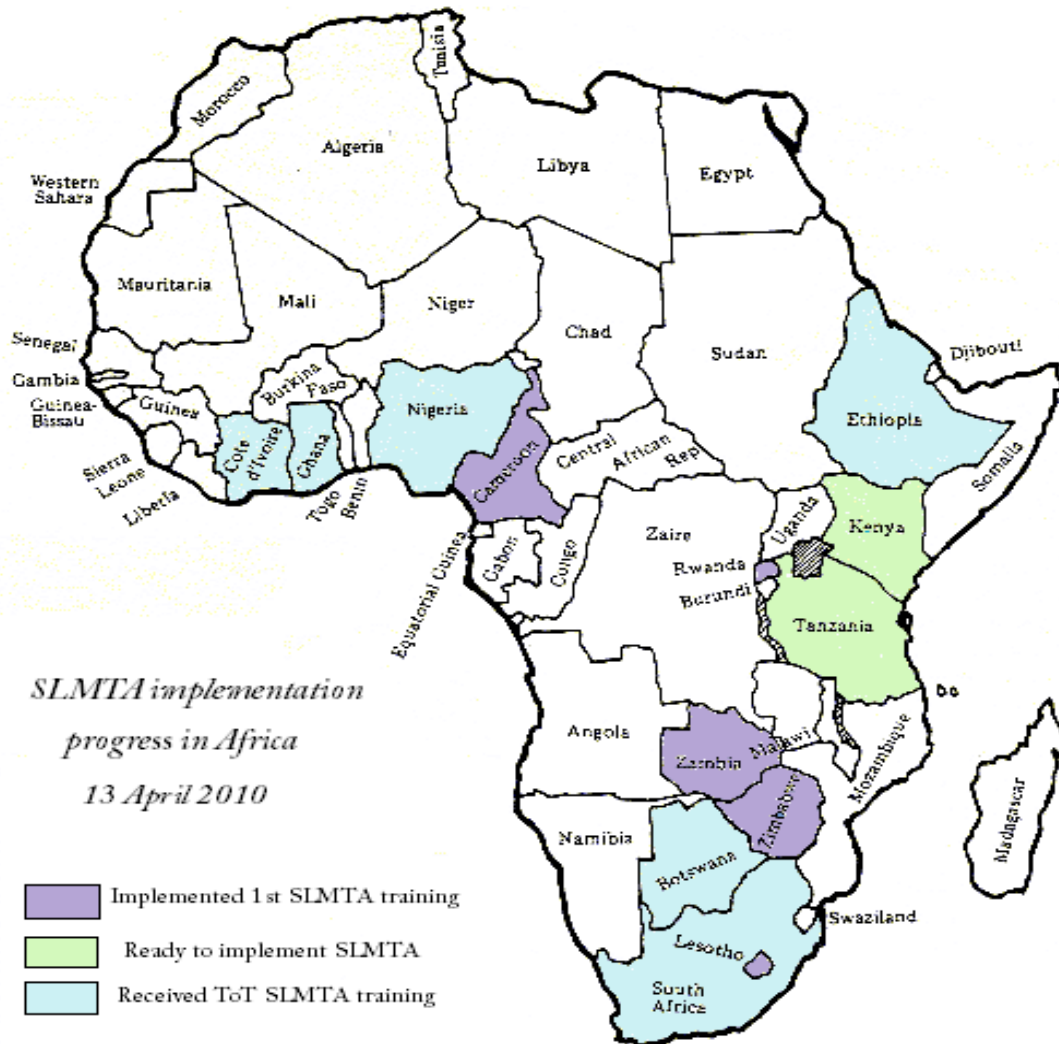
- A laboratory mentor has been hired by the partnership to provide mentoring assistance on site at the central laboratories in all districts.
- An initial round of laboratory mentorship was conducted from April 2008 – November 2008, which formed the basis for the current round of laboratory mentoring in April 2009.
- The programme was designed with significant portions of time being allocated to each district laboratory –10 weeks of mentoring in two stretches of six weeks, and four weeks; with two five week stretches at the central laboratory in Maseru.
- Mentoring has resulted in a significant number of new quality documents being developed in each lab, as well as in the review of existing documents, and the implementation of laboratory strengthening activities.
- Pre-and post mentoring assessments show significant increases in the knowledge level of laboratory employees.
- The partnership seeks to build capacity within the Quality Assurance (QA) office at the MOHSW who will take over quality improvement efforts. A QA officer accompanied the mentor at each assessment visit and was mentored on how to assess, report to lab staff, and offer onsite mentorship. An accreditation scheme linked to that of the WHO AFRO stepwise laboratory accreditation system has been put in place and a Strengthening Lab Management Towards Accreditation (SLMTA) training system that will eventually target all labs in the country has begun.
- The experiences of SLMTA in Lesotho are now being emulated in other African countries. The program is driven under the Quality Assurance Department Laboratory Directorate of the MOHSW working together with the CHAI Laboratory Mentor. Map 1 reflects a “visual - snapshot” of what is happening in Africa as the SLMTA expands.

L2.3.2 Recruitment and training of human resources

The goal of the human resources program under the partnership agreement is to support the MOHSW in strengthening the human resource capacity for quality health service delivery in Lesotho.

With this goal, the partnership seeks to increase human resource capacity, particularly at rural mountain clinics so that scale up HIV/AIDS and TB care and treatment can be achieved.

Map L1. Expansion of Strengthening Lab Management Towards Accreditation (SLMTA) model



In 2006 the partnership saw the shortage of nursing staff in Lesotho as a key problem in service delivery. The focus on decentralization of HIV and AIDS care and treatment resulted in a shortfall in the number of nurses available to staff health centres – the shortage was especially noticeable in rural areas. As a result, the partnership funded an additional 150 positions for nurses on a three year contract so that staffing shortfalls could be addressed.

- Initial recruitment in Lesotho met with some difficulties as there were an insufficient number of qualified Basotho in the country. As a consequence, a request was sent to the Kenyan government in January 2007 seeking assistance with the recruitment of Kenyan nurses to be deployed in remote healthcare facilities as part of the initiative. A formal response towards the recruitment by the Kenya government came in October 2007 and an advertisement for 75 nursing positions was placed in Kenyan newspapers.
- In total 150 nurses of Basotho (40), Kenyan (60), and Zimbabwean (50) nationalities were hired and placed at 77 health facilities across the country – as a result patients across the nation were able to see clinicians close to their homes and distances they have to travel have been drastically reduced.

- In many cases, the difficulty in hiring nurses to be placed in rural clinics stemmed from the nurses unwillingness to live in what was seen as inadequate accommodation. The partnership renovated sites with sub-par housing, as well as providing nurses with furnishings required.
- A hardship payment known as a mountain allowance is paid to nurses placed in remote parts of the country. The partnership helped to subsidize a top-up of all mountain allowances to provide a bigger incentive for nurses to relocate to rural locations and is supported with a view to that it will be taken over by the MOHSW in line with the Human Resources Development and Strategic Plan 2005-2025 and before the expiration of the agreement.
- An assessment of the nursing initiative that hopes to measure the impact of the initiative is currently in the planning stages.

The purpose of the deployment was twofold; to meet an immediate need in health centres nationwide, and to act as an advocacy tool for the MOHSW to see the urgent need for expansion of the nursing cadre. The 150 nurses are supporting the roll out of ART to health centres in rural areas. These nurses were contracted for three years under the partnership. It is envisaged that the posts will be absorbed into the public service establishment at the end of three year contract period. To date 100 positions have been created by the Ministry of Public Service; contracts for five nurses have expired towards the end of 2009; three were eligible for absorption – and two have accepted positions within the public service.

L3 Lessons Learnt from the Partnership

L3.1 The context of the partnership itself

As the relationship between Irish Aid and CHAI is a dynamic rather than static one. Lessons learnt during the history of the partnership have had impacts on the nature of the partnership and allowed for the evolution of the relationship. Highlights of lessons learnt include:

- The integration of the work conducted by the partnership with the MOHSW long term plans. The Cooperation Framework was integrated with the CSP enhancing ownership of the programmes by the Government of Lesotho.
- The rural access programme has highlighted other development problems faced by communities in the mountains, and have lead Irish Aid to work on supporting other partner organisations engaged in food support and livelihood generation. WFP has been supported in their work to provide food to those most in need, and Catholic Relief Services is engaged in engaging communities in sustainable agriculture as well as income generation schemes.
- The partnership has learnt the importance of being able to lean on Irish Aid's ability to work in a multi-sector environment with regards to their capacity to negotiate and follow up with other ministry departments beyond MOHSW. This has allowed the partnership to encourage the Government of Lesotho to create positions, and raise concerns over salary levels and gratuities that other partners may not be able to.
- Irish Aid has a large overall mandate with an emphasis on strengthening human resources. This systems approach has helped the partnership see the need to direct certain focuses areas of their work on human resources.

L3.2 Replicability in National Context in Lesotho

Various aspects of the work that the partnership has conducted have been seen as worthy of replication, and as a guideline for other related projects. Both the Government of Lesotho and other partners have seen the opportunity to learn from and build on facets of the work that has been carried out, and there are a number of programmes under way that reflect this. Highlights include:

- The Millennium Challenge Account is in the process of calling for bids for the infrastructure renovation and development that it will finance at 138 health centres nationwide. The model

being used for the infrastructure development is based on the rural access model that renovated clinics at LFDS sites in the highlands of Lesotho. The work done was seen as replicable and worthy of being scaled up from a handful of sites, to a national level encompassing the majority of all health centres in the country.

- The clinical mentoring model under the partnership supports four national mentors. Through their work, and support and advocacy by CHAI and Irish Aid, the Government of Lesotho has seen the need to scale up the clinical mentoring programme. Through funding support from the Global Fund, an additional six national mentors are being recruited bringing the total to ten. This will allow for the placement of one national mentor per district and will greatly increase the coverage and the ability of all health centres to benefit from on-site, on the job mentoring.
- The laboratory mentoring programme is one that the MOHSW has expressed a willingness to replicate if funding is available. The accreditation process for laboratories that has been spear-headed by the partnership has now been identified by the MOHSW as a process it is eager to take ownership of. As a result the laboratory department has sent a member of its team to be trained on the WHO sponsored laboratory accreditation process as proposed by the partnership.
- In August 2007, an event marking the one year anniversary of the partnership was held at Nohana – one of the rural access sites. It was attended by the Irish Ambassador, the Prime Minister of Lesotho, and a Congressman from the United States of America. It was at this event that the Prime Minister announced that the Government of Lesotho would provide financial support for all Basotho working as community health workers (CHWs) nationwide. A major impetus for this was the work being done at the rural access sites which, under the management of PIHL, have excellent networks of CHWs that ensure high levels of patient follow up, and by consequence, low levels of patients defaulting on treatment.
- The Irish Aid and CHAI partnership has a potential for growth and sustainability as it is integrating a broad range of services into one successful package. **The partnership is:**

- Working in alignment and under government leadership

Not only are the MOHSW protocols, cycles and systems used for the procurement and supply of equipment and supplies, but the partnership works to ensure that these systems are strengthened to make them more efficient and effective.

- Integrating services

The rural access clinics provide excellent maternity, immunisation, nutrition, and TB services which are fully integrated into comprehensive HIV services.

- Culturally sensitive and family focused

At rural access clinics, Traditional Birth Attendants (TBAs) are recognised and are paid a small fee for bringing expectant mothers to the ante-natal clinic and to deliver. TBAs have therefore become active partners in health seeking behaviours. Some clinics are made “child friendly” by the presence of a small playground within the compound.

- Ensuring effective communication and working in partnership with other organisations

Communication is a formidable challenge in Lesotho. However, the partnership addresses the challenge extremely well and constitutes a great example of what can be done with a relatively modest budget. A satellite dish provides reliable internet communication at rural access clinics. LFDS provide the required logistics for rapid human transport, lab samples, and spare parts. Donkeys are sometimes used to transport food to the needy; Riders’ for Health is also available in some clinics to transport lab samples.

- Addressing the issue of shortage/attrition of HRH

In many cases, the difficulty in hiring nurses to be placed in rural clinics stemmed from their unwillingness to live in these hardship areas, due to **inadequate accommodation, poor pay and security** reasons. In addressing this, the partnership took the process of renovating sites with sub-par housing, as well as providing nurses with furnishings and security fencing. A hardship payment known as “mountain allowance” is paid to nurses placed in remote parts of the country; the partnership also helped to subsidise a top-up of all mountain allowances to provide a bigger incentive for nurses to relocate to rural locations. All these reflect the

importance of this **partnership** in addressing the HRH shortage while at the same time ensuring equity and access to health services.

- Adopting the Paris Principles on Aid Effectiveness

Principles of harmonisation, alignment and ownership are being implemented as reflected in many of the points above.

L3.3 Major achievements of the programme:

- The rapid and tremendous scale up of HIV and AIDS services including PMTCT accessible to people living in most remote rural areas of Lesotho. This has led to a huge increase of people enrolled in PMTCT programmes and registered in HIV and AIDS care and treatment
- The mentorship program which has led to provision of quality HIV and AIDS services
- The partnership’s intentions to use and strengthen the government system rather than setting up a vertical program and collaborating with and understanding the needs of local partners.
- Contributions to infrastructure improvements through rehabilitation of clinics, providing security and installation of solar power.
- Addressing the issue of shortage of HRH. The two goals of the nursing initiative were both met; temporary nurses were introduced to meet an immediate need. These nurses assisted in the decentralisation of ART care and treatment to the health care level, as a result numbers of patients enrolled on ART increased dramatically. The MOHSW recognised the need for increased staffing numbers at health centres, and increased the nursing establishment list by 100 positions.
- Although HIV and AIDS prevalence in Lesotho remains high at 23.2%, according to data from 2004 DHS, access to quality and comprehensive HIV and AIDS services has increased to all parts of the country including the most rural areas from 104 sites in 2007/8 to 190 centres in 2008/09
- With the adoption of the “Three Ones” principle (one overall national authority with broad-based multi-sector mandate to lead and coordinate the entire response; one HIV and AIDS Action Framework that drives alignment of all partners and one agreed country level M&E system), the Government of Lesotho has facilitated synergy of actions among all players (including CHAI and IA) in the multi-sector HIV and AIDS response and this has led to a success in the achievement of some of the goals such as on the roll out of HIV and AIDS services throughout the country (see table L2 below)

Table L2. Trends on HIV and AIDS indicators

Indicator	Baseline 2007/08	Progress 2008/09	Increase by a factor of
% of general population who received HIV test in the past 12 months and were informed of results	8.5% ³	63%	7.4
% of people with advanced HIV infection receiving anti retroviral treatment	25%	44%	1.8
% of health facilities providing PMTCT services across all health centres	63%	87%	1.4
Health facilities providing ART services	104	190	1.8

³ 2008 UNGASS country Report

L4 Conclusion and Recommendations for the Future Partnership

L4.1 Conclusions

The role that the partnership plays in Lesotho is unique, both in terms of the emphasis on capacity building, and in the on-the-ground work carried out. As outlined above, activities that have been conducted under the partnership have led to increased quality of care, available to a wider audience. This increase in access to care has, as expected, led to an increase in the uptake of care, with ever increasing numbers of patients enrolled in care and treatment

However, the greater impact that the partnership has is in acting as a catalyst for change. As outlined above, the work conducted by the partnership has acted as role-models for scale up by other NGOs, and the Government of Lesotho – allowing the lessons learnt to be replicated on a wider scale.

Much of the work that is being done by the partnership has reached a stage which would require additional funding to continue. For example, the laboratory mentoring programme will not have completed roll out to all district hospitals upon the expiration of the partnership, however, it is a programme that the MOHSW approves of, and has some buy-in with. In order for the programme to reach culmination, additional funding will be required.

An extension of the partnership would allow the parties involved to continue with new, innovative work supporting the strengthening of health systems in the country, as well as to ensure that existing programmes are transitioned fluidly to the Government of Lesotho for the well being and health of all Basotho.

L4.2 Recommendations

Based on the information above, it is recommended that the CAHI/IA partnership is continued as:

- It has assisted Lesotho to achieve broader development goals of universal access to health services and as such have contributed towards MDG 4, 5 and 6
- It has shown potential for growth and sustainability, but continued partnership is required to enable smooth transition to government
- The full benefits of strengthening health systems through HRH support can only be reaped when the mentorship and nursing programmes have been completed and supervision and support is fully under the responsibility of Government
- The approach of supporting the GoL in the achievement of their own development priorities has worked very well, but the Partnership is now needed more than ever to ensure Paris Principles of harmonisation, alignment, ownership and mutual accountability are fully established across the health sector and that the Accra Agenda for Action is implemented in full.

Part C

Overall Conclusions

Overall conclusions are drawn from the two country reports and refer to:

- I) OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability⁴, and
- II) The need for an extension of the partnership agreement.

I) **OECD/DAC evaluation criteria**

i) **Relevance**

The three goals of the Partnership as per the 2006 agreement remain relevant and are:

- To provide financial and technical support to assist in the implementation of national plans for the prevention, treatment, care and support of people affected by, or living with, **HIV and AIDS**
- To contribute towards the **strengthening of the health system** in a manner consistent with national strategies and plans for the delivery of equitable health services
- To respond in particular to the crisis in **human resources** which is weakening the capacity of the public sector to improve health services and to implement national responses to HIV and AIDS

The HIV **prevalence** amongst adults is 15% in Mozambique and 23.2% in Lesotho. HIV is recognised as the biggest challenge to socio-economic development in both countries, with significant losses already being seen on previous gains made, and must therefore be addressed as a core priority by Irish Aid.

Health systems and human resource strengthening are emphasised globally as crucial for the attainment of the health MDGs. The current number of doctors and nurses is 0.03 and 0.21 per 1000 population respectively in Mozambique as compared to 0.12 and 1.74 respectively in neighbouring Zambia, highlighting an extreme shortage of trained health staff. The crisis in Lesotho is almost as bad with 0.05 doctors and 0.6 nurses per 1000 population⁵. By comparison Ireland has 2.9 doctors and 19.5 nurses per 1000 population⁵, about 100 times the number in Mozambique.

The Clinton Foundation/ Irish Aid **partnership is unique** and showcases how a bilateral donor and a global health initiative can work in synergy to achieve common development goals. Partnering with the Foundation remains particularly pertinent and effective because of the technical strength of the Foundation in both countries entailing a dynamic and innovative approach to the rolling out of **health services** supported financially by Irish Aid.

The evidence based scientific approach is balanced by a **cultural sensitivity** by partnering with grass-root leaders such as traditional birth attendants, thus propagating health-seeking behaviour at **community and household level** and providing ownership across the continuum of the populations from policy makers in Government to individual service beneficiaries. National **Civil Society** and Community Based Organisations (CBOs) are also supported, further improving the quality and depth of interventions and local accountability. CBOs also have a special role in monitoring **nutritional status**.

Attention to **finding root causes of system weaknesses** and subsequently innovative problem solving are inherent to this dynamic model of support which thus remains relevant as circumstances change. It has therefore been possible to roll out effective models for scaling up health services and improving equity and access in a challenging and rapidly evolving environment. Decentralisation, integration and task shifting from doctors to nursing staff helps to

⁴ http://www.oecd.org/document/22/0,2340,en_2649_34435_2086550_1_1_1_1,00.html

⁵ <http://www.who.int/countries/en/>

make rapid expansion of services possible while mentoring and integrated supervision safeguard quality.

Irish Aid's long history of supporting both Lesotho and Mozambique in achieving their own development goals across a range of priority sectors has given Ireland an excellent reputation and an influential standing in both countries. Further credibility has been added by the professional and sensitive approach of the Foundation in providing policy, technical and implementation support. The combination of competencies provided by this joint initiative to support respective Governments in line with **Paris principles of Aid Effectiveness and the Accra Agenda for Action** has made this a flagship partnership for both the Clinton Foundation and Irish Aid.

ii) Effectiveness

In keeping with the new Irish Aid HIV and AIDS Strategy and Policy, the most important elements of Aid Effectiveness are arguably **alignment** with Government programmes and cycles and **ownership** by Government of donor supported development programmes. This puts the onus of **management for development results** firmly within the remit of Government. The approach in Mozambique of allocating the funds to sector budget support, aligned to Government of Mozambique programmes, budgets, implementing protocols, and monitoring and evaluation frameworks nests the effort solidly in the heart of the Government programme for poverty reduction and development both within and outside the health sector- thus also ensuring Government ownership of both the implementation and the results of the activities supported. In Lesotho the tripartite partnership is also solidly aligned with and embedded in the Government programme with all funds provided directly to the Ministry of Health and Social Welfare (MoHSW), and ownership is demonstrated by the willingness of the Government to take over and replicate key components of the joint programme.

Perhaps the most important aspect of the Partnership is that it incorporates crucial and high quality technical support in the area of HIV and health systems strengthening within a sector-wide approach to health sector development. The considerable technical arm of the Clinton Health Access Initiative (CHAI) in both countries provides powerful **capacity building** and specialised **health systems strengthening** support in parallel with monetary input ensuring that the funds are absorbed effectively. Broader systems strengthening support and **policy oversight** is added by a team of Irish Aid health, HIV/AIDS and general development specialists – thus completing a robust, multifaceted and **synergistic** partnership in both countries. Furthermore Irish Aid in Mozambique has a **Process Fund** in its budget which is a clever facility enabling rapid funding to resolve unforeseen bottle necks as they emerge in the health sector – ensuring smooth implementation of annual plans. The effectiveness of the partnership approach is ultimately demonstrated by the impressive **results** achieved.

The Mid Term Review (2006) concluded that the partnership strongly supports the Ministry of Health in its **leadership** position, encouraging the buy-in of other stakeholders to the sector **harmonisation** and **partnership** structures, thereby ensuring that HIV and AIDS is dealt with not as a vertical issue but as a core priority within and across the health sector. This leadership is reflected in the development of several key strategic and operational plans for disease specific responses as well as cross-cutting health system elements for delivery against MDGs 4, 5 and 6.

The partnership works firmly within the SWAp partnership framework in Mozambique which ranges from Government to donors and implementing partners. In Lesotho the partnership also works at the heart of a similarly constituted partnership but furthermore handpicks local and international implementing partners with proven track records and addresses their needs. This integrated and pro-active way of working in the respective countries ensures that **best use is made of all capacity** available in the specific country context.

iii) Efficiency

The Foundation's programmes in Mozambique were reviewed in 2008 leading to a more **integrated** systems-based programmatic approach rather than gap-filling projects as in previous years. This is in keeping with Irish Aid's sector-wide approach (SWAp), and has positive efficiency

implications in terms of using all available human, infrastructural and system resources for **broader development gains**. Key actions such as **human resource strengthening** thus provide a broad and sustainable platform for achieving **MDGs 4, 5 and 6**, rather than just benefiting the fight against HIV and AIDS. Significant food security, nutritional and livelihood generating interventions weaved into the programmes in both Mozambique and Lesotho contribute to **MDG 1**.

Low-cost and high-quality technology ensures that **communication** is safeguarded, key to the efficient management of programmes. Energy efficient solar panels, satellite dishes and point-of-care technology, in combination with appropriate use of air, motorbike or donkey-back transport depending on context and urgency, ensure that services can be undertaken efficiently even in the inhospitable mountain terrain of Lesotho or vast rural expanses of Mozambique. The partnership has also been catalytic in creating informal rural networks for primary health care providers who would otherwise be isolated and unsupported.

iv) **Impact**

The partnership model remains evidence-based and results-oriented, as was highlighted in the conclusions of the 2006 Mid Term Review. The **drivers** of the HIV epidemic are becoming progressively better known as are effective measures to address them. Results have been extraordinary since the start of the partnership in Mozambique and Lesotho, not only in addressing the three goals of the partnership as laid out above, but in terms of broader development gains. Because of the unequivocal Government leadership of the programmes in both Lesotho and Mozambique, and clarity on responsibilities and obligations as laid out in respective partnership agreements, there is an emphasis of **mutual accountability** for results.

Both Ministries of Health have been asked to manage the resources mobilised and lead the respective programmes. This has encouraged a prioritised and appropriately sequenced approach which has combined quick results with more long term and sustainable gains. Both CHAI and Irish Aid are responsive to Government needs and now support broader development targets resulting in impact right across the spectrum of MDGs 4, 5 and 6 and even MDG 1. A good example of Government leadership to effect broader development gains is the transition in Mozambique from counselling and testing just for HIV (which is the global norm) to nationwide counselling for health in general, including nutrition.

The Foundation has a highly responsible and professional approach towards measuring impact, even in the challenging area of systems strengthening. It has thus promoted and helped develop guidelines for mentoring and mechanisms that enable the quantification of capacity strengthening and subsequent accreditation. These mechanisms are now being replicated throughout the Ministry of Health in Lesotho.

v) **Sustainability**

Although many of the gains made in Lesotho and Mozambique as a result of this partnership are permanent in nature (systems strengthening; country ownership; grass-root involvement; health-seeking behaviour), the respective country programmes are currently at a critical phase where further support is needed to ensure adequate and sustainable impact in the face of the 2015 MDG targets. The respective Ministries of Health want to replicate and roll out some the more innovative interventions nationwide, and although this will lead to increased value for money in terms of development gains, it will also require further external funding.

II) **The need for extension of the Partnership Agreement**

– **Division of Labour:** Whereas many other donors have left the health sector as a result of multi-sector wide division of labour exercises, Ireland has declared that it will stay in support of the Ministries of Health in both countries. One of the principles behind committing to a Division of Labour exercise is that savings from pulling out of one sector is added to the sectors where the donor agency has decided to remain, thus avoiding a net loss of resources to the overall development programme.

The expectation from Government and other donors is therefore that Ireland's decision to streamline its programmes in Mozambique entails a commitment to deepen its engagement in the sectors where it remains. Reduction in funding to the sector may carry a **reputational risk**.

– **Financial Need:** According to the Second Consultation on Macroeconomics and Health⁶ the annual per capita requirement to finance a basic health services package was US\$ 34 in 2003. This is more likely to be around US\$ 50 now. The current US\$ 19 per capita in Mozambique falls well short of this and leaves an **annual funding gap of US\$ 600 million**. Irish Aid is the main bilateral donor to the health sector in Lesotho, and to the Ministry of Health managed sector wide programme in Mozambique. A significant reduction in aid, especially in the Division of Labour context described above, will pose serious challenges to the achievement of the Millennium Development Goals.

– **Quality of Funding:** Whereas the majority of aid to health and HIV in both countries is locked into projects that lie outside the control of the respective Ministries of Health (referred to as “vertical” funding), Irish funds are transferred directly to and are managed by these Ministries. This not only ensures better expenditure (90% Vs 30% in Mozambique) and implementation rates but also ensures Government leadership and ownership, and implementation of a more balanced and better prioritised sector programme with due attention paid to system strengthening and sustainability. Already the balance of “vertical” versus Government managed funding is being skewed dangerously towards the former because of mega-projects like the US President's Emergency Programme for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, TB and Malaria (GFATM). A reduction in Irish funding would thus reverse many of the aid effectiveness gains that Irish Aid has championed in these countries, and have a **disproportionately negative effect on outcomes**.

– **Predictability:** Predictability of funding will be crucial in the lead up to 2015 in terms of the programming and budgeting of activities to achieve the MDGs. All donors, in so far as it is feasible in the current economic climate, should aim to optimise the predictability of their funding.

– **Technical Dependency:** The synergistic model of technical and financial inputs in this partnership is highly appreciated by the respective governments. The national programmes find themselves at a **critical phase** in rolling out key services countrywide and the targeted and prioritised technical support provided will be pivotal to their success, and ultimately the attainment of the health related MDGs. The honouring of responsibilities by members of both country partnerships and the substantial results achieved have led to mutual respect and growing confidence at all levels, paving the way for even greater success in the next 5 years as long as financial and technical support is maintained. The seamless transition from the current dependency on technical support to self-sufficiency is likely to take 5 years or more in both countries.

– **Universal Access:** Substantial expansion of service networks is still required to achieve Health for All and Universal Access to prevention, treatment, care and impact mitigation of HIV and AIDS. Significant rural/urban and geographic inequities still prevail in both countries and need to be addressed. The extreme shortage of human resources for health is highlighted above, and national Human Resource Development Plans were recently approved in both countries to address the crisis. As an example, an additional US \$79 million will be needed in 2011 alone to finance the plan in Mozambique. It is noteworthy that in spite of the volume of funds required this plan actually represents prudent fiscal management since it will still leave the number of health workers per 1000 population at only 1.87 by 2015, well below the minimum ratio of 2.3 per 1000 as advised by the WHO in the 2006 World Health Report.

– **Public Health Obligation:** There is an inherent long-term commitment to finance treatment for HIV/AIDS as soon as it is started since the treatment itself must be life long for every patient. Interruption of funds leading to interruption of treatment will not only cause the death of these patients but exposes whole populations to public health risks by increasing HIV resistance to life saving drugs, and thus not only reverses gains made implying a waste of the human capital

⁶ http://www.who.int/macrohealth/events/health_for_poor/en/E_REPORT.pdf

investment already made but also risks causing serious harm not only in these countries but world wide.

Part D

Overall Recommendations

Global level

In view of the excellent performance of the partnership as demonstrated by the application of the OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability and the strong arguments made for the critical need to continue the partnership, a formal extension until 2015 with a view to at least maintaining current levels of funding is recommended. Any further funding beyond this will be dependent upon a review in 2014.

The partnership is a flagship for both Irish Aid and the Clinton Foundation that showcases how a bilateral donor and a global health initiative can work in synergy to support developing country governments in achieving their own development goals successfully, fully in line with Paris principles of Aid Effectiveness and the Accra Agenda for Action. Both partners should therefore make use of the positive visibility that this implies and encourage the replication and roll-out of innovative and successful elements of the programme of support, as well as the partnership model itself.

Irish Aid and the Clinton Foundation should separately and jointly consider the findings and implications of this review with a view to identifying additional areas for leverage of respective resources and maximising of efforts and influence at the international and national levels.

Country level

It is recommended that the Partnership:

- In line with new Irish Aid HIV and AIDS Policy and Strategy, and in the interest of supporting more balanced national HIV programmes, should advocate for increased focus on prevention and addressing the drivers of the epidemic
- Continue with a health systems strengthening approach and a focus on Human Resources
- Put additional emphasis on strengthening community health systems
- Consider broader development results, across all MDGs but especially MDG1, in all its actions
- In particular, look at all interventions through a “hunger lens”
- Improve the communication of results achieved and in particular encourage respective Governments to communicate these results
- Encourage the replication and roll-out of innovative and successful elements of the programme of support, and of the partnership model as a whole

Annex 1.

Background to the Partnership, Mozambique

Irish Aid's Role in supporting the Health Sector's response to HIV and AIDS

At this time of the original agreement Irish Aid had been supporting the health sector in Mozambique for a number of years and the intent from the outset was that any additional funding to the sector should be coherent with existing support and Irish Aid's broader development goals. Although Irish Aid and the CF shared a common objective to improve HIV services and to build capacity of the MINISTRY for an effective and sustainable response, agreement on the approach to be adopted took careful negotiation between Irish Aid, the CF and the GOM.

Keeping in mind its broader development objectives and the extreme need to strengthen the health system as a whole, Irish Aid had advocated strongly for the development of a balanced, comprehensive approach to HIV&AIDS in the health sector, and also for using the existing financing mechanisms of the Ministry of Health. Irish Aid felt that this would guarantee a solid platform for launching a service as complex and challenging as HIV care and treatment, and would ensure that issues such as long-term sustainability would begin to be addressed together with the broader needs of the health sector (See Box 1.).

Following extensive consultations and in-country discussions, agreement was reached on adopting a systems-strengthening approach under Ministry of Health leadership. It was agreed that additional funding and support from the Irish Aid-Clinton Foundation partnership would be situated within the Ministry's framework and that an HIV&AIDS Strategic Plan to be developed by the Ministry of Health would be the sole basis for cooperation. It was further agreed that additional funding would be channelled through already existing funding mechanisms and pooled arrangements.

Box 1 – Irish Aid approach (14,15)

- Situate **Irish Aid/Clinton Foundation support within the framework of the Ministry of Health**, in keeping with Irish Aid strategy and policy for support to health and to HIV and AIDS in Mozambique
- **HIV strategic plan** of the Ministry would be the basis for co-operation
- **Irish Aid would actively participate in the elaboration of this Strategic Plan** and would advocate for a balanced approach to HIV and AIDS
- **Monitoring of the impact of the partnership** would be commensurate with monitoring of implementation of the strategic plan as a whole
- Irish Aid commitment to HIV and AIDS in the health sector would be supported by the creation of an **additional technical assistant position** based in the Embassy in

The strong leadership taken by the then Minister of Health in providing guidance and laying out the framework for all partners wishing to work in the area of HIV&AIDS steered this whole process. It was made explicitly clear by the Minister that the strategic plan would be the guiding document for all, regardless of funding modalities used, and that the Ministry would be leading the health sector response with all partners accountable to them.

Irish Aid subsequently engaged actively in the development of the health sector's HIV&AIDS Strategic Plan which began implementation in 2004 after a year of intensive work that included consultations with the provinces, donors, UN and implementing partners, including civil society organisations. Irish Aid, together with other health SWAp partners, and with strong leadership from the then Minister of Health, advocated strongly for the plan to provide a comprehensive strategy for the prevention,

treatment and care of HIV and AIDS through a systems-strengthening approach building on the work already undertaken in reforming the health sector in Mozambique.

The strategic plan was largely informed by the Clinton Foundation 'Business Plan' that had been approved by the Council of Ministers in 2003, and was crucial in emphasising the need for HIV care and treatment services in the country. The existence of this five year plan provided a solid basis on which the broader strategic plan could be developed. Irish Aid, together with the Ministry and other partners recognised that this new impetus and focus on treatment could be maximised to benefit the development of a comprehensive, broad-based approach to HIV&AIDS in the health sector. Spurred on by lowered ARV prices and growing external support, ambitious targets set by the plan were adopted by the Ministry of Health.

HIV&AIDS continues to be a key priority for Irish Aid Mozambique in the current CSP 2007-2010. Within the context of this CSP, Irish Aid has adopted a 'programmatic approach', restructuring of the overall programme to fit with the pillars of the PARPA II with HIV&AIDS, health and education grouped under the 'Human Capital' pillar. This approach aims to facilitate a more strategic and aligned support to the Government of Mozambique in implementing PARPA II.

Irish Aid engages actively with the National AIDS Council (NAC) and currently chairs the group of donors providing Common Fund support to the NAC. Within this forum and through other fora, e.g. the HIV/TB working group of the health sector (founded by and chaired for over two years by Irish Aid) Irish Aid has been able to participate in nationally led processes such as development of the third National Strategy for HIV&AIDS (PEN III), the Strategy for Accelerated Prevention, and the Health Sector Response to HIV&AIDS. This positioning has allowed Irish Aid to advocate for the implementation of a national response that addresses the key drivers of the epidemic in Mozambique and to deliver services that reach those most vulnerable and in need. In line with its support to the health sector, Irish Aid continues to emphasise the need for a systems-strengthening approach to HIV&AIDS, and to advocate for a balanced approach in the context of other needs and priorities in the health sector.

Clinton Foundation Mozambique

Since the inception of the Irish Aid-Clinton Foundation partnership, the mandate and strategy of the Foundation have evolved considerably beyond negotiating procurement agreements and supporting national scale-up plans in 2003.

Over the years, the global response to HIV/AIDS has changed recognizing a need for system strengthening and integration, of which the Clinton Foundation has supported in the last few years and expanding its focus and resources. Today, the Clinton Foundation HIV&AIDS Initiative is working in 22 Partner countries (with 50 consortium partner countries), with a total of 640 staff. Under this Initiative (CHAI), Mozambique falls under one of the 12 high volume countries out of the 22 Partner countries.

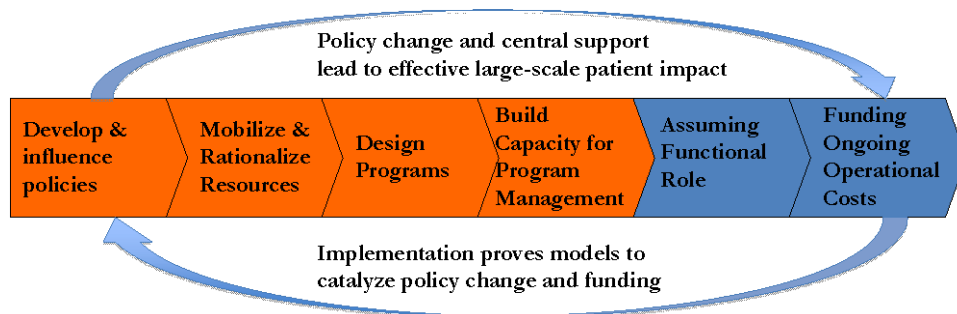
Other Initiatives have developed under the Foundation and now include Clinton Climate Change, Clinton Global Initiative, Clinton Economic Opportunity Initiative, Clinton Hunter Development Initiative and the Clinton Giustra Sustainable Growth Initiative and the Alliance for Healthier Generation.

Though the Foundation's mandate has evolved, the approach remains the same by mobilizing technical and business expertise to improve the management and organization of health systems and allowing developing countries to maximize resources available to them. In each area of its work, Clinton seeks to have an immediate and large-scale impact, while also ensuring sustainable solutions that can be owned and maintained by government partners. The areas of work under CHAI now include Paediatric HIV&AIDS, Prevention of Mother to Child transmission (PMTCT), Human Resources for Health, Rural Health Care, Access (Labs and Commodities) and UNITAID programmes.

In 2008 CHAI conducted an internal review to assess the programmes and develop a more comprehensive global strategy. As part of the assessment, two key areas were reviewed:

- i) What was the impact that CHAI was achieving?
- ii) Was it transformational and large scale?

The assessment determined that in order for these two mutually exclusive areas to be effective, CHAI's work at the Country Level must engage both the left and right hand side of the below schematic diagram in a continuum of engagement:



At both the Country and Global Level, CHAI has significantly increased its engagement with lead institutions in policy, financing and implementation such as WHO, UNICEF, PEPFAR, Gates Foundation, Global Fund providing a more coordinated and leveraged collaboration in fighting HIV/AIDS. For example, a CHAI Paediatrician is an active member of the WHO Paediatric TWG that develops new guidelines and policies adopted by Governments and implementation supported by CHAI Country operations.

In recognizing that donor funds have stretched human resources and structural capacities in developing countries to their limits in the response to HIV, new technologies and advancements to improve productivity within the existing framework is an area the Foundation is pursuing as part of effective aid. These include the current implementation of Point of Care technologies and using SMS technology, printers on site that expedite CD4, PCR and other results to the health Centre in real time.

To support a harmonized response in Country, CHAI continues to engage and work closely with the Ministry and Partners from the National to district levels. This also ensures strengthening within the National Health Service system from policy to implementation and monitoring.

References:

- (1) Memorandum of Understanding between the Government of Ireland as represented by Irish Aid and the William J. Clinton Presidential Foundation, July 2003
- (2) Irish Aid-Clinton Foundation Mid Term Review, 2006
- (3) Memorandum of Understanding between the Government of Ireland as represented by Irish Aid and the William J. Clinton Presidential Foundation, 29th September 2006
- (4) Medium Term Review Report, Irish Aid Country Strategy Mozambique 2007-2010, 13th January 2010
- (5) Memorandum of Understanding, PROSAUDE II, July 2008
- (6) Draft Annual Review Report 2000, March 2010
- (7) National Strategic Plan for HIV&AIDS (Plano Estratégico Nacional de Reposta ao HIV e SIDA), 2010 – 2014
- (8) National Plan for HIV/AIDS/STIs in the Health Sector (PEN Saude), 2004-2008
- (9) Strategy to Accelerate HIV prevention, 2008
- (10) National AIDS Spending Assessment for the period 2004-2006
- (11) National Plan for the Development of Human Resources for Health (Plano Nacional de Desenvolvimento dos RNS), 2008 – 2015
- (12) Demographic Health Survey, 2003
- (13) Multicenter Indicator Survey 2008
- (14) Case Study - 'Irish Aid and Clinton Foundation HIV/AIDS Initiative in Mozambique, An Innovative Partnership' 2006
- (15) Case Study - 'Working with Global Initiatives at Country level – Ministry of health-led synergies between a Bilateral Agency and a Global Foundation, The Mozambique Experience', 2008

List of Persons Met:

- Dr Mouzinho Saide, Ministry of Health
- Dr Lisa Nelson, CDC
- Dr Luisa Brumana, Unicef
- Dr Neil Squires, Focal Partner for the Health Sector, DFID
- Dr Ferruccio Vio, Country Director, Health Alliance International

Annex 2.

Scope of Work Review of Irish AID-Clinton Foundation Partnership 2010

1. Background

The partnership agreement between the Clinton Foundation and Irish Aid began in July 2003 with the signing of a Memorandum of Understanding (MoU) by the Taoiseach, Bertie Ahern, and President Bill Clinton. With this agreement, the Irish Government committed an additional €50 million (2003-2007) to be channelled to Irish Aid's existing HIV & AIDS efforts in developing countries. Furthermore, Irish Aid and the Clinton Foundation committed to working together to assist the development of:

- integrated treatment care and prevention programmes,
- human resources to strengthen the public health system in line with the country health sector strategy,
- quality management and information sharing mechanisms to allow treatment and care programmes to scale up rapidly.
- pharmaceutical procurement strategies, including assistance in negotiations with companies that produce patented and generic drugs.

Mozambique:

It was decided at that time that €40 million would be directed to Mozambique as a priority country of the Irish Government, and one in which the Clinton Foundation had already established agreements and working relationships with Government, Irish Aid and other partners. The Foundation and the Government of Mozambique had already signed an agreement in October 2002, in which they committed to help Mozambique roll-out treatment as a matter of urgency. Between 2003 and 2006 a total of €28 million was allocated to Mozambique, channelled through the health sector common fund (PROSAUDE), with a smaller amount of €500,000 managed as a flexible process fund intended to support those areas prioritised in the agreements signed between IA and CF and in the IA policy for improving access to treatment. A new agreement was signed between Irish Aid and the Foundation in 2006, bringing Irish Aid funding to Mozambique for HIV/AIDS in the health sector to a total of €76 million by the end of 2010, and a further €16.4 million to Lesotho between 2006 and 2010.

Mozambique was one of the first countries for which the Clinton Foundation secured agreement from the main pharmaceutical companies for the lowest priced antiretrovirals (ARVs), test kits, and other diagnostics. The Foundation also engages on the ground in an advisory/facilitatory role to the Ministry of Health, and as a technical partner in assisting with a number of key priority areas, e.g. human resources for health, procurement of ARVs and diagnostics, and logistics and laboratory capacity development.

Reviews undertaken in Mozambique to date, e.g. CSP Evaluation 2006, CSP mid-term review 2009, and the IA-Clinton Foundation Partnership mid term review in 2006 have highlighted the progress made by the health sector in Mozambique in rolling-out of HIV services and in achieving results. It is also notable that the Clinton Foundation partnership sets the context for a significant engagement by Irish Aid in the health sector with Irish Aid now the largest bilateral donor to health sector budget support.

Lesotho:

Under the new agreement in 2006 the partnership was expanded to include Lesotho. Lesotho, one of Irish Aid's priority programme countries, has one of the worst rates of HIV in the world (23.2%). As in Mozambique, Irish Aid is a major donor to the health sector and works closely with the Government of Lesotho and other partners in the roll-out of a comprehensive and equitable HIV and AIDS response. Total

Irish Aid funding to Lesotho through this partnership will be €16.4 million by the end of 2010. The Clinton Foundation in Lesotho has become one of the critical technical and strategic partners of the Ministry of Health in making considerable progress in achieving results. Through a tripartite agreement between Irish Aid, the Clinton Foundation, and the Ministry of Health, the key programme areas of procurement and supply chain management of ARVs, human resources for health, clinical mentoring of health care providers and a rural initiative in the most remote mountain regions of the country are supported.

2. The Current Partnership:

A mid-term review undertaken of the Irish Aid-Clinton Foundation Mozambique partnership in early 2006 validated the approach undertaken to date and recommended that both organisations continue with this approach for future resource commitments. The recommendations from this review were considered in the updated agreement in mid 2006 which continues the partnership until the end of 2010. The partnership in Lesotho has since been extended from October 2008 to December 2012 in line with the Country Strategic Plan (CSP) for Lesotho.

The agreement of 2006 built on the existing partnership and committed the Government to continue working with the Foundation up to 2010. The agreement commits Irish Aid to work jointly with the Foundation in Mozambique and Lesotho towards the achievement of three goals:

- iv) To provide financial and technical support to assist in the implementation of national plans for the prevention, treatment, care and support of people affected by, or living with, HIV and AIDS
- v) To contribute towards the strengthening of the health system in a manner consistent with national strategies and plans for the delivery of equitable health services
- vi) To respond, in particular to the crisis in human resources which is weakening the capacity of the public sector to improve health services and to implement national responses to HIV and AIDS

These goals, updated from those of the 2003 agreement, reflect the progression of the partnership, developments in the international arena around HIV and AIDS (in particular the increasing focus on health systems strengthening issues such as human resources for health as a priority) and the experiences gained within Mozambique and Lesotho in implementation of a national care and treatment programme for HIV and AIDS.

This mandate of the Clinton Foundation has been modified to reflect this progression and experiences gained at country-level between 2003 and 2009 in terms of how their engagement can be optimised to the benefit of all stakeholders and to inform their approach on a broader level. As a result, the Foundation has recently changed its name from Clinton HIV/AIDS Initiative (CHAI) to Clinton Health Access Initiative (CHAI) to reflect the fact that it has moved beyond focusing just on scaling up access to treatment, to a broader systems-strengthening approach, as reflected in their focus on human resources for health, laboratory capacity-building and logistics, nutrition, etc.

3. Rationale and Objective of a Review of the Partnership in 2010:

In the context of the fact that the current agreement between Irish Aid and Clinton Foundation is due to end in 2010 (although a country specific agreement has extended the partnership in Lesotho until 2012), discussions have been initiated at country-level regarding next steps for the future of the partnership.

It has been decided that IA and Clinton Foundation should undertake a review of the partnership to date based on findings from the MTR in Mozambique, a case study published in 2006, and progress and results

demonstrated in both countries to date. This will then inform both IA and Clinton Foundation in taking forward discussions at a HQ level.

The objective of the review will be to document progress towards attaining the goals as outlined in the 2006 agreement:

- i) To provide **financial and technical support** to assist in the implementation of national plans for the prevention, treatment, care and support of people affected by, or living with, HIV and AIDS
- ii) To contribute towards the **strengthening of the health system** in a manner consistent with national strategies and plans for the delivery of equitable health services
- iii) To respond, in particular to the crisis in **human resources** which is weakening the capacity of the public sector to improve health services and to implement national responses to HIV and AIDS

And in doing so should:

- **Document results** and progress to date, including benefits to systems-strengthening of the health sector and progress towards achieving broader development goals such as Universal Access and MDGs 4 to 6, , etc.
- **Document lessons learnt** from engagement between a Foundation and a bilateral donor with specific mandates and different ways of working
- **Summarise relevant findings** from relevant existing reports (as mentioned in section 3.)
- **Identify the achievements and 'value-added'** of the partnership from the perspective of Irish Aid, the Clinton Foundation, and that of the respective HIV efforts in the health sectors as a whole (e.g. maximising of resources, capacity development, aid effectiveness, improved delivery of services, etc)
- **Outline recommendations** on the merits of continuing the partnership

The last point should be the main focus of the review bearing in mind that there are still considerable opportunities to maximise synergies through such a partnership. The emerging broader systems strengthening focus of the Clinton Foundation fits well with the development focus of Irish Aid as an organisation and as such can be demonstrated to have benefits beyond the country-level engagements in Mozambique and Lesotho as there are substantive cascade effects from such a partnership, e.g. benefits to all IA programme countries from Clinton Foundation work around overall system strengthening, implementation of new technologies to improve quality of care as well as advocacy and technical support around human resources for health and lower priced drugs and commodities.

The review paper will optimise these elements and demonstrate how there could be an overarching beneficial effect for both IA and the Clinton Foundation beyond demonstrating country-level results.

4. Methodology

The exercise will be undertaken by Irish Aid and Clinton Foundation staff in both Mozambique and Lesotho, with support from the respective country offices and HQs. The Thematic Sectors and Special Programmes (TSSP) and the Policy, Planning and Aid Effectiveness (PPE) sections will provide key inputs.

The process will include a desk review of relevant documentation, interviews with key stakeholders as necessary, and an analysis and compilation of results and progress achieved to date. Most importantly, clear recommendations on the merits of continuing the partnership beyond 2010 should be elucidated.

5. Output

A review report, no larger than 20 pages excluding annexes, of the Clinton Foundation / Irish Aid partnership in Mozambique and Lesotho will be delivered that responds to the objective as outlined in section 3. The report will consist of a one page executive summary, 5-7 pages relating to Mozambique specifically, 5-7 pages relating to Lesotho and 5-7 pages of common and general findings, conclusions and recommendations.

6. Time Frame

The review will start immediately and first draft country specific reports will be made available by respective country IA/CF teams by March 5, to HQ, for circulation and comment. A complete review report will be finalised by March 16.