February 2010

7 Questions with Michel Kazatchkine, Executive Director, The Global Fund to Fight AIDS, Tuberculosis and Malaria 4

Collaborative Scale-Up of Male Circumcision 7

Hope for Uganda’s Women 11

United Against Malaria 17

Coordinated Action Meets Child Need 19

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### TABLE OF CONTENTS

2 WORLD MAP

4 7 QUESTIONS  
Michel Kazatchkine, Executive Director, The Global Fund to Fight AIDS, Tuberculosis and Malaria

5 PARTNERSHIPS  
The Way Forward: Partnerships Build Local Capacity

7 HIV  
Collaboration for Successful Scale-Up of Male Circumcision  
Cameroon Launches Counter Attack on AIDS  
Concurrent Sexual Partners Are ‘Risky Business’

11 REPRODUCTIVE HEALTH  
Hope for Uganda’s Women  
Improving Services for India’s Urban Poor  
Advocates Raise Call for Universal Access to Family Planning

15 MALARIA  
New Research Reveals ACT Drug Access Startlingly Low  
Football Teams Unite Against Malaria  
Crossing a Threshold: 100 million Nets Delivered

19 CHILD SURVIVAL  
Coordinated Action Meets Urgent Health Need  
Global Handwashing Day Celebrates Partnership in Action  
Bold Network Prevents Diarrheal Disease Worldwide

22 POLICY NEWS

23 MEASURING RESULTS

24 FINAL WORD  
Karl Hofmann, CEO and President, PSI

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PSI is a leading global health organization with programs targeting malaria, child survival, HIV and reproductive health. Working in partnership within the public and private sectors, and harnessing the power of markets, PSI provides life-saving products, clinical services and behavior change communications that empower the world’s most vulnerable populations to lead healthier lives. www.psi.org
PASMO Joins in Guatemala’s Congress on Masculinity

The Pan American Social Marketing Organization (PASMO), a PSI affiliate, and its regional partners participated in Guatemala’s National Congress on Masculinity in December. The Congress generated discussion and promoted the exchange of experiences and information on the subject of masculinity, including how it relates to violence and health; and social construction and public policy. PASMO presented research on masculinity in Central America and its Hombres de Verdad (Real Men) campaign, under the slogan “No todos los hombres son iguales. ¿Y vos, cómo te protegés del Sida?” (Not all men are the same. How do you protect yourself from AIDS?).

PASMO Author: Alejandra Cabrera

Nigeria has embarked on an ambitious initiative to reduce its malaria burden, which currently accounts for 30 percent of childhood mortality in the country. By December 2010, it will place two insecticide-treated nets in every household. In support, the Global Fund to Fight AIDS, Tuberculosis and Malaria signed its largest single malaria initiative, providing resources for 30 million nets. PSI affiliate Society for Family Health will help the Nigerian Federal Ministry of Health implement the initiative.

Global Fund Provides 30 Million Mosquito Nets in Nigeria

SFH Sponsors ‘Rage for the Revolution’

Society for Family Health’s New Start program in South Africa recently sponsored the fifth Levi Strauss® Rage for the Revolution Music Festival. The music festival increases HIV prevention awareness and debunks HIV myths that create testing barriers. South Africa’s top 15 most popular musicians and DJs, featured at the concert, pledged support by undergoing HIV/AIDS training. The New Start program serves about 20,000 clients per month.

PSI Author: Tsabeng Nthite

Former Miss Universe Dayana Mendoza advocated for the “Hombres de Verdad” campaign in Nicaragua in 2009.
US Officials Visit Top Réseau Clinic

U.S. Ambassador Niels Marquardt and USAID Representative Noe Rakotondrajaona visited PSI’s Top Réseau clinic in Fort Dauphin, Madagascar — one of 130 USAID-funded Top Réseau socially franchised clinics, offering youth-friendly, affordable reproductive health services. The clinic receives about 250 youth clients each month for consultations regarding sexually transmitted infections, voluntary HIV counseling and testing, family planning and reproductive health.

PSI Author: Brian McKenna

Debra Messing Visits PSI/Zimbabwe

In December, actress and PSI Ambassador Debra Messing visited PSI programs in Zimbabwe. A highlight of her trip included visiting the Black Beauty Hair Salon outside of Harare. Through a program funded by UKaid, hairdressers are trained as peer educators and talk with their female clients about HIV prevention and the benefits of using the female condom. The program has trained 1,500 hairdressers. View a short film of the project at www.DFID.gov.uk.

PSI Author: Mandy McAnally
1. In the current economic environment, many people worry about the future financing for HIV, TB and malaria. How is the Global Fund navigating through these difficult economic times?

Our main message to donors is that the world has the opportunity to achieve some tremendous successes in global health over the coming five – six years: eliminate malaria as a global health problem; ensure that virtually no child is born with HIV anywhere in the world; stabilize and reduce the AIDS pandemic in most countries; and reach global targets in TB control. These successes are in our hands. We only need to ensure there are sufficient investments so that we do not start to slide backwards. We are also showing donors that the Global Fund is a highly effective tool to achieve these successes. Our overhead is extremely low, our funding follows results; in short, we provide value for donors’ money. We have further emphasized this by imposing efficiency savings throughout our grant portfolio to limit any unnecessary expense and ensure that we drive down the cost of services to a minimum while not compromising quality or results.

2. What do you think are the key challenges and opportunities for the Global Fund today?

The Global Fund must continue to adapt to the changing environment in which we work. We need to balance the efficiency, speed and country ownership of programs with the demand from donors for accountability, and to fit in alongside the other tools used to deliver resources for health. We must maintain our focus on achieving results, saving lives and reducing the impact of the three diseases on people’s and countries’ economy and development while at the same time ensure that our resource flows are sustainable and that they help countries build up comprehensive health services.

3. Since its launch, the Global Fund has provided funding to help countries around the world better design and implement their national HIV/AIDS, TB and malaria programs. What do you think has been the Global Fund’s biggest success?

Our greatest success is that this audacious experiment in development finance has worked. We have shown results and efficiency so that donors have provided large amounts of resources and that implementing countries and organizations have continued to apply for money. As a result, 5 million people walk on this earth today who otherwise would have been dead. They bring up their children, work and live normal lives where – had it not been for the resources channeled through the Global Fund and the hard work of organizations like PSI and thousands of health workers – their deaths would have left suffering and poverty for millions in their wake.

4. What do you think is the role of international nongovernmental organizations (NGOs) in the Global Fund partnership?

The international NGOs do invaluable work where country governments or local NGOs don’t have the capacity to manage large grants. They can also ensure that the most effective interventions are being used even in settings where these – like harm reduction programs etc. – are controversial locally. At best, they bring in good standards of management and implementation and build capacity among local organizations. For the Global Fund, it is important that they work in several regions and can compare efficiency and spread best practice between countries and regions.

5. One of the challenges with a demand-driven model is that the Global Fund occasionally receives fewer proposals in an area it would like to fund, such as sexual minorities, male circumcision and HIV prevention. What are some ways to increase demand for these services?

Wide partnerships like Stop TB and Roll Back Malaria have been very successful in assisting countries in shaping grant applications around important priorities. WHO and UNAIDS, of course, also do a good job in many countries. But here the international NGOs could play an important role, especially in countries where they have built up trust and recognition as strong Principal Recipients or Sub-Recipients. The Global Fund itself walks a fine balance between encouraging country ownership and a focus on global priorities and best practices. Our Gender Strategy and our Sexual Orientation and Gender Identities Strategy are attempts at walking this balance in a way that is in line with our basic principles.

6. CCMs have been described as a great experiment in democratic processes. What do you think is working about CCMs, and what would you like to change?

Country Coordinating Mechanisms (CCMs) have been described as a great continued on page 22
The Way Forward: Building Local Capacity Through Partnership

Wealthy nations and international agencies have committed billions of dollars to improving the health of the millions of people living in the world’s poorest places, and there is growing recognition that these investments are achieving real results. For example, as United Nations Children’s Fund (UNICEF) reported earlier this year, the annual number of children dying before their fifth birthday has fallen below 9 million for the first time in history. This is remarkable. Yet, these same nations and agencies are also beginning to understand that much more needs to be done to ensure the sustainability of such achievements.

The President’s Emergency Plan for AIDS Relief (PEP-FAR) developed guidance for its partners to help promote greater sustainability. In it, PEPFAR noted that greater sustainability required greater support for partner governments in growing their capacity to lead, manage and, ultimately, finance their health systems to the greatest extent possible.

The Global Fund to Fight AIDS, Tuberculosis and Malaria puts a similarly strong focus on building local capacity and is seen by many to be a leader in this arena. The Global Fund itself is unique in that it brings governments, civil society, the private sector and affected communities together, in collaboration with other bilateral and multilateral organizations, to support each other in jointly tackling the three diseases. Thanks to the Global Fund’s leadership, more and more efforts are being made to ensure that local ministries of health, community-based organizations, affiliates and other partners are properly strengthened through, for example, greater technical support and training.

PSI and its local affiliates currently serve as Global Fund Principal Recipients for 16 grants in 10 countries, in addition to being Sub-Recipients in many others. In an independent analysis of Global Fund grant ratings published in 2008, PSI was ranked number five out of 16 international nongovernmental organization (NGO) Principal Recipients – and the only international NGO in the top five that was Principal Recipient for more than two grants. A key to PSI’s success is its emphasis on strengthening institutional development in the countries where it works, particularly through the creation and capacity building of local affiliates. PSI’s local affiliates...
and country program offices benefit from the combined strengths of their local staff and in-county presence as well as their membership in PSI’s growing global network. As their skills and capacities grow, PSI’s local affiliate organizations have increasing independence from PSI headquarters.

Several local affiliates have such significant local ownership, capacity and autonomy that they only require technical support from PSI headquarters. The Society for Family Health (SFH), for example, is an NGO based in Nigeria and financially consolidated with PSI. Founded in 1983 with initial funding from PSI for pilot condom social marketing, it was incorporated as a Nigerian Trust just two years later and is currently governed by a Board of Trustees, which is controlled by Nigerian nationals. Starting with two employees and one office in Lagos, SFH has grown to more than 300 employees working out of 16 offices across the country. While SFH continues to receive technical support from PSI, it is now the largest indigenous NGO in Nigeria and, in 2005, it became the first Nigerian NGO qualified to receive funding directly from the U.S. Agency for International Development (USAID). In October 2009, it became one of the leading implementing partners in the largest single malaria grant ever signed by the Global Fund, which aims to provide the resources for 30 million mosquito nets – half the number needed for Nigeria to meet universal coverage by December 2010.

PSI’s capacity building goes far beyond the creation of local affiliates and technical support for their efforts. PSI also offers technical support to countries receiving Global Fund grants in program management, financial management, monitoring and evaluation, procurement and contracts. In Togo, PSI is the Principal Recipient for a US $30.5 million Global Fund Round 4 HIV grant. With the support of the government of Togo, PSI works closely with networks of people living with HIV and AIDS and other members of civil society to implement an HIV prevention education program that includes: distributing subsidized male and female condoms; training health care workers; implementing innovative multi-layer behavior change communication campaigns; HIV counseling and testing; and treating sexually transmitted infections. PSI has achieved its targets in Togo and has been selected as the Principal Recipient for the Round 8 HIV grant, signed in September 2009.

PSI builds local capacity as a way to increase health impact and sustainability. But such success at building local capacity was not inevitable. By working with the Global Fund, PEPFAR and other institutions focused strongly on building local capacity and ownership, PSI learned to strengthen its local capacity building experience without ever sacrificing bottom-line implementing effectiveness. PSI managers learned to become collaborative leaders, influencers and partners and, overall, PSI has become a much more active partner and collaborator. In the end, PSI and its partners have found that such actions have only amplified the collective health impact – an impact that will be more effectively sustained over the long term.

**PSI Author: Celina Schocken, Director, International Organizations**

<table>
<thead>
<tr>
<th><strong>WHAT THE GLOBAL FUND HAS SUPPORTED</strong></th>
<th><strong>WHAT IS SPENT ON OTHER ITEMS</strong></th>
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<tbody>
<tr>
<td>1.46 million lives saved, and</td>
<td>US$ 13.7 billion spent on Valentine’s Day</td>
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<tr>
<td>• 770,000 people currently receive ARV treatment</td>
<td>• US$ 41 billion spent to protect computers from spam email</td>
</tr>
<tr>
<td>• Two million people treated for TB under DOTS</td>
<td>• US$ 7.9 billion on mobile phone use in South Africa, Tanzania, the Democratic Republic of Congo</td>
</tr>
<tr>
<td>• 18 million ITNs distributed to protect families from malaria</td>
<td>• US$ 8.8 billion in bonuses paid to London financial staff at Christmas 2006</td>
</tr>
<tr>
<td>In addition</td>
<td>• US$ 15 billion on UK Health IT project</td>
</tr>
<tr>
<td>• 9.4 million people reached with HIV counseling and testing</td>
<td>• US$ 32 billion on SMS messages in the EU</td>
</tr>
<tr>
<td>• 1.2 million orphans provided with basic care and support</td>
<td>• US$ 2 billion spent by South Africa government on the football World Cup</td>
</tr>
<tr>
<td>• 23 million people reached with community outreach services</td>
<td>• US$ 1.1 billion revenue of a single large hospital in the UK</td>
</tr>
<tr>
<td>• 23 million reached with malaria treatment</td>
<td></td>
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Above: What US $3 billion provides through the Global Fund and can purchase in other situations. Graph Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV page 7


Above: An MC service provider conducts a training at the national MC training site in Harare, Zimbabwe. Photo credit: Eric Gauss

PSI has a long history of collaboration with government partners in Zimbabwe. Since the inception of its social marketing program in 1999, PSI has worked closely with the Ministry of Health and Child Welfare (MOHCW) and the National AIDS Council to implement HIV prevention programs.

Building on this strong partnership, PSI began advocating for male circumcision (MC) as an HIV prevention intervention in early 2007. When the minister of health announced that Zimbabwe would include male circumcision as part of a comprehensive HIV prevention package, PSI collaborated with the MOHCW in the situational analysis and feasibility study on MC service delivery.

Beginning in 2008, PSI utilized its own funds to establish a national male circumcision training program, one national training site and five pilot male circumcision sites. These sites, established in collaboration with the Health and Child Welfare Ministry, each represent a different model of MC service delivery, utilizing both the public and private health sectors.

Demand for male circumcision services in Zimbabwe is high; recruitment for the pilot relied solely on word of mouth and the referral of HIV-negative males from PSI’s New Start testing and counseling sites. About 2,500 Zimbabwian men were circumcised within the first few months of operation at three of the initial pilot sites in the urban areas of Harare, Mutare and Bulawayo.

Based on mathematical modeling using Zimbabwe’s epidemiological baseline data, 2,500 male circumcisions could translate into 360 HIV infections averted.1 Two additional sites are now open – Manayame Airbase near Harare, managed by the Zimbabwe Air Force, and Karanda Mission Hospital in Mount Darwin District in the northern part of the country.

Recognizing the current weakened health delivery system in Zimbabwe, this expansion of male circumcision will continue to emphasize the integration of MC services for HIV prevention into routine clinical care provided by health care facilities. High-volume, stand alone MC sites and outreach services will also be scaled up. Funds for male circumcision will be used to improve the health infrastructure at public sector and mission hospitals and to build the capacity of health care providers for safe circumcision


Above: An MC service provider conducts a training at the national MC training site in Harare, Zimbabwe. Photo credit: Eric Gauss
In early 2009, the Pan American Social Marketing Organization (PASMO) in Honduras took stock of its work with underserved populations, namely gays, bisexuals and transgenders – including cross dressers, people who choose to wear clothing generally associated with the opposite gender; and transexuals, people who seek to live as a gender different from the one assigned at birth.

Reaching At-Risk Populations in Honduras

To improve its outreach to these most at risk populations, PASMO Honduras, a PSI affiliate, identified and approached three local nongovernmental organizations (NGOs) working with targeted populations in the country’s northern coast, where HIV incidence is highest. The organizations – Centro Integral Imágenes Positivas, Pro union Ceibeña and Asociación Colectiveo TTT – joined PASMO to
help develop the Integral Communication Unit strategy to make HIV prevention products, such as condoms and lubricants, more accessible to the targeted population.

The partnership developed a marketing and sales plan to build capacity among field educators and to ensure products were available at friendly retail outlets and in other ‘hot spots’ and gathering places for gays, bisexuals and transgenders. The NGOs were also supported to create internal databases to monitor and track condom and lubricant sales. Since the program began, sales of products have tripled and nearly 200 condom and lubricant dispensers have been sold. With continued improvements, these local NGOs could achieve self sustainability.

Improving Communication

In addition to improving sales and distribution of HIV prevention products, PASMO Honduras set goals to improve communication around HIV prevention and increase capacity among local NGOs. An organization that PASMO was already working with, Asociación Colectivo TTT, stood out for its successful work among transgenders. Trained to use PASMO methodologies, Asociación Colectivo TTT began employing a network of peer educators for interactive interpersonal communication strategies, such as games and one-on-one counseling, to engage the target population in discussions on correct and consistent use of condoms and lubricant, and how to talk openly about HIV with all sexual partners.

As a result of PASMO’s work with Asociación Colectivo TTT, the organization’s “I wear it; I control it,” campaign continues to reach the transgender population with tailored promotional and educational materials and activities to help prevent HIV.

PASMO Author: Henry Sabillon, Honduras

Cameroon’s Defense Ministry Launches Counter Attack Against AIDS

Military personnel are especially vulnerable to HIV. They are highly mobile, often away from their regular partners for extended periods of time and may engage in risky sexual behavior. In Cameroon, HIV prevalence among the armed forces is more than twice that of the general population, at 11.5 percent compared with 5.5 percent among the general public.

To tackle this problem, the Ministry of Defense and PSI’s local affiliate Association Camerounaise pour le Marketing Social (ACMS) joined to raise awareness about HIV among military personnel and their families and motivate positive behavior change. During the summer, ACMS held an advocacy workshop for more than 50 senior military officers, securing the commitment and support of high ranking military officials in the program’s catchment area.

The military high command participated as equal partners in defining the program’s goals, developing a work plan and naming the project Coup D’Arret SIDA (Counter Attack Against AIDS). The name was selected because it demonstrates the Defense Ministry’s commitment to the D’Arret SIDA project.

At the end of the workshop, the Ministry of Defense pledged comprehensive support to the prevention program, including support during baseline data collection, assistance with monitoring and evaluation and access to a special budget to assist military personnel with program-related expenses.

Moving forward, the program plans to train 20 military personnel as peer educators in the Army; hold seven counseling and testing events; organize 2,300 educational talks; and distribute 100,000 condoms for the military services.

ACMS Author: Ines Tchomago, Public Relations Consultant, Cameroon

HIV prevalence among Cameroon’s military personnel is double the rate of the general population—11.5% vs. 5.5%.

ACMS Author: Ines Tchomago, Public Relations Consultant, Cameroon
Meet David. Exhausted from a long day at the office and a longer night out drinking with the boys, David trudges up his front steps. He looks in on his sleeping wife, grimaces, then tiptoes out of the bedroom. He dials his cell.

“Hello sweetheart. I need to see you.”

What David doesn’t know is that his wife is awake. She listens by the door and hears every word.

Will David’s wife confront him about his mistress? How will David’s second relationship affect his marriage? Has David put himself and his wife in a risky ‘sexual network’ by having more than one partner?

These are some of the questions raised in “Club Risky Business,” a television drama created in partnership with Society for Family Health (SFH) in Zambia. The series provides a glimpse into the life of people who choose to have multiple, long-term sexual relationships with numerous partners over a particular period of time.

Increasing evidence shows that this practice, also known as concurrent sexual partnerships (CSP), is a driving force behind the HIV epidemic in much of Southern Africa. “Club Risky Business” aims to raise awareness, provoke thought and dialogue, and increase self risk perception about CSP and HIV.

In Zambia, where HIV prevalence is 14.3 percent, traditional prevention methods targeting high-risk groups often ignore the majority of risk – heterosexual transmission among the general population. To address this, SFH, a PSI affiliate, began conducting extensive qualitative research on concurrent sexual partnerships, holding focus group discussions and in-depth interviews with single and married men and women. SFH discovered that CSP is a common practice among Zambians, regardless of age, sex, marital status or economic situation. Both men and women view these steady, regular partners as people they love and trust, failing to consider the risk involved.

All elements of the television series and supporting campaign are thoroughly grounded in this research. SFH partnered with several organizations to create and produce “Club Risky Business,” with the Health Communication Partnership taking the lead on script writing. The campaign was branded under the regional “Onelove Kwasila!” (That’s Enough!) campaign led by the South Africa-based non-profit Soul City. The National AIDS Council of Zambia and Family Health International are also working with SFH on additional CSP research to feed into future episodes. The campaign is supported by the U.S. government and the United Nations Population Fund through the U.S. government.

The first 10 episodes, all produced in English, chronicle the lives of David and two of his friends. The series targets comparatively wealthy and educated urban men, age 25-50, who are most likely to engage in CSP. Future episodes of “Club Risky Business” will present CSP from a woman’s perspective.

Launched in June 2009, the series has reached an estimated 3.5 million viewers, roughly one quarter of Zambia’s population. The supporting campaign features cell phone competitions, a call-in radio show, radio and animated TV spots, billboards, bus posters, a website and a Facebook page.

Preliminary research indicates that more than 50 percent of the intended audience knows the campaign slogan and nearly 30 percent have seen the show.

PSI Authors: Richard Harrison, Chief of Party; Mannaseh Phiri, Country Representative, SFH/Zambia; Beth Skorochod, HIV Communications Technical Advisor, Washington
Nearly 93 miles south of Uganda’s capital, Kampala, is the bustling district known as Rakai, where the first case of HIV in Uganda was recorded. While Rakai has held the attention of international HIV advocates, its inhabitants are fighting other lesser-known battles against maternal and child death, hunger and poverty. At the center of the struggle lies a critical component - access to contraceptives. In Uganda, 41 percent of the population is in need of family planning.

Fatuma and Kobusingye are two Ugandan women who have struggled throughout their lives to plan their families and to provide for them. Both are farmers, but without farms. They move from home to home, village to village, offering to till other people’s gardens for a small fee. For a day’s work they are paid US $1 and a meal. Fatuma and Kobusingye’s husbands are informally employed, working as casual laborers on construction sites to earn a bit of cash, yet they rarely return with money for their families. While many Ugandan men take pride in having numerous children, men often believe it’s their wives’ responsibility to care for them.

Like many Ugandan women, Kobusingye had her first child at 15. She grew up in a family of 19 children. Her parents were poor and couldn’t afford to send all their children to school; Kobusingye never stepped foot in a classroom. “Because of the pain I went through seeing my siblings go to school while I stayed at home, I wanted to have a few children whom I could afford to take to school,” Kobusingye said. Yet the hospital, which offers modern family planning services, is 27 miles away, and she would have to miss a day of work to get there. Kobusingye now has seven children. With little financial support, she worries that her children might face the same fate – not enough money, no education and limited opportunities in the future.

Fatuma has six children and, like Kobusingye, also wants to use contraception. She is acutely aware of the lack of access to contraceptives and family planning in her community: “If I want a soda, I don’t even have to go far. It is just three shops away. Why can’t we have family planning services accessible like that?” she asks.

Lack of family planning services and access to contraception are underlying factors in several poor health outcomes affecting women in developing countries. As John Cleland et al pointed out in a 2006 article in The Lancet, “Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger.
and avert 32 percent of all maternal deaths and nearly 10 percent of childhood deaths. It would also contribute substantially to women's empowerment, achievement of universal primary schooling and long-term environmental sustainability."

Capitalizing on the Private Sector

Fifty-two percent of women have access to family planning services through the private sector in Uganda; however, this access is limited to a few modern methods and supply is intermittent. Agencies like PACE, a PSI affiliate, work with the Ministry of Health to train and support private clinics to provide long-acting family planning methods including the intrauterine device (IUD) and hormonal implant. These efforts have helped build a network of more than 60 accredited clinics branded as ProFam.

In September, PACE organized a marketing campaign to build support for the Munazzmat clinic, a newly accredited clinic in Kyazanga, about 17 miles from Rakai in the neighboring Masaka district. The clinic is often overwhelmed by women who are willing to pay the full fee for a long-acting method of family planning.

"When we heard that our Munazzmat clinic had joined ProFam and was now able to provide family planning services we were happy. I went there, and I got the implant, so I can now concentrate on taking care of the children I have without adding another," Fatuma said. "I honestly was tired," she said. "I needed a break." The hormonal implant is a highly effective form of contraception that will prevent pregnancy for three to five years.

Fatuma is lucky; her husband Zubairu supports the use of modern contraceptives. "We are aware of the value of family planning, but we didn't think of using it...until we started thinking about the cost of educating our children at the secondary school level," Zubairu said.

Kobusingye has also accessed family planning services at a ProFam clinic. She said that before she was afraid of the side effects of contraceptives. Kobusingye now has an IUD – a highly effective method of contraception with no hormonal side effects that can prevent pregnancy for up to 12 years.

Fatuma has since joined the league of family planning promoters in her community. Together with village health team members, she mobilizes women in her community for discussions on family planning often held at a volunteer’s home – continuing to spread their message of hope to other women.

To learn more about the need for family planning services in Uganda and the solutions being implemented, go to PSI’s channel on YouTube, Healthy Behaviors, and view PACE’s documentary (youtube.com/HealthyBehaviors).

PACE Author: Julius Lukwago, Director of Marketing and Communications, Uganda

Above: Fatuma, age 24, is a migrant farmer. She works, tilling other people’s gardens for a small fee and a meal.
Improving Services for India’s Urban Poor

In India, nearly 21 percent of all pregnancies are unintended and each year about 117,000 women die from complications arising from pregnancy and childbirth, while many more suffer debilitating complications.

To address the country’s critical need for family planning and maternal health services, the Federation of Obstetric and Gynaecological Societies of India (FOGSI) has entered into an innovative partnership with PSI to expand access to affordable high-quality family planning and maternal health products, services and counseling among urban poor.

FOGSI is a leading Indian organization comprised of nearly 200 medical societies with more than 20,000 members providing OB/GYN services. Combining PSI’s innovative social marketing with FOGSI’s clinical expertise affords the partnership great potential for positive health impact.

The partnership will particularly focus on increasing general awareness and use of long-acting reversible intrauterine devices (IUDs), among low and middle income groups, as well as changing provider behavior to amplify promotion of this neglected method.

IUDs are highly effective for up to 12 years, which has the potential to greatly reduce unmet need for family planning.

FOGSI and PSI will collaborate on promotional events, offering clients services at highly subsidized costs; publication of articles in leading newsletters and FOGSI’s journal to raise awareness of family planning and IUDs among providers; and identification of “IUD Champions” to promote the method to clients and peers.

“The partnership will provide a cost-effective option for women in target groups to access family planning services and counseling from highly skilled professionals,” said FOGSI President Dr. C. N. Purandare. The program will begin in areas with a large population and high unmet need, including the states of Uttar Pradesh and Rajasthan.

With India accounting for more than 22 percent of all maternal deaths in the world, the PSI-FOGSI partnership will also address the critical issue of maternal mortality. By acknowledging unsafe abortion as a driver of maternal deaths, the PSI-FOGSI partnership will act to increase access to safe, legal medical abortion through activities directed towards certified providers. PSI’s Senior Technical Advisor Dr. Jyoti Vajpayee said, “Family planning is central to the reduction of maternal mortality and ill health by reducing the number of unintended pregnancies, unsafe abortions and high-risk births.”

PSI Author: Jeffrey Matthews, Reproductive Health Intern, Washington
Advocates Call for Universal Access to Family Planning

More than 1,200 public health practitioners, advocates and African leaders gathered in Kampala, Uganda, in November, to raise the urgent call for “Universal Access to Family Planning.” Participants shared research findings and best practices with implementing partners from around the globe at the International Family Planning Conference – the largest family planning conference in 15 years. Conference organizers included the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health, Uganda’s Makerere University School of Public Health, and the Implementing Best Practices Initiative.

Fifty staff from PSI and its local affiliates in 16 countries attended the conference, offering evidence of effective family planning programs and strategies. Society for Family Health (SFH) in Nigeria, a PSI affiliate, presented evidence on the effectiveness of using private medical vendors to promote oral contraceptives, and shared research on the use of CycleBeads within monogamous and polygamous families. PSI platforms from Benin to Pakistan to Tanzania presented on a variety of topics including the men’s role in family planning; the effectiveness of social franchise networks offering service delivery of long-acting contraceptive methods; and barriers and drivers to promoting the intrauterine device (IUD).

At the conference’s conclusion, Ward Cates, president of Research at Family Health International, recognized important PSI contributions among his “10 Pearls of Wisdom.” He noted the feasibility of post-partum IUD services, as evidenced by SFH’s success in Zambia, and highlighted the significance of creating demand and training providers for increasing IUD use, as shown by the more than 200,000 IUD insertions completed in one year by PSI.

Training Staff on Quality Assurance

Direct service delivery of family planning methods such as IUDs and implants requires dedicated quality assurance systems that ensure patient safety. Under two large grants, the Dutch-funded SALIN (Strategic Alliances with International NGOs) project and a private grant, PSI has expanded its role as a family planning service delivery organization. Dr. Paul Blumenthal, global medical director for Reproductive Health, gathered 45 PSI clinical staff from 13 African countries for an in-depth training on ensuring quality of services for the provision of long-acting contraceptive methods. The meeting was an opportunity for Quality Assurance teams to share lessons learned, medical practices and service delivery approaches between countries.

PSI Author: Corina Clemente, Associate Program Manager for Reproductive Health, Washington

Clarification: The chart on page 15 of the December 2009 issue of Impact depicting couple years of protection (CYPs) delivered by PSI from 2006-2009, excluded condoms, a short-acting method of contraception. PSI’s total CYPs, including CYPs generated through condom distribution, were 10.6 million in 2007 and 12.4 million in 2008. Projected total CYPs for 2009 are 13.5 million.
Each year nearly 1 million lives are claimed by malaria. The majority of these deaths are among children under 5 in sub-Saharan Africa. Although malaria is a preventable illness, new evidence indicates that artemisinin-based combination therapies (ACTs), the most effective medicines for treating malaria, continue to have a significantly low presence on the market among populations considered to be most at risk.

ACTwatch, a research project led by PSI, in collaboration with the London School of Hygiene and Tropical Medicine, aims to provide evidence on the current state of the antimalarial market across six sub-Saharan African countries and Cambodia. Data on availability, pricing and volumes for 23,000 antimalarials, sourced from 20,000 outlets, revealed a diverse market structure across countries.

The majority of malaria endemic countries changed malaria treatment policies more than three years ago in the face of widespread drug resistance to monotherapies, adopting extremely effective ACTs. However, years later, the availability of these more effective medicines has been shown to be as low as 20 percent in public sector health facilities. Even in the private sector, where the majority of patients seek treatment, availability is still relatively low compared to cheaper, but less effective, drugs.

Worriedly, in most countries, ACTs currently make up only five to 15 percent of the total volume of antimalarials on the market, with ineffective monotherapies dominating the market share. More disturbing still, despite a call by the World Health Organization to ban artemisinin monotherapies, these continue to permeate private sector markets in key countries such as Nigeria and the Democratic Republic of Congo, which together account for 30 percent of the malaria burden in sub-Saharan Africa. In the Nigerian context this is particularly important as approximately 95 percent of all antimalarials are delivered through the private sector.

With most people accessing antimalarial medication through the private sector, price becomes a critical barrier affecting demand and utilization of the more expensive but also most effective treatments. ACTs can be over 20 times more expensive than ineffective therapies such as chloroquine. For example, some ACTs cost as much as US $11 in the private sector, while ineffective antimalarials typically cost a mere 30 cents.

“These data confirm that access to
ACTs is restricted by their high price. A full course of an adult treatment of ACTs can be up to 65 times the minimum daily wage. This provides an overpowering incentive for a consumer to make the wrong antimalarial choice,” says Dr. Desmond Chavasse, vice president of Malaria Control and Child Survival at PSI.

ACTwatch data from Cambodia, a country that has implemented a subsidy with the support of PSI, reveals that the most effective antimalarials are sold at around US $1.20, which although still expensive compared to ineffective monotherapy sold for 20 cents, is a marked improvement compared to other countries. In fact, 60 percent of all antimalarials provided to patients in Cambodia are now the more effective ACTs.

“The operation of the distribution chain has a major influence on which antimalarials are available to retailers, and their price and quality,” says Dr. Kara Hanson of the London School of Hygiene and Tropical Medicine. “Influencing practices of providers near the top of the chain may be the most cost-effective way to change outcomes in this market.”

Funded by a US $10 million grant from the Bill & Melinda Gates Foundation, ACTwatch is providing the critical information necessary to make evidence-based policy decisions around the issue of increasing access to ACTs. The project will serve as a thermometer for the success of global interventions aimed at reducing the price and increasing the availability of the most effective antimalarials, including global financing mechanisms such as the Affordable Medicines Facility for malaria.

PSI Authors: Chris White, Malaria Technical Advisor; Kate O’Conell, Principal Investigator, ACTwatch

Source of graphs (bottom of page): Availability, Volumes, Price and Use of Antimalarials in 7 Malaria Endemic Countries. ACTwatch.
Foes on the Field; United Against Malaria

Held on African soil for the first time, the World Cup in South Africa will be a momentous event for the sport of football and for the continent. Capitalizing on this historic occasion, the Bill & Melinda Gates Foundation is leading and funding a communications and advocacy campaign focused on the fight against malaria.

Founding partners of this United Against Malaria (UAM) campaign are executing strategic activities and partnerships across Africa. These partners include Johns Hopkins University (JHU) Center for Communication Programs of the Bloomberg School of Public Health, PATH, Comic Relief, Malaria No More, ONE, United Nations Foundation, PSI and the Roll Back Malaria partnership.

“United Against Malaria has helped us bring new partners to the discussion around malaria control. African corporate partners see the advantage of being linked to this campaign where results are tangible and football is the draw,” said Claudia Vondrasek, project director for the JHU Voices Malaria Advocacy Project.

UAM has indeed opened the door for collaboration on a variety of new projects. In Mozambique and Côte d’Ivoire, PSI is collaborating on creative public service announcements (PSAs) featuring prominent footballers. The Mozambique PSA shows footballer Chiquinho Conde tucking his three-year-old grandson into bed under a treated mosquito net. Conde is one of the most famous Mozambican footballers and now coaches one of the country’s leading professional teams. Exxon and others are working with PSI/Angola to organize events around the Africa Cup of Nations. MTN, one of the campaign’s largest corporate partners, is exploring partnerships with PSI in Cameroon and Liberia that would utilize SMS technology to communicate life-saving messages.

The football community has embraced the campaign. With support from the Fédération Internationale de Football Association, Roll Back Malaria partnership has developed relationships with local clubs and players. Gabrielle Fitzgerald, deputy director for Global Health Policy & Advocacy at the Bill & Melinda Gates Foundation said, “It is exciting to see the support and enthusiasm the United Against Malaria campaign is receiving from individuals and groups worldwide. I am confident that the programs and partnerships developed through the campaign will help in the fight against malaria long after the games are played.”

PSI Author: Tracy Zuckerman, Senior Manager, Corporate Marketing, Washington

Above: Charles, UAM’s mascot, heads a football during a UAM-sponsored game in Uganda, his home country. Photo credit: UN Foundation

Watch PSI/Mozambique’s United Against Malaria PSA at psi.org.
Under the leadership of national ministries of health and in collaboration with global malaria partners, PSI has provided more than 60 million insecticide-treated nets (ITNs) to date in more than 30 countries worldwide, the majority in sub-Saharan Africa where the burden of malaria is highest.

In 2010, PSI will deliver more than 45 million long-lasting insecticide-treated nets (LNs) — bringing its total to more than 100 million nets delivered.

During mass distribution campaigns, LNs are provided through community-based channels and public health facilities to enable every person, every night to sleep under a treated net.

As a member of the Roll Back Malaria partnership’s Alliance for Malaria Prevention, PSI works closely with other organizations to advocate for additional resources in support of national malaria prevention strategies.

In 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria chose PSI to be a Procurement Services Agent for the Voluntary Pooled Procurement (VPP) mechanism. As such, PSI procures LNs at competitive prices, helping Global Fund Principal Recipients overcome net procurement bottlenecks and capitalize on economies of scale. PSI has procured nearly 5 million LNs through the VPP already and another 55 million will be procured in 2010 through this mechanism.

With the urgency to reach the 2010 malaria targets, PSI is committed to scaling up and maintaining cost-effective, evidence-based LN delivery interventions in accordance with national strategic plans under the leadership of ministries of health.

The governments of Malawi, Kenya, Southern Sudan and the Democratic Republic of Congo (DRC) have been among the most aggressive in scaling up net distributions with direct support from PSI. Malawi — one of the first countries to approach targets set at the African Summit in Abuja, Nigeria, in 2000 — has delivered more than 8 million insecticide-treated nets since 1998. Kenya has delivered more than 16 million nets to date, 10.5 million through routine clinic distribution. Southern Sudan is delivering more than 4 million long lasting insecticide-treated nets (LNs) from 2008-2010. DRC delivered some 3.5 million LNs in 2008 via mass distribution campaigns in Kinshasa and the province of Equateur.

PSI Authors: Anna Dirksen, Senior Manager, Communications, Washington; Trey Watkins, Communications Coordinator, Washington

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In late 2009, the Rwandan government embarked on an ambitious goal: mobilize 500,000 pregnant women and breast-feeding mothers to participate in a nationwide child nutrition and vaccination campaign. At 2,000 centers across the country, health care workers would vaccinate children for measles, treat them for worms and give them vitamin A to strengthen their immune systems.

As part of the campaign, the government planned to incentivize mothers by distributing new insecticide-treated nets at vaccination sites. But with a series of delays in shipping the nets, it didn't look like the plan could work. So the Ministry of Health and United Nations Children's Fund (UNICEF), an initial partner in the project, turned to PSI to see if it would provide 500,000 bottles of its branded water treatment product, Sur'Eau, at all the vaccination sites, for a national sampling effort.

PSI/Rwanda hopped on board to raise awareness about the campaign and to increase public sector commitment to a safe water program, from the Health Ministry down to Rwanda’s 60,000 community health workers. UNICEF provided the funds to purchase the water treatment, U.S. Agency for International Development (USAID) provided the distribution and communications support, the Ministry led the effort to integrate Sur’Eau messaging into national communications and PSI was tasked with figuring out how to get 500,000 bottles to 2,000 centers in just under one month.

PSI faced several logistical challenges. The local producer lacked the capacity to produce sufficient quantities of Sur’Eau, so the platform turned to PSI/Kenya for their help in producing and importing from the Kenyan supplier. The cross-border partnership delivered results.

Working a minor miracle, PSI/Kenya pushed the supplier to produce the quantity needed in half the estimated time. The product arrived with one week remaining for distribution to the vaccination sites, increasing the logistical demands for vehicle support and temporary supervisors.

Using 12 10-ton Fusos, 47 Landcruisers, and 50 supervisory agents, PSI delivered Sur’Eau to 40 District Hospitals, 400 health facilities and 2,000 vaccination sites in Rwanda. In some cases, public commitment was high enough for the health facilities to move the product on their own, a sign of

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Above: A mother brings her child for immunizations and a bottle of the household water treatment Sur’Eau at one of the 2,000 vaccination sites open during the Rwandan government-sponsored campaign in mid-2009. PSI supported the execution of this campaign.
October 15, 2009, was a special day for school kids in Mabvuku, a high density suburb of Harare, Zimbabwe. Cholera epidemics ravaged their region and many others in 2008 and 2009. During the 2008 rainy season, the epidemic claimed almost 4,000 lives nationwide. It continued throughout 2009, causing 116 cases of cholera and five deaths by early November.

PSI, United Nations Children’s Fund (UNICEF) and the Zimbabwean government, using their respective strengths, became emergency responders in affected regions, preventing infection when they could and helping to treat the illness when they couldn’t. In October, the partners and beneficiaries who had weathered that storm came together for Global Handwashing Day. Nearly 2,000 children from 13 schools joined the event with U.S. Agency for International Development (USAID), UNICEF and Ministry of Education partners. Children giggled watching their peers participate in a handwashing coaching session, and they roared with laughter as the Mavambo Trust staged a cholera awareness drama skit. As part of the event, PSI/Zimbabwe’s Farai Chieza distributed 3,000 soap bars and 300 buckets donated by UNICEF to the community.

During last year’s epidemic PSI/Zimbabwe distributed 28,352 water treatment tablets, which had been donated by UNICEF to 4,430 individuals through its partner Action Aid. USAID and the U.K. Department for International Development (UKaid) also donated vital water treatment tablets. Since March 2008, PSI’s Hygiene Promotion & Home-Based Water Treatment program has distributed more than 40,000,000 water treatment tablets.

Global Handwashing Day Celebrates Partnership in Action

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PSI Authors: Tanaka Urayai, Hygiene Promotions Coordinator, Safe Water Systems, Zimbabwe
The Democratic Republic of Congo (DRC) is home to 17 percent of all cholera epidemics, with 31,000 cases appearing in the country in 2008 alone. Beyond cholera outbreaks, millions of Congolese also struggle with diarrheal disease, caused by a lack of access to a safe source of drinking water and inadequate hygiene and sanitation.

Household water treatment and safe storage interventions can dramatically improve drinking water quality and reduce waterborne illnesses. Indeed, around 50 percent of diarrheal episodes can be averted through household water treatment.

In 2005, the World Health Organization (WHO) established a network of more than 100 nongovernmental organizations, multilateral agencies, health ministries, universities and private sector companies aimed at promoting household water treatment and safe storage. The WHO Household Water Treatment and Storage Network uses collective advocacy, communication, research and implementation to carry out its mission of contributing to a significant reduction in waterborne disease, especially among vulnerable populations. The network operates worldwide, but focuses its efforts in countries that need the most critical support, like the DRC.

L’Association de Santé Familiale (ASF), a PSI affiliate, works with members of the network to provide safe drinking water to thousands in DRC. ASF distributes PUR Purifier of Water and Aquatabs, both robust point-of-use water treatment systems. In 2008, ASF sold 2.6 million PUR systems, averting nearly 11,000 cases of diarrheal disease. In May 2009, Aquatabs was launched in order to increase options on the market. PUR and Aquatabs are promoted in schools, health centers, churches and through mass media, incorporating communication strategies that emphasize the key hygiene and safe water storage messages.

In emergency situations, network partners are vital first responders.

This year alone the DRC Ministry of Health, United Nations Children’s Fund, WHO, Red Cross, Centers for Disease Control and Prevention (CDC) and ASF came together to battle cholera outbreaks in five provinces; shigella in Kasai Occidental and Oriental provinces; and typhoid in Kinshasa province.

Under the leadership of ASF Safe Water Program Manager Albert Chikuru, the WHO network convened a cholera prevention workshop in Lubumbashi, the capital of Katanga province, to call attention to the cholera relief efforts. The meeting, which drew key policy makers and stakeholders, took place at the same time as a provincial ministers meeting in Katanga on water and sanitation. The simultaneous events resulted in a new national plan on waterborne and diarrheal diseases that can be integrated into the DRC Ministry of Health guidelines.

Above: Community members observe a PUR demonstration at a health center in Matadi, Congo.
2010 Global Health Funding

United States

Wins and Losses

President Barack Obama signed legislation on December 16 that set levels of U.S. foreign assistance for fiscal year 2010.

Global health accounts receiving the most robust increases over 2009 levels were international family planning (19 percent), tuberculosis (38 percent) and malaria programs (53 percent). In a time of economic uncertainty, these are very significant gains.

However, despite enacting a bipartisan 2008 bill to dramatically scale up funding for global HIV/AIDS programs over five years, Congress and the president gave those programs only a slight increase, throwing into question the potential for continued dramatic progress against HIV/AIDS that the U.S. set in motion in 2003 when the President’s Emergency Plan for AIDS Relief (PEPFAR) was initiated.

While disappointed by the funding level, HIV/AIDS advocates are celebrating a policy victory in the bill: it eliminated a ban against spending federal funds on U.S. needle and syringe programs to prevent HIV among people who inject drugs. The Obama administration is expected to follow the removal of this domestic ban with a new policy to permit PEPFAR funding of needle and syringe programs internationally, as well.

New PEPFAR Strategy Emphasizes Sustainability, Country Ownership

The Office of the U.S. Global AIDS Coordinator released a new five-year strategy for PEPFAR on December 1. PEPFAR envisions working through partner governments to support a sustainable, country-led response to HIV/AIDS that also touches on other health- and non-health-related challenges to individuals affected and infected by the virus.

The strategy indicates that HIV prevention will be a major priority in PEPFAR’s next five years, and that proven prevention approaches will be targeted in combinations to most at risk populations as identified by epidemiological assessments.

Having laid out this new strategy, the Global AIDS Coordina-
tor must now signal to implementing organizations and partner governments the specific programming changes that can and will be made to achieve the vision.

Europe

Dutch Development Aid Decreasing

The current financial situation has its implications for the Dutch development aid budget, which will be €4.7 billion in 2011, as opposed to €5.2 billion in 2009. The overall Dutch spending on HIV/AIDS, tuberculosis and malaria for the coming year will be €162 million, compared with €192 million in 2009 (down by 15.6 percent).

Spending among multilateral agencies will vary in 2010. For example, the Joint United Nations Programme on HIV/AIDS disbursement will decrease substantially, while the Global Fund to Fight AIDS, Tuberculosis and Malaria spending will increase slightly. Overall, multilateral spending is expected to decrease from €220 million to €208 million in the coming year. The Dutch SALIN fund, of which PSI is receiving substantial funding, will remain at €8.25 million. A recently published governmental report indicates that, due to the economic crisis, the budget is expected to continue to decrease after 2010.

New European Parliament and Lisbon Treaty

The recently ratified Lisbon Treaty gives the new European Parliament new lawmaking powers: it now decides on the vast majority of European Union (EU) legislation.

While, the EU Parliament is more conservative as a whole, the Lisbon Treaty clearly states that the reduction and the eradica-
tion of poverty is the primary objective of the Union’s develop-
ment cooperation policy. This also implies that the development policy is a policy in its own right, rather than forming part of common foreign policy.

PSI Authors: Iris Tzur, Communications Manager, Europe; Jennie Quick, Governmental Affairs Manager, Washington

Questions

Professor Michel D. Kazatchkine continued

experiment in democratic processes. Ideally, they provide a model for how all health planning should take place – in a meeting place between different sec-
tors which all need to be involved, take ownership and responsibility for improved health services. We recognize, of course, that this experiment is a dramatic change from previous practice and that many ac-
tors do not have the resources to contrib-
ute fully. I also recognize that in several countries, the CCMs still run a parallel process to other health planning – in some cases for the same three diseases. The Global Fund is providing substantially more support to CCMs than before and we are putting in place a performance-based system for CCMs similar to what we practice in every other area of our work. However, our international partners, bilateral agencies, international organiza-
tions and international NGOs, all have a responsibility to make CCMs work better. All of these organizations are “co-owners” of the Global Fund and it is in their inter-
est that the CCMs work optimally and in harmony with other health planning and oversight mechanisms.

Many people are critical of verti-
cal funding for single diseases

because health systems are in disarray in many countries. The Global Fund
now funds Health Systems Strength-
ening. Do you see the Global Fund
evolving further in this direction?

Combined with the GAVI Alliance, the Global Fund is the world’s largest funder of health systems. Between a quarter and a third of our financing is invested in strengthening health systems. This fact is often not recognized. We are now work-
ing closely with GAVI and the World Bank to further expand these investments. We will support health systems strengthen-
ing work fully within the framework of our basic funding model: within a context of fighting the three diseases and within a performance-based model. We have seen some very good examples of how initial investments in one of the three diseases have had positive effects across several health delivery areas. We must continue to explore these synergies.
PSI spends an average of US $26.98 per year of healthy life added, according to the latest research. Programs costing US $50 or less in developing contexts are considered highly cost-effective by World Bank standards. Traditionally PSI’s health impact has grown at a faster rate than its expenditures. Malaria is now PSI’s most cost-effective health area, in large part due to new technologies that provide longer periods of protection against infection. In 2007, the net cost of malaria interventions accounted for nearly 30 percent of PSI’s total net cost, while its impact accounted for just less than 50 percent of PSI’s total health impact. To view PSI’s Cost-Effectiveness Report, visit psi.org.
Effective partnerships can magnify our impact at empowering vulnerable people to live healthier lives. In our line of work, we make it our business to affect lasting and meaningful change among the people we serve through sustainable programs, trusted products, effective communication and quality services. Getting to “lasting and meaningful change” often requires strong relationships across many sectors and among many stakeholders at a country level; there are more ideas at the table, more hands on deck and usually there is more money in the collective bank.

For example, when a cholera outbreak devastated communities in Zimbabwe in the summer of 2009, United Nations Children’s Fund, PSI and local organizations used their resources and expertise to form a team of rapid responders – a role that PSI could not have filled alone.

PSI has always focused on delivering measurable results, rapidly and at scale. In the past, working in partnerships sometimes took a back seat. In recent years, we have paused to analyze our approach, looked at what we can learn from other accomplished implementers, and are now making a concerted effort to improve our partnering, collaboration and collective action skills.

In 2010, PSI expects the largest share of our funding to come from the Global Fund for AIDS, Tuberculosis and Malaria. On page 5 of this Impact, “The Way Forward: Building Local Capacity Through Partnership” describes the Global Fund’s approach to this aspect of development. PSI and our local affiliates currently serve as Global Fund Principal Recipients for 16 grants in 10 countries. The Global Fund’s approach is built on country ownership of programs through Country Coordinating Mechanisms (CCMs) – large, sometimes unwieldy, but ultimately necessary structures that forge agreement among stakeholders across diverse sectors. In the context of CCM decision-making, PSI’s ability to be an effective partner and collaborator is key to our ability to put Global Fund resources to work through our results-oriented approach.

Partnership frameworks such as the CCMs are challenging, though we welcome the enhanced accountability they can bring. Working with the Global Fund, we think we’ve strengthened our partnering experience without sacrificing our bottom-line implementation effectiveness. PSI country representatives, the multinational corps of development leaders who manage our platforms, now must be excellent collaborative leaders, influencers and advocates, in addition to their traditional skill-set: delivering measurable results. They are rising to this challenge.
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des nuits tranquilles sans moustiques ou autres insectes

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EN REPUBLIQUE DEMOCRATIQUE DU CONGO

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