

## Lesson learning by global health partnerships



Taking steps to improve immunisation coverage

**Since its launch in 2000, the Global Alliance for Vaccines and Immunization (GAVI) has been working to increase global vaccine coverage.**

In line with the Millennium Development Goals and Global Immunisation Vision and Strategies targets, GAVI is supporting

country efforts to reach 90% of all children in all countries by 2010.

Over the last five years, GAVI has provided support to 71 countries (which have less than US\$1000 per capita income) to access new vaccines and improve coverage of existing vaccines through strengthened immunisation systems.

As GAVI looks to new ways of providing vaccine support in the next phase, HLSP undertook a consultation to identify lessons learned.

The process covered 56 GAVI supported countries with participation from a range of respondents including ministers of health, immunisation specialists and partner agency representatives. Telephone and online questionnaires, group meetings and individual country visits were all used.

Sustainability was the key concern. All countries reported that five years is insufficient time to introduce and transfer responsibility for funding new and more expensive vaccines, although a few countries have managed to start co-financing these vaccines. A key task for GAVI now is to exert downward pressure on vaccine prices. Support to strengthening immunisation systems is also needed for longer periods, with extra support for hard to reach populations.

The results of the consultation were presented at the GAVI Board meeting on 19 July 2005 in Paris. The findings were well received by Board members and will be used to inform the next phase of GAVI support.

## Rwanda advances HIV and AIDS care

**In 1994 genocide claimed the lives of an estimated 800 000 Rwandans. Today, the reconciliation process in Rwanda is still ongoing.**

DFID, Rwanda's biggest bilateral partner, recently pledged over £4 million to improve the social welfare of genocide survivors both infected and affected by HIV and AIDS.

Through our contract as the DFID Health Resource Centre, HLSP recently assessed plans to provide care and treatment through local non-government survivor associations. The aim was to

ensure that DFID funding was deployed to maximum effect in supporting survivors.

Rwanda has an HIV prevalence rate of around 5%; however this figure is significantly higher among genocide survivors, many of whom are women who were raped. The taboo surrounding rape victims in Rwanda has made it difficult for survivors and their families to access treatment. Added to this only a small number of doctors in Rwanda can provide anti-retroviral therapy.

Run by NGOs PACFA (Protection and Care of Families against AIDS) and SURF

(Survivors' Fund), this DFID-funded project will specifically target women and the families of women infected by HIV during the genocide in Rwanda through the provision of treatment, care and support for HIV in the community and social support initiatives.

The consultancy team made recommendations on distribution and funding mechanisms, monitoring and evaluation, human resources and training.

With the firm support of Rwanda's First Lady, Madame Jeanette Kagame, this is one of many projects demonstrating Rwanda's efforts to leave the past behind.



## ***A fragile business?***

In July 2005, the G8 at Gleneagles agreed to release an extra US\$50 billion in development aid over the next five years. But, as 2015 and the Millennium Development Goals (MDGs) deadline draws ever nearer, one of the key obstacles to attaining these goals is how to implement meaningful change in fragile states. Liz Talyer looks at the complex issues facing donors working in these countries.

How donors operate in fragile states is important. People living in fragile states are more likely to suffer ill health and die prematurely. Most existing models of development and aid instruments are based around the concept of a partnership between donor and recipient governments, but, in the case of fragile states, one or other side may not be willing or able to develop such a relationship.

There is a growing realisation of the negative impact failing states have on progress towards the MDGs. And, in some quarters, there are concerns of the security threat these states pose. This has led to increasing pressure to step up the volume and effectiveness of aid flows to fragile states.

When looking at the problems facing these countries, definitions and criteria of fragility

are less important than the appreciation of the range of factors that contribute to this state. These include conflict, ethnic fragmentation, corruption, macro-economic instability and neo-patrimonial politics.

The fluidity of most countries' situations and the fact that even so called 'good performers' may experience fragility in certain geographical or thematic areas defies fixed definitions. While there is no one accepted definition, the various classifications tend to include Afghanistan, Angola, Democratic Republic of Congo, Myanmar, Niger, Nigeria, Somalia and Sudan.

The political imperative to address fragile states may be escalating, and the needs are indisputable, however the capacity to use increased donor funds effectively – the absorptive capacity – may be constrained by several factors.

Politically, disagreements over the importance of poverty reduction, governance or human rights may be a problem, while lack of government accountability to citizens and issues of endemic corruption also impact upon donor operations.

Economically, there are concerns about weak financial management systems, the fungibility of aid, macro-economic impact, and diminishing returns in aid effectiveness.

Practically, it is much more difficult to spend money well in fragile states. Lack of infrastructure, systems and human capacity are all major problems, which in many instances are increased by insecurity and the duplication of systems.

### **Compounding the problem**

But the problem is not one sided. Donor short-termism, rigid adherence to over designed projects and fragmented, unharmonised inputs can compound the problem. And since donors often experience difficulty in recruiting experienced staff to work in fragile states, the staff deployed may lack the appropriate skills and confidence to carry out their work. In addition to these general problems there are specific issues related to health.

Performance against the health MDGs is particularly poor in fragile states. For while many developing countries struggle to manage the complexities of an effective health system, the governments of fragile states often fail to take up this challenge.

So what are the principles and approaches that will help to address these constraints and support long term development of health systems? Using the WHO health systems framework (which sets out four key functions: stewardship, resource development, service delivery and financing), the following suggestions are proposed for consideration in design of support to fragile states.

Context is crucial and should dictate the appropriate instrument and the steps that need to be taken. And whatever approach is developed, donors should avoid undermining those systems already in place and must not overwhelm existing capacity or divert it from more important functions.

### Deciding priorities

When developing a programme the design and approach should depend upon whether the donor's first priority is to improve health outcomes, to strengthen the health system or to catalyse broader societal change. Scope should be proportionate to the investment – donors contributing a small proportion of the health budget are likely to have less impact. And, although working through government poses a higher risk, it is important to consider that the potential benefits and influence are usually greater when it is possible to work in this way.

The main difficulty donors face is in the prioritisation and implementation of interventions. Criticising activities and approaches within fragile states is all too easy and there is a tendency to redesign too frequently. This is particularly unhelpful in a context of limited capacity.

Funding has to be predictable. Donors need to be realistic about sustainability in fragile states. They should plan and finance over long time frames allowing for frequent reviews, built in flexibility and scope for redesign. Even where there is not an absolute shortage of resources, financial flows may be erratic and donors wanting to make a real difference will need

to be prepared to pay recurrent costs and supplement salaries.

### Understanding and engaging

Working within fragile states is politically sensitive and development agencies must have a much better understanding of risk and of the political context in which they operate. Donors need to be more adept at managing political expectations, and clearer and more consistent about their objectives. If they want to change the way that a state works, they will probably have to engage and work with that state, even if the risks are high.

Improving health is a political process. A sustainable quality service is ultimately ensured by the effective demand of people on their governments and on those responsible for providing services. Since government accountability in fragile states is often lacking, donors should look for opportunities to support the provision and dissemination of information, to work with civil society and professional groups trying to improve service quality and accountability, and with those working on participatory monitoring and budgeting and other 'tools of accountability'.

Traditionally, service delivery has been supported through the subsidy of budget line items such as salaries and transport. A new and encouraging move has seen donors providing performance-related supplementary payments. In Rwanda and Afghanistan, health facilities receive additional payments in accordance with coverage rates of certain high priority services (skilled birth attendance, immunisation completion rate, TB

*HLSLP is working to address some of the challenges facing Afghanistan*



*Fragile states need extra support to achieve the health MDGs*

detection and cure). This change in funding has led to significant increases in utilisation for priority conditions and an apparent decrease in out of pocket expenditure by the target population.

### Making headway

While many donors have adopted a lower risk strategy of minimal engagement with governments in fragile states, channelling most of their assistance through NGOs, there have been some successful exceptions. The UK government offered budget support to the government of Sierra Leone, and the Norwegians have established a reputation as donors who can, and do, work effectively in difficult environments – such as Guatemala and Nicaragua in the past and Angola and Mozambique more recently.

There is a lot that can be done to improve health outcomes in fragile states and in the run up to the MDG deadline major gains can be made. But it is clear that there is no 'right answer', no blue print for success. Work on health in fragile states is beset by conflicting imperatives. And future donor successes will be part luck and part balancing act.

# PPPs for medicines – do they improve access?

**HLSP Institute consultants led a series of country case studies for the Initiative on Public Private Partnerships for Health (IPPPH) to assess the impact of public private partnerships with pharmaceutical companies on access to drugs.**

This analysis represents the most comprehensive assessment to date of the health and health systems impact of public private partnerships (PPPs) for improving access to pharmaceuticals in low and middle income countries. These PPPs often involve a UN agency such as WHO and a research and development-based pharmaceutical company that has committed to providing drug donation or discounted pricing arrangements for selected countries and disease control programmes.

The studies were designed to examine issues of 'ownership' by the national government, integration with the national health system, co-ordination, implementation and impact. Case studies took place in Uganda (the pilot country), Botswana, Sri Lanka and Zambia in 2003/04. They were undertaken through country-based evaluations by independent teams from the Institute, the London School for Hygiene and Tropical Medicine and in-country consultants with financial support from DFID.

The clearest finding is that tropical disease drug donations – usually linked with elimination efforts – have been of considerable benefit. However, while drug donation is important it is not sufficient to initiate and support a full national elimination/control programme. Operational support also needs to be mobilised and the donation sometimes helped to catalyse this.

Diseases that can be 'eliminated' as major public health problems are good choices for health commodity-focused PPP support because of their time-limited nature, thereby minimising any risk of setting up unsustainable programmes. The transition from the elimination/reduction phase to sustainable routine control and the importance of integration into the local health system were highlighted as points for further consideration.

Drug access initiatives addressing HIV and AIDS were complicated by fragmentation, questions of funding



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*Drug access partnerships support efforts to scale up ARV treatment in Botswana*

sustainability and certain conditionalities. The studies found that the programmes were welcomed by some governments and healthcare providers but that there were problems and limitations.

Compared to the overall need for access to HIV and AIDS treatment, the scope of PPP efforts has been modest. Since many PPP initiatives operate through the public sector, this may restrict access in countries where private clinics are a major source of care. At national level, establishing which product offers provide maximum benefit for their cost is difficult and it was not possible to quantify the public health, equity, health system and market impacts of donation programmes.

Poorer countries lacked support to navigate the complex and evolving global policy environment for anti-retrovirals (ARVs) including issues of intellectual property protection, incentives for innovation, relationships between brand name and generic products, prices, and trade in general.

The long-term indirect effects of donation programmes for ARVs or opportunistic infections may rule out local competition and create market distortions. There were individual instances of onerous reporting requirements and patient literature that were not in line with national drug policy.

Addressing companies, low and middle income country governments, international organisations, and bilateral aid agencies, the report makes several recommendations.

It is suggested that there should be an assessment of opportunities for new donation programmes for disease elimination, where public health needs, company commitment, and health system, technical and market considerations are in line with the success criteria identified by the study. Increased efforts are needed to improve co-ordination and maximise synergy between programmes at national and international levels. Furthermore, a review should be carried out of lessons learned and issues arising in relation to costs and sustainability, and of risks of diversion and access through the private sector for the Coartem® programme (Novartis' new anti-malarial, artemisinin combination treatment).

In relation to HIV and AIDS, the study recommended continued efforts to rationalise the fragmented ARV market and drug procurement systems, and to increase transparency in the prices obtained. It was suggested that there should be more focus on simplifying and harmonising product discounts and procedures, including eligibility criteria and conditionalities. The study also proposed better integration of product reporting requirements into national drug management information systems and more provision for offering discounts through public sector partnerships with quality assured private providers.

The full study is accessible at [www.hlspinstitute.org](http://www.hlspinstitute.org)

# Funding for TB and malaria: a changing picture

**As the 2015 deadline approaches, there are concerns that some of the health Millennium Development Goals, including targets for communicable diseases, are receiving less profile than needed. Are sufficient resources allocated to TB and malaria, plus HIV and AIDS? Do global health partnerships (GHPs) really bring in additional resources?**

Recent studies by the HLSP Institute have attempted to answer these questions. The findings were presented at the 5th International Health Economics Association congress in July 2005. This work comprised the findings of three separate pieces of work – on the economics of GHPs and on international funding for TB and malaria.

Donor funding commitments for both TB and malaria increased between 1999 and 2004, although some funding is 'hidden', in that it is given through budget support or a sector wide approach rather than earmarked by development agencies for a particular disease.

Overall, GHPs have brought welcome additional resources, particularly the Global Fund to Fight AIDS, TB and Malaria (GFATM). And, at least for TB and malaria, the resources are mostly well-targeted in that they are spent on cost-effective interventions and are generally pro-poor.

While money from the GHPs is relatively minor in terms of overall public funding for health, it does significantly add to existing resource flows in several countries. In Ethiopia, Liberia and Malawi the partnerships

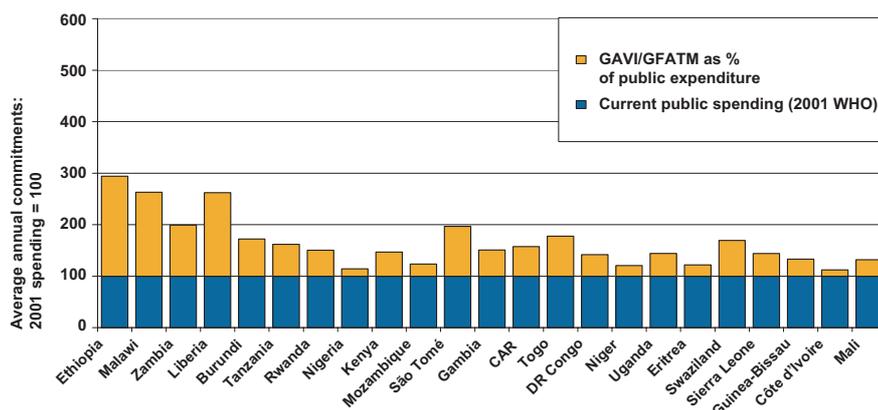
account for a more than 100% increase in health spending commitments. This is demonstrated in the graph below, which shows the ratio of government to partnership spending on health.

Given these funding levels, support to GHPs raises issues of sustainability. Many partnerships provide money for a limited time period, after which countries may have to take over funding. This is often unrealistic and may take place at the expense of other funding priorities. Many low income countries will have great difficulty in funding ongoing costs if partnership funding for current activities ends as planned after a five-year period. In this context, the period 2008 to 2010 is crucial, as this is when initial Global Alliance for Vaccines and Immunization (GAVI) and GFATM commitments come to an end.

The overall funding environment is changing, creating uncertainties about the future. The burden of disease associated with TB and malaria, and the availability of cost-effective interventions, justify greater spending on these diseases. And as international funding is likely to remain volatile for the next few years, national successes in the fight against TB and malaria will depend as much on the stability and predictability of funding flows as on the magnitude of support they receive.

Note: For more information on GHP financing, please see studies commissioned by DFID, available on the DFID Health System Resource Centre website, [www.healthsystemsrc.org](http://www.healthsystemsrc.org)

## Potential impact of major health partnerships on health spending



## In brief

### New guide to sector wide approaches

In recent years several Latin American countries have shown great interest in sector wide approaches (SWAs). This new publication aimed at Spanish speaking countries covers the various stages of the SWAp process from development to implementation, as well as themes such as harmonisation and alignment. 'Qué son y cómo se emplean los enfoques sectoriales' is available at [www.hlspinstitute.org](http://www.hlspinstitute.org)

### Key issues in regulation of the medical profession

This new technical brief is of particular relevance in countries where the health system has recently undergone, or is currently in the process of, reform. While developed for a middle income context, much of the learning and general principles are transferable to settings in both developed and developing countries around the world. 'Understanding medical regulation' can be downloaded at [www.hlspinstitute.org](http://www.hlspinstitute.org)

### About the HLSP Institute

The HLSP Institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health.

The Institute builds on HLSP's experience and expertise in health, HIV and AIDS policy and practice, health systems and aid management. As part of its role to ensure the technical excellence of all HLSP's work, the Institute is responsible for sharing experience and information about wider development issues through regular learning events, and technical updates and papers. Contact us at [institute@hlsp.org](mailto:institute@hlsp.org)

### Yemen

#### Assessment of Childhood Development project, UNICEF

**Yemen is one of the countries with the highest gender disparities in education worldwide. In addition, there is a strong urban-rural discrepancy in access to basic social services.**



HLSP evaluated UNICEF's childhood development project in Yemen

The five-year Child Development Project (CDP) is a tripartite partnership between the government of Yemen, the World Bank and UNICEF. Started in 2001, it aims at improving basic social services for women and children in 30 districts in nine Yemeni governorates selected on the basis of social deprivation.

With its budget of US\$45 million CDP is the largest collaboration between UNICEF and the World Bank to date. Another important feature of CDP is its decentralised approach to project planning and implementation, which has taken place in close partnership with district councils and communities.

In 2005, HLSP undertook the first external and independent evaluation of this project. The key components of the assessment included project management, community readiness, health, nutrition, education and early child development (pilot project).

A team of three international experts, Dr Monika Zabel (Team leader and HLSP's M&E specialist), Dr Claudio Schuftan and Ali Dastgeer, assessed the CDP to gauge its achievements against all the project components (in a selected number of districts) and to generate findings, conclusions and recommendations. As the project is close to its end, the assessment will also include lessons learned for future, similar projects.

### Mozambique

**Evaluation of the Spanish Cooperation Programme, AECI**  
**In 2004 the new Spanish government signalled a change in the way Spanish Development Cooperation (AECI) is planned and delivered, with a view to making Spanish Official Development Assistance more poverty focused and aligned with individual countries' needs. To support this process, HLSP was commissioned to carry out an evaluation of the AECI's health work in Mozambique over the last four years and covering four key projects.**

From our findings, HLSP proposed a change in the way sector policies are defined. It was argued that it is the role of the receiving government to define sector policies, while donor governments should concentrate on setting their own aid strategies to serve those sector policies in the best possible way. This in turn necessitates a much greater understanding of developments in key sectors in the recipient country. Therefore, HLSP stressed the need for more responsibilities to be devolved to national representative offices and the cultivation of improved analytical skills in-country.

HLSP's evaluation recognised the need for increased interaction with other donors and with the recipient government. Furthermore, the Spanish government was encouraged to increase its involvement in the ongoing health SWAp mechanism and to consider allocating some development assistance through common funding agreements that are in place in Mozambique. It was also recommended that AECI adopted a more transparent approach to competitive tendering.

Finally, HLSP underlined the importance of investment in staff resources to ensure there were sufficient technical skills and familiarity with new aid instruments in country offices and at headquarters in Madrid.

There are signs that AECI is taking these lessons seriously. HLSP has just delivered training on new aid instruments to AECI staff in Central America and a couple of high level seminars in Madrid for senior AECI staff. And, for the first time, Spain has been contributing to Mozambique's Health Sector Fund.

### Russia

**Responding to AIDS in Nizhny Novgorod, DFID**  
**The AIDS epidemic in the Russian Federation is at a critical stage. Following the collapse of the Soviet Union, socio-economic upheaval and an increasingly mobile population have left Russia ever more vulnerable to HIV and AIDS. A dramatic increase in the number of infections in the past three years indicates a shift towards a more generalised epidemic.**

While the current total of registered HIV cases sits at around 300 000, experts estimate the actual number of HIV-infected persons is between 1.5 and 2 million – accounting for 1%-2% of the adult population.

Nizhny Novgorod Oblast is one of the largest and most populous regions in the European part of Russia. The Nizhny Novgorod/UK DFID Partnership Programme addressing HIV and AIDS is aimed at enabling the local government to prioritise and mobilise a multi-sectoral response to the epidemic.



Poor quality of life is associated with injecting drug use and risk of HIV

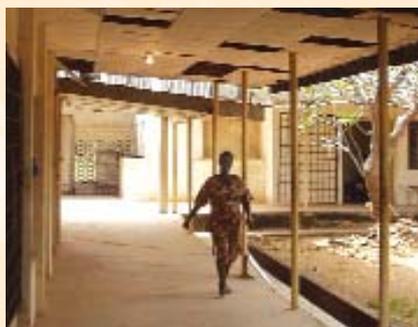
HLSP is providing technical assistance to the Oblast Administration to develop and implement cohesive, cross-sectoral policies and programmes for the cost-effective and sustainable prevention and control of HIV and AIDS in the region.

Not only will this partnership work to reduce poverty and improve quality of life, it also seeks to establish Nizhny Novgorod as one of Russia's leading regions in HIV and AIDS prevention with the capacity to disseminate best practice throughout the sub-continent.

## Nigeria

### **PATHS – Hospital improvements in Enugu State, DFID**

**HLSP is heading the consortium for PATHS (Partnership for Transforming Health Systems), a £39 million implementation programme funded by DFID. Aiming to advance Nigerian health systems at a national level and in several states, the programme works to improve partnerships, local ownership and responses from existing health services.**



*Agbani Hospital, Enugu State, Nigeria*

As the PATHS programme enters its third year, it has become necessary to upgrade the entire hospital infrastructure of certain states to facilitate many of the management improvements that have been made. At Agbani General Hospital, in Enugu State, a new programme is underway to renovate dilapidated hospital buildings and to provide a quality essential package of services at secondary care level. Work to improve a further five hospitals and a School of Midwifery is due to start in the coming months.

One of the main challenges facing this initiative is ensuring that, following many years of under-investment, the public utilities of water and electricity are still in working order. Currently electricity supply is sporadic and water has to be carried in, sometimes by the patients themselves or, in more fortunate cases, by tankers offloading at large plastic or steel water tanks.

This ambitious work aims to bring Enugu's hospitals up to a level where patients have confidence that both staff and buildings are able to provide good quality care.

## India

### **Programme Management Organisation, DFID**

**India is set to overtake South Africa in terms of the number of people living with HIV and AIDS. The spread of HIV within India is as diverse as its society, with the epidemic being made up of a collection of different epidemics, in some places within the same state. In India, vulnerability to infection is closely linked with poverty and lack of access to services, as well as to stigma and discrimination.**

Overall India's response to the HIV and AIDS epidemic needs major behaviour change, an urgent scale up of evidence-based prevention interventions and increased access to treatment.

Building on lessons learnt during NACP-I, the second phase of India's National AIDS Control Programme (NACP-II) was launched in 1999 with funding from the World Bank, DFID and USAID. NACP-II has three programme components – priority targeted intervention programmes for vulnerable groups, preventive programmes for the general community and low cost AIDS care – and two system strengthening parts – to strengthen capacity to implement NACP-II and to improve inter-sectoral collaboration.

HLSP is working on the Consultancy for Management of a DFID supported HIV and AIDS and Sexual Health Programme, which will manage DFID's support to the government of India's NACP-II.

Under the contract HLSP, in partnership with our regional colleagues Dalal Mott MacDonald, is responsible for the implementation and monitoring of existing and new contracts comprising DFID's support to NACP-II. This includes contract and grant management, and monitoring and evaluation of programmes contributing to the reduction of HIV infection and its impact, especially in Andhra Pradesh, Kerala, Gujarat, Madhya Pradesh, West Bengal and Orissa.

Our technical response will focus on a cost-effective management structure, professional contract management processes, monitoring and evaluation and bringing added value to the contract through applied lesson learning.

## Bulletin board

### **Introducing HLSP UK**

A new UK division was established in January 2005 to provide healthcare consultancy services in the UK. The division builds on HLSP's reputation for providing pragmatic, hands-on support to healthcare providers and policy-makers.

As well as being a source of expertise and knowledge on changes in the UK healthcare market, the division aims to support colleagues across the Mott MacDonald Group on healthcare-related capital projects and to ensure that international colleagues remain up-to-date with developments in UK healthcare. The division's main areas of expertise include service design and reconfiguration, activity planning and costing, commissioning, organisational development, patient involvement and governance.

### **Nairobi office, Kenya**

HLSP is committed to establishing its presence in Africa as part of developing our business with African partners. At the end of 2005, we will open an office in Nairobi to continue growing our portfolio of projects, and to support our existing activities in Kenya and Zambia. It is expected that the office will also serve as a base for our Mott MacDonald colleagues working in East Africa.

### **HLSP in Georgia**

As part of the EC's support to Primary Health Care Reform, HLSP has started work on an 18-month project aiming to retrain the medical workforce and practice managers from the Kakheti region in Georgia.

# Aid instruments: what works?

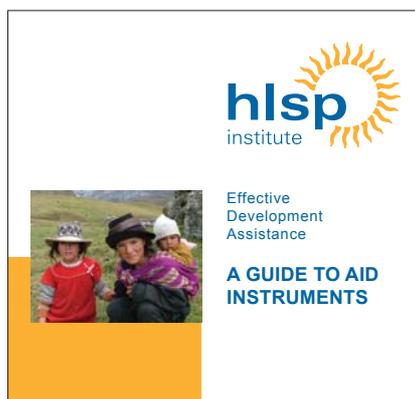
**What are the main ways in which development aid is channelled to low income countries? How are different processes helping to improve the quality of policies and strategies? These and other issues surrounding aid instruments and aid effectiveness are explored in a CD-ROM developed by the HLSP Institute.**

'Effective Development Assistance: A Guide to Aid Instruments' is an interactive learning resource providing a structured overview of the key issues in aid instruments and development assistance.

Organised into five modules, the CD-ROM covers development context (poverty, the architecture of international aid, the Millennium Development Goals and poverty reduction strategy papers), aid instruments (such as projects, sector wide approaches and direct budget support) and practical issues including partnership working, fiduciary risk, procurement and monitoring.

The 'teach yourself' format allows users to work at their own pace – moving rapidly through the modules or exploring issues in more detail. The main sections are complemented by practical exercises, a bibliography and links to other resources.

The CD-ROM hopes to have something for everyone. It will be of particular use to sector specialists or consultants involved in designing programmes and working through the various different approaches, instruments and ways that donors operate. It will also assist aid agency administrators



seeking a better appreciation of the context and rationale for different ways of working, and officials in partner countries needing to understand donor priorities and perspectives.

Originally prepared for the Swedish International Development Cooperation Agency (SIDA), the CD-ROM has been revised recently to meet the needs of a wider audience, and has already been presented and distributed to a number of agencies such as the World Bank, the World Health Organisation and the Inter-American Development Bank. It has also been used very successfully for group training organised by HLSP in various countries and as a tool to complement work on donor harmonisation in Ethiopia.

**To request your free copy of the CD-ROM, or to discuss your training needs, e-mail: [institute@hlsp.org](mailto:institute@hlsp.org)**

## About HLSP

**At HLSP we work to provide client focused services tailored to reflect the different needs of the countries we work in.**

We respond to the wide ranging requirements of our clients and their development partners with short, mid and long term technical assistance and project management. HLSP has earned a reputation for delivering to deadlines and adding value, drawing on our 20 years' experience of working in the health sector.

We offer our services through a core group of in-house health experts and through a sizeable database of tried and tested international and in-country consultants. We provide full quality assurance of all our consultants and constantly seek to supply highly respected practitioners in their respective professional disciplines.

HLSP manages the contract for the UK Department for International Development's Health Resource Centre (HRC). The HRC provides access to technical assistance and information in support of pro-poor health policies as well as health systems, service delivery and public health topics and programmes.

In 2005 we established the HLSP Institute. It provides policy analysis, training and applied research on issues relevant to better development practice and improving health systems.

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*HLSP is a professional services firm specialising in the health sector both in the UK and globally. Working with international agencies and national governments, HLSP strives to advance health systems, reduce poverty and combat HIV and AIDS through long-term sustainable solutions.*

