Partners for Health Reform*plus*

Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies

September 2005

Prepared by:

Kate Stillman, MPA
Abt Associates Inc.

Sara Bennett, PhD
Abt Associates Inc.

With inputs from:

Sourou Gbangbade, Assomption Hounsa, Owen Smith and Lynne Franco (Benin Study)

Hailom Banteyerga and Aklilu Kidanu, Miz-Hasa Research Center (Ethiopia Study)

Brian Mtonya, Victor Mwapasa and John Kadzandira, Alliance Group (Malawi Study)

This document was produced by PHR*plus* with funding from the US Agency for International Development (USAID) under Project No. 936-5974.13, Contract No. HRN-C-00-00-00019-00 and is in the public domain. The ideas and opinions in this document are the authors' and do not necessarily reflect those of USAID or its employees. Interested parties may use the report in part or whole, providing they maintain the integrity of the report and do not misrepresent its findings or present the work as their own. This and other HFS, PHR, and PHR*plus* documents can be viewed and downloaded on the project website, www.PHRplus.org.

Abt Associates Inc.
4800 Montgomery Lane, Suite 600 ■ Bethesda, Maryland 20814
Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:
Development Associates, Inc. ■ Emory University Rollins School of Public Health ■ Philoxenia International Travel, Inc. ■ PATH ■ Social Sectors Development Strategies, Inc. ■ Training Resources Group ■ Tulane University School of Public Health and Tropical Medicine ■ University Research Co., LLC.

Order No. TE 080

PHR*plus*

Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- *Implementation of appropriate health system reform.*
- *Generation of new financing for health care, as well as more effective use of existing funds.*
- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

September 2005

Recommended Citation

Stillman, Kate and Sara Bennett. September 2005. *Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

For additional copies of this report, contact the PHR*plus* Resource Center at PHR-InfoCenter@abtassoc.com or visit our website at www.PHRplus.org.

Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: Karen Cavanaugh, CTO
Health Systems Division
Office of Health, Infectious Disease and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

This paper reports interim findings from research conducted under the auspices of the Systemwide Effects of the Fund (SWEF) research network to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) on the broader health systems in Benin, Ethiopia, and Malawi. The overarching objective of the SWEF research is to assess how GF support has interacted with the health systems of recipient countries, focusing on four thematic areas, namely the effects upon: (i) the policy environment; (ii) human resources; (iii) the public/private mix; and (iv) pharmaceuticals and commodities. Baseline data were collected through document review, key stakeholder interviews, and facility and provider surveys.

Overall, the findings suggest that GF support has caused a range of different types of effects on health systems. There is some evidence of GF processes contributing to stronger health systems, while in other cases GF-supported processes have revealed long-standing systems weaknesses. Findings highlight several areas of concern, such as a disconnect between GF-related processes and existing national policies on decentralization and cost recovery; human resource constraints; and the creation of parallel systems for procurement of drugs and commodities. Examples of positive effects include the creation of new public/private partnerships, and training and infrastructure strengthening efforts that may have positive spin-off effects to other areas of the health system.

The research's reported aim is to improve stakeholders' understanding of the range of possible effects that GF support may have upon health systems so that negative effects can be ameliorated and positive effects reinforced. Several recommendations are highlighted that stakeholders – including the GF and the broader international development community – should consider, to improve opportunities for beneficial effects upon broader health systems. The Partners for Health Reform*plus* will conduct follow-up SWEF surveys in the three study countries in 2005/2006, allowing for more in-depth consideration of systemwide changes related to the influx of resources from the GF.

Table of Contents

List of Tables

Acronyms

AIDS	Acquired immunodeficiency Syndrome
ART	Antiretroviral Therapy/Treatment
ARV	Antiretroviral
CAME	*Centrale d'Achat des Médicaments Essentiels*
CCM	Country Coordinating Mechanism
CCM/E	Country Coordinating Mechanism for Ethiopia
CHAM	Christian Hospitals Association of Malawi
CMS	Malawi Central Medical Stores
DFID	Department for International Development (UK)
DOTS	Directly Observed Treatment, Short-course
EHRP	Malawi Emergency Human Resource Relief Programme
EMSAP	Ethiopia Multisectoral AIDS program
FMA	Financial Management Agency
GF	Global Fund To Fight AIDS, TB and Malaria
HAPCO	HIV/AIDS Prevention and Control Office (Ethiopia)
IAWP	Integrated Annual Work Plan (Malawi)
ITN	Insecticide-treated Net
LFA	Local Fund Agent
MAP	Multi Country AIDS Program (World Bank)
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NAC	National AIDS Commission
NGO	Non-governmental Organization
PASS	Ethiopian Pharmaceuticals Administration and Supply Services
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHR*plus*	Partners for Health Reform*plus*
PR	Principal Recipient
PSI	Population Services International
SPSS	Statistical Package for Social Science
SWAp	Sector-wide Approach
SWEF	Systemwide Effects of the Fund
TB	Tuberculosis
TRW	Technical Review Board
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UO	Umbrella Organization
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Preface

The Systemwide Effects of the Fund (SWEF) Research Network[1] is a collaborative research network, composed of research organizations in the South and in the North. The SWEF research seeks to understand how monies being disbursed by the Global Fund affect the broader health care systems of recipient countries. The network was launched in 2003, following consultations with the GF Secretariat and other international stakeholders. A workshop was organized for country researchers, and a common research protocol was developed to serve as the foundation for country studies. The countries implementing part or all of the SWEF research protocol are Benin, Ethiopia, Malawi, Georgia, and Nicaragua. Work in Nicaragua and Georgia was conducted by the Curatio International Foundation and the Central American Health Institute, and supported by the European Union. The collaboration has also been informed by the work undertaken by colleagues at the London School of Hygiene and Tropical Medicine via the "Tracking Study."

The Partners for Health Reform*plus* Project[2] (PHR*plus*), funded by the United States Agency for International Development, has coordinated the network to date and has directly supported studies in Benin, Ethiopia, and Malawi. These individual country studies are available on the SWEF website. This paper synthesizes SWEF findings from the three countries coordinated by PHR*plus*. The paper however draws upon discussion at SWEF workshops and credit is due to all members of the network.

[1] Further information about SWEF is available at http://www.phrplus.org/swef.php
[2] PHR*plus* is USAID's flagship project for health policy and systems strengthening in developing and transition countries; it is supported under contract HRN-C-00-00-00019-00.

Acknowledgments

This research would not have been possible without the dedicated efforts of our local research counterparts in each country, who helped to adapt the research protocol to fit the country context and information needs, implement the studies, and analyze the data whose results are described within. We are grateful for the support of the Ministries of Health in Benin, Ethiopia, and Malawi for being supportive of this work. Special thanks to USAID for funding this activity, especially Karen Cavanaugh at the USAID/Washington Bureau of Global Health. Thank you also to Pascal Zinzindohoue of USAID/Benin, Holly Fluty Dempsey and Omer Ahmed of USAID/Ethiopia, and Mexon Nyirongo of USAID/Malawi, all of who provided invaluable support to the studies.

The authors wish to thank David Hotchkiss of PHR*plus* for his technical review and comments on previous drafts of the report. They also thank Linda Moll and Maria Claudia de Valdenebro for their assistance with the final editing and production of this report**.**

Finally, we are indebted to all of those in Benin, Ethiopia, and Malawi who participated in this study, agreeing to be interviewed and surveyed, and providing us with essential information and insights. Their contributions have made this research possible.

Executive Summary

This paper reports interim findings from research conducted under the auspices of the Systemwide Effects of the Fund (SWEF) research network, to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) on the broader health systems in Benin, Ethiopia, and Malawi. The country studies reported here aim to improve stakeholders' understanding of the range of possible effects that GF support may have upon health systems so that negative effects can be ameliorated and positive effects reinforced.

Health System and the Global Fund

Since its launch in 2002, the GF alone has raised and committed over $3 billion to fight HIV/AIDS, tuberculosis (TB), and malaria. The GF is one of several new global health initiatives – such as the U.S. President's Emergency Plan for AIDS Relief and the World Bank Multi-country AIDS Program – that have significantly increased the scale of resources dedicated to achieving health goals. While these new resources are a welcome contribution to saving lives and fighting these diseases, depending on how these funds are used in-country, they may overwhelm already weakened health systems or they may serve to strengthen them. To ensure short-term success and longer-term sustainability of the programs they support, the GF and other global initiatives must rely upon functional health systems.

SWEF Research Objectives, Methods, and Limitations

The overarching objective of the SWEF research is to assess how GF support has interacted with the health systems of recipient countries, focusing on four thematic areas, namely the effects upon: (i) the policy environment; (ii) human resources; (iii) the public/private mix; and (iv) pharmaceuticals and commodities.

Methods. A common research protocol was developed at one of the SWEF network's collaborative workshops. The core protocol was adapted to fit the context, policy, and information needs of each of the countries. Three primary forms of data collection were used, including: (i) document review; (ii) in-depth stakeholder interviews at national and sub-national levels; and (iii) a facility survey, with provider interviews. SWEF research teams sought to engage key stakeholders, at the national and global level, in conceptualizing the research, interpreting study findings, and considering implications for policy. The studies are designed to be evaluative, and will include both baseline and follow-up studies. This report presents *baseline* findings.

The majority of findings presented in this report are derived from the baseline qualitative findings. Additional focus will be placed on the quantitative data once the follow-up surveys are conducted, allowing for comparative analysis and more in-depth examination of changes between the baseline and follow-up.

Limitations. In many countries, including Benin, Ethiopia, and Malawi, the implementation of GF-supported activities has been slower than anticipated and accordingly effects upon health systems are just beginning to emerge. Furthermore, the context within which the GF is operating is becoming increasingly complex in terms of the numbers and scale of donors and new disease-specific initiatives. This makes it difficult to ascertain what the systemwide effects are of the GF itself, and also complicates the environment that the GF and its supported programs are operating in, potentially placing even greater demands upon health systems.

The GF describes itself as a funding agent and not an implementing body. Many of the observations below arise because of how countries have chosen to interpret GF policies and implement GF grants, i.e., they are country choices rather than GF policies. That said, there is a complex interplay between decisions made at the country level, and the policies and practices of the GF. Conclusions from the study apply variously, to countries, the GF, and the broader donor community.

SWEF Findings

Overall, the findings suggest that Global Fund support has caused a range of different types of effects on health systems. There is some evidence of GF processes contributing to stronger health systems. In other cases GF-supported processes have revealed long-standing systems weaknesses. But it also appears that GF support can exacerbate such weaknesses particularly in contexts where there are multiple, parallel, large-scale disease or service-specific initiatives. Which of these effects dominates depends on the country context, and the planning and implementation strategies adopted. Select findings are presented below within each of the key thematic areas of the studies.

Policy Processes

The Global Fund aims to support programs that reflect local priorities and fit within existing country structures. In practice, the extent to which this occurs varies widely, and is affected by how countries themselves interpret GF requirements and develop approaches to spend GF monies.

- ***Alignment with national priorities and plans***. The majority of GF-supported programs in Benin, Ethiopia, and Malawi, appear to be well aligned with overall national health priorities and plans. In Ethiopia and Malawi, many informants noted that the GF was "gap-filling," providing funds to support priorities already identified in the national context. Some concerns were noted in Malawi, the only one of the three countries to have adopted a Sector Wide Approach (SWAp), regarding planning processes in country that have been further complicated by the new influx of GF funding.

- ***Alignment of institutional structures and processes for planning and implementing GF grants***. Country coordinating mechanisms (CCMs) were commonly viewed to be relatively weak and were sometimes perceived as "rubber-stamping" bodies. Although the CCMs in the study countries abided by GF guidelines on CCM composition, knowledgeable respondents frequently described discussions to be dominated by government stakeholders. Private for-profit actors appeared to be particularly excluded.

- In addition to CCMs, many new structures were being created in the study countries in response to receiving GF monies – including financial management authorities, umbrella organizations, and national technical review panels, among others. Some of these new

structures have the potential for longer-term positive impacts on the broader system, when the development of local capacities serves as the rationale for their creation.

- ***Decentralization***. The planning processes that countries have adopted to respond to GF requirements and requests appear highly centralized, even in decentralized contexts, leading to problems at the implementation stage due to lack of ownership at sub-national levels. A short turn-around time for proposal development was the most frequent reason for why regional and district stakeholders were not consulted. Malawi, on the other hand, benefited from an extensive national planning process that occurred prior to the initial GF call for proposals, and had involved sub-national stakeholders. Concerns were also expressed about the lack of transparency in terms of how GF resources were distributed between different districts or regions.

- ***Verticalization of services.*** In Benin, Ethiopia, and Malawi, many sub-national stakeholders felt disempowered by how the GF support to countries had been managed, often describing a "re-verticalization" of services. This consequence is counter to the general trend in many countries towards greater integration of health services.

- ***Ownership.*** While alignment of GF-supported activities with the governments' plans should be conducive to a strong sense of country ownership, in practice, a number of respondents questioned the extent to which countries were able to make independent decisions regarding the funding made available by the GF. This perceived lack of ownership was most acute in Malawi, where informants provided several examples of the GF Secretariat providing advice or requesting procedures that were in conflict with the Malawian view or national policies.

- ***Donor harmonization***. In all three countries respondents typically believed that GF support was harmonized with the support provided by other donors, although in some cases respondents noted room for improvement.

- ***Additionality.*** In general, the concept of additionality is not well understood at the country level (and many respondents were not aware of it as a condition of the GF grant), and there is a lack of understanding about how it is to be measured.

Human Resources

Most Global Fund proposals include training activities for health workers, but very few address issues of staff retention and motivation. Where health workers are in short supply, GF-supported activities have the potential to overburden already limited capacity. These issues, if not addressed, are likely to undermine GF-supported programs.

- ***Human resources capacity constraints***. Given the early stage of implementation in each of the three countries, the size and nature of human capacity constraints on implementation of GF-supported activities were not yet fully apparent. To date, the key human resource capacity constraint in dealing with GF resources has occurred at the central level: the process of applying for, planning, and launching GF-supported programs has consumed a considerable proportion of the time of key country decision makers. Many respondents in Ethiopia and Malawi voiced concern about how the lack of human resources at all levels of the health system would influence successful implementation as activities are rolled out more broadly.

- ***Human resource policies***. Despite the concerns which respondents voiced about the impact of human capacity constraints on successful implementation of GF-supported programs, in only one of the study countries (Malawi) did an overarching national-level strategy exist to address human resource constraints to scaling-up health services. Without overarching human resource strategies, many stakeholders at national and sub-national levels were experimenting with their own solutions to promote health worker retention and motivation. This lack of a uniform approach is likely to distort incentives faced by health workers.

- ***Impact of the GF on incentives for health workers***. In most cases, the additional responsibilities of implementing GF-related activities did not correspond to increases in grade or salary. Training allowances were often viewed as the most significant financial motivation for health workers. Malawi was an exception: decision makers were able to utilize GF monies to facilitate the implementation of a broader health sector program to increase all health worker salaries.

- ***Impact of the GF on training opportunities and working environment***. Most GF proposals include substantial allocations for training, however such training focused largely on clinical issues, while the managerial and planning skills critical to successful implementation were rarely addressed.

Public/Private Mix

One of the Global Fund's underlying principles is to stimulate the development and growth of new, innovative collaborations between the public and private sectors. The private sector (including both for-profit/commercial and non-profit entities) is viewed as an essential partner in the rapid scale-up of services, as well as a means to strengthen civil society participation. This may lead to a greater role for private sector actors.

- ***Public/private relationships.*** In all three countries, there was a degree of mistrust and tension between public and private sector actors; this was most acute in Ethiopia. Nonetheless, in all three countries some respondents felt that the new forms of public/private partnership fostered by GF support might have a lasting impact, in terms of improved trust and cooperation between public and private sectors. In Benin, several respondents were extremely positive about the new partnerships with the private sector (particularly non-governmental organizations [NGOs]) that GF support had led to.

- ***Private sector participation in GF planning processes.*** In countries where there has been a lack of trust between public and private sectors, government-dominated CCMs had been reluctant to include strong private for-profit stakeholders. This was particularly the case in Ethiopia, but in both Benin and Malawi some private sector representatives felt that it had been difficult to find a voice within the CCMs.

- ***Forms of collaboration between public and private Sectors for GF implementation.*** GF monies have stimulated new types of collaborations between public and private sectors, both in planning for the use of monies and in the execution of funded programs. In Malawi, for example, the GF has stimulated an existing, but new, public/private collaboration, through the use of NGO umbrella organizations that help to channel funds from the principal recipient (PR) to sub-recipients, but also serve to improve the capacity of local district structures, and local NGOs and community groups**.**

- ***Growth in non-profit private sector***. In Benin, Ethiopia, and Malawi, country stakeholders expressed concern about the rapid growth of the NGO sector, believing that many new NGOs had limited capacity and were only weakly accountable**.** Very little attention had been paid to ensuring adequate regulation or quality control in the private sector.

Pharmaceuticals and Commodities

Approximately 50 percent of Global Fund money committed across the globe will procure pharmaceuticals and commodities. This injection of funding may affect procurement, supply, and distribution systems, and the quality and prices of other drugs and commodities.

- ***Alignment with existing pharmaceutical supply and distribution systems***. In Benin and Malawi, existing procurement and distribution systems were bypassed for the implementation of GF programs, with responsibilities being granted to UNICEF in both cases**.** In both countries, this decision was meant to be a "quick fix" solution; however, the establishment of such parallel, external, procurement systems for the target diseases are likely to lead to inefficiency and duplication of efforts within the country. Ethiopia provides a contrasting example; here the Pharmaceutical Administration and Supply Service (PASS) (a branch of the Ministry of Health) was responsible for all procurement. While procurement had initially been slow, several positive changes have emerged within PASS' mode of operation to improve existing systems.

- ***Alignment with existing policies***. In Benin, parallel pricing and revenue management structures have emerged for insecticide-treated nets, which considerably complicates the job of health workers at the facility level.

Conclusions and Recommendations

Many of the health system barriers that the Global Fund is encountering at the country level are predictable, and other research has identified similar constraints to scaling up health efforts. The constraints encountered by the GF up to now are not unique to the GF but rather reflect existing weaknesses in underlying health systems. While the preliminary research findings presented here suggest that although the GF may not have led to widespread negative effects upon health systems thus far (which some feared), neither has GF support yet materialized as a means to strengthen health systems. The GF's recent policy shift – including health systems strengthening in its Round 5 application process – appears essential to the achievement of its specific disease-related objectives. As the GF begins to engage more in health system strengthening, it needs to be aware of how its own policies and procedures, and particularly its quest for speed, may potentially undermine health system strengthening goals and strive for an appropriate balance between quick outcomes and sustainability.

There are five general areas highlighted by these findings that warrant particular mention as countries, the GF, and other global stakeholders try to answer the important question of how to scale up the fight against specific diseases while also supporting the health systems on which they rely.

Do no harm. The GF is under much pressure to move speedily but an excessive focus upon fast implementation and rapid results may undermine health system strengthening and ultimately sustainability, as well as inhibit participation and inclusiveness. While adhering to the GF's core principles, that it is not an implementing agency but a financing one, there are measures that could be taken by the GF to address problems such as these, including changing proposal formats, roles of

CCMs and legal fund agents, or development of guides for recipient countries that would help them to anticipate likely system effects of their GF-supported programs.

Health system strengthening to achieve GF goals. Health system strengthening is often needed in order for targets specified under GF programs to be met. While GF support is already contributing to health systems strengthening, to date this contribution appears to have been relatively small. In order for financing agents such as the GF to support health systems strengthening, there is the need for greater consensus at the global level about which health system strengthening strategies work, and countries need to develop clear policies or strategies for key health system themes such as human resources, drug procurement and supply systems, and the role of the private sector.

Mutual accountability and transparency. While the GF itself has clearly embraced the principles of mutual accountability and transparency, there is still scope for greater progress in this area at the country level, in terms of how GF grants are managed. Information about GF grants was scant outside of a few key stakeholders and there was a lack of transparency about how resources were allocated. CCMs can play a critical role in providing clear information about GF-supported activities within the country.

Sustainability. The country case studies revealed several instances where country policymakers hesitated to undertake major reforms of existing systems, or adopt new treatment regimes, primarily because they were uncertain that they could depend upon the GF as a reliable source of finance into the future. It is imperative that GF financing is perceived by country stakeholders to be, and in reality is, secure. The GF can serve to strengthen health systems, and stimulate changes in bureaucratic culture that may have long-lasting effects for all health programs; however, such changes are unlikely to occur unless the GF is perceived to be here to stay.

Learning from doing. The diversity of approaches adopted by countries to make use of GF resources (enabled by the GF's very country-driven approach), together with the GF's unique ability to learn from past experience and adapt its procedures and policies accordingly, raises the importance of timely evaluation and cross-country transfer of knowledge. Monitoring and evaluation of what is happening is critical to ensure that all stakeholders – the GF, as well as country and global decision makers – can learn and continue making improvements.

1. Introduction: The Global Fund and Health Systems

1.1 The Health System Dilemma

In recent years, there has been a rapid increase in international commitments of resources to address global health priorities such as HIV/AIDS, tuberculosis (TB), and malaria. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) alone approved nearly US$3.7 billion to combat the three focal diseases between 2002 and 2005 (GF 2005). Other new funding mechanisms such as the Multi Country AIDS Program (MAP) of the World Bank, and the U. S. President's Emergency Plan for AIDS Relief (PEPFAR) have further increased the amount of resources dedicated to achieving health goals. These resources hold the promise of saving lives among some of the most disadvantaged populations in the world, and are clearly a welcome contribution to the fight against these epidemics.

In some countries, the three financing sources listed above are providing a larger source of funding than the entire annual public health budget. Depending on how these resources are used in-country, they may either overwhelm health systems, by placing excessive demands upon already weakened systems, or they may serve to support and develop the broader health system. Probably in many contexts both of these types of effects will occur, in different aspects of the system: for example, additional funding may help purchase needed equipment, facilitate supervision, and motivate staff, but also may result in competition for scarce national resources (such as health workers) and the creation of parallel systems (such as pharmaceutical procurement systems specific to particular disease programs).

This question of how GF support to countries affects health systems is far from academic. To be effective in the short term and sustainable in the long run, GF-supported interventions will require well-functioning health systems. This is increasingly being recognized, not only by the GF, but also by a broad swathe of other actors in the global public health arena (see Box 1). Recognition of the critical role of health systems in supporting service delivery gives rise to a complex challenge: how should funding agents such as the GF best target their resources in order to build stronger health systems while retaining a primary focus upon the diseases which constitute their core mandate?

Box 1. Select Quotes – Importance of Health Systems to Achieving Health Goals

Our ability to meet the Millennium Development Goals turns on our ability to think differently and act differently about our health systems... Freedman et al. 2005

The 3 by 5 initiative cannot be implemented in isolation from a regeneration of health systems. World Health Organization 2004

The overarching objective of the research reported here is assess how, to date, GF support has interacted with the health systems of recipient countries. In so doing, we hope to improve understanding of the range of possible effects that GF support may have upon health systems so that negative effects can be ameliorated and positive effects reinforced. The research also provides an empirical foundation for beginning to consider what type of health systems strengthening activity it makes sense for the GF to support.

1.2 The Global Fund and Health Systems

The GF was created to "dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need." One of the principles of the GF is that it is a financing entity and not an implementing entity. Its mission is to attract, manage and disburse resources to fight AIDS, TB, and malaria (rather than to directly implement such programs). In principle therefore, much of the responsibility for deciding what activities to include in proposals submitted to the GF, or how to implement approved grants, rests with in-country stakeholders – such as the country coordinating mechanisms (CCMs) and the principal recipient (PRs) (see Box 2 for an explanation of these terms). In practice, what occurs is more complicated. For example, unless there are clear and explicit guidelines about what the GF will and will not support, country-level stakeholders may try to "read between the lines" as to what the GF is interested in supporting.

Box 2. Global Fund-related Terms

Country Coordinating Mechanism (CCM): country-level partnership that develops and submits grant proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), and then monitors implementation if proposals are funded. CCMs are intended to be multi-sectoral, involving broad representation from government agencies; non-governmental, community- and faith-based organizations; private sector institutions; individuals living with tuberculosis or malaria; and bilateral and multilateral agencies.

Principal Recipient (PR): local entity nominated by the CCM and confirmed by the GF as legally responsible for program results, monitoring and evaluation, and financial accountability in a recipient country. Once the GF Board approves a proposal, the GF Secretariat negotiates and signs a two-year grant agreement in which disbursement of funds to the PR is based on the achievement of measurable results, i.e., performance-based funding. There may be multiple public and/or private PRs in a country.

Local Fund Agent (LFA): independent professional organization that the Global Fund contracts to assess the capacity of the PR to assume financial and programmatic accountability prior to signing a grant agreement. Subsequently the LFA provides independent oversight and verification of progress and financial accountability.

From its early days, the GF stated its commitment to support country programs that addressed HIV/AIDS, TB, and malaria "in ways that contribute to the strengthening of health systems." However, for the first four grant rounds, proposals were submitted under different rubrics that responded to the three focal diseases supported by the GF. While applicants were allowed to submit "crosscutting" proposals that addressed more than one disease, very few such crosscutting proposals appear to have been submitted or approved. Furthermore, there lacked any guidance from the GF about what types of broader health systems strengthening – if any – *could* be included in proposals to the GF. Thus during early rounds, many country proposals avoided health system strengthening interventions, as it was uncertain how acceptable they were.

The SWEF Network research collectively confirms that few activities were included in country proposals to the GF to improve overall health systems or to address health systems constraints that might inhibit the success of disease-specific programs. There are, in fact, specific examples of countries that submitted proposals oriented to health systems strengthening during early grant rounds that were either not funded, or substantially cut back. For example, Malawi's GF proposal included comprehensive and crosscutting systems issues such as broad human resources and infrastructure development, in alignment with a broader national strategy which recognized the importance of such issues to the implementation of activities targeted to the focal diseases. Malawi's Principal Secretary for Health (and CCM Chair) further noted the importance of health systems issues in his cover letter that accompanied Malawi's GF proposal, noting:

> *Priority should be given to systems strengthening in the first year, so that all future expanded support from the Fund can be wisely, confidently and effectively directed.* Dr. R.B. Pendame, cover letter accompanying Malawi's Round 1 GF Proposal, March 2002.

Unfortunately, most health system strengthening elements were removed from the scope of activities approved in the final grant agreement. The London School of Hygiene and Tropical Medicine, a SWEF Network partner, noted a similar observation in Uganda whose early round systems-oriented proposal to the GF was rejected (the GF subsequently requested that Uganda resubmit its request in disease-specific components).

In Round 5, the GF for the first time included in its call for proposals, a health systems strengthening component in addition to components addressing the three priority diseases. Despite this development, the proposal development guidance on what is acceptable under this component is rather unclear. Of the 32 eligible health systems strengthening components submitted to the GF under Round 5, the GF Technical Review Panel (TRP) recommended only three for funding.

1.3 Structure of the Report

This report is structured in the following way. Section 2 provides a brief overview of the level and scope of GF support in Benin, Ethiopia, and Malawi. Section 3 describes the Systemwide Effects of the Fund (SWEF) research initiative, and presents the research objectives and methods used in the country case studies, as well as the status of the studies in each of the three countries. Sections 4 through 8 discuss the SWEF findings within each of the four thematic areas of the research – policy processes, human resources, public/private mix, and pharmaceuticals and commodities. The report closes in Section 9 with a set of conclusions, lessons learned for various stakeholder groups, and recommendations about moving forward.

2. The Global Fund in Benin, Ethiopia, and Malawi

As previously noted, the Global Fund to Fight AIDS, TB and Malaria acts primarily as a financing agent, and is not directly involved in the design or implementation of the activities that it supports. In its guidelines, the GF places special emphasis on supporting programs that reflect national ownership and seeks to stimulate the creation of new alliances between the public and private sectors to fight the target diseases. As a financing agent, the GF largely maintains a country-driven approach, and states its intent to bolster local responses to the focal diseases in alignment with existing national plans. Although supportive of country-developed programs, there are GF rules and requirements that each country must address to receive GF monies (such as the creation of a country coordinating mechanism, cooperation with the technical review panelts, and others).

This country-driven approach results in a wide array of programs and interventions that receive GF support. Furthermore, the means by which each country responds to GF policies and processes is quite different, as demonstrated in the countries discussed in this report. The following sections provides a brief overview of the nature and scale of GF support in Benin, Ethiopia, and Malawi, as well as some discussion of the GF-related mechanisms in place within each country.

2.1 Global Fund in Benin

GF financing represents a substantial increase in health funds available for Benin, raising the overall budget for health by approximately 15 percent (Smith, Gbangbade et al. 2005). In 2002, prior to the arrival of the GF, the national programs for AIDS, TB, and malaria constituted approximately a 19 percent share within the Public Investment Plan account (excludes operating costs, but includes donor contributions). GF expenditures raised this share to nearly 40 percent. Other global health initiatives operating in Benin include the World Bank MAP, with a $23 million grant focusing on HIV/AIDS activities.

Benin's Country Coordinating Mechanism (*Comité National de Coordination*), the main stewardship body for GF activities, was created in March 2002 with the Minister of Health as its chair. It has 46 members: 18 are from the public sector, 14 from civil society, and 14 from international partners. A smaller technical group consisting of nine CCM members has also been formed. The principal recipient for the first two rounds of GF grants is the U.N. Development Programme (UNDP), while the Round 3 (malaria) PR is the international non-governmental organization (NGO) Africare. The main secondary recipients are the national AIDS, TB, and malaria programs. The local fund agent is PricewaterhouseCoopers in Abidjan, Côte d'Ivoire.

In the first round of GF grants, Benin was awarded US$2.9 million to fight malaria; the grant agreement was signed in March 2003 (Table 1). In the second round it received US$17.3 million for HIV/AIDS and US$3 million for TB; grant agreements for these programs were signed in July 2003. In the third round the malaria program received US$1.4 million; the grant agreement was signed in

September 2004. Fourth round applications for all three diseases were submitted in April 2004, but none were approved.

Table 1. GF Grants in Benin

	Round 1	Round 2		Round 3
Component	**Malaria**	**HIV/AIDS**	**TB**	**Malaria**
Approved Funding (2 year)	$2,973,150	$ 17,324,228	$3,104,104.00	1,383,931.00
Principal Recipient	UNDP	UNDP	UNDP	Africare
Local Fund Agent	PriceWaterhouse Coopers	PriceWaterhouse Coopers	PriceWaterhouse Coopers	PriceWaterhouse Coopers
Grant Agreement Signed	20 March 2003	17 September 2003	17 September 2003	29 September 2004
Grant Start Date	01 May 2003	25 July 2003	01 November 2003	01 October 2004
First Disbursement Date	14 April 2004	26 September 2003	26 September 2003	21 October 2004
Total Disbursed as of 1 May 2005 (% total)	$2,317,139 (77%)	$8,436,027 (49%)	$1,983,698 (64%)	$646,754 (47%)

The Benin study's findings to date are largely based on how the Round 1 and 2 funds affect the broader health system. According to the grant agreements:

- Approximately 60 percent of HIV/AIDS spending is for antiretroviral (ARV) drugs for approximately 2,000 AIDS patients,
- Almost 50 percent of malaria spending for its first round grant is for the purchase of insecticide-treated nets (ITNs),
- Training activities are also a prominent part of all three programs.

2.2 Global Fund in Ethiopia

The Country Coordinating Mechanism for Ethiopia (CCM/E) was established in February 2002. A CCM/E document states, "As the Fund deals with the Federal government, the CCM/E derives its legal status from the Government, represented by the Federal Ministry of Health, Ministry of Finance and Economic Development and HIV/AIDS Prevention and Control Office" (CCM/E 2003). Ethiopia's CCM was originally established with 12 seats, representing the government (five seats, including the chairmanship and Ethiopia Health and Nutrition Research Institute), U.N. and bilateral agencies, civil society, and the private sector. The number of seats was later increased to 15. The CCM/E has among its responsibilities a mandate to strengthen the system for working within the health sector, across government ministries, and with communities to build on, complement, and coordinate with existing programs in Ethiopia including the government, public/private partnerships, and civil society initiatives. In addition, the CCM/E seeks to ensure that resources from the GF are designated to support national policies, priorities, and partnerships, including Sustainable Development and Poverty Reduction Program (CCM/E 2003).

Table 2 shows a breakdown of Ethiopia's approved GF grants, two for HIV/AIDS and one each for malaria and tuberculosis. The National HIV/AIDS Prevention and Control Office (HAPCO) was

the PR of the HIV/AIDS grants, while the Department of Disease Control, Ministry of Health (MOH), was the PR for the TB and malaria grants. The LFA is KPMG, based in Nairobi.

Table 2. GF Grants in Ethiopia

	Round 1	Round 2		Round 4
Component	**Tuberculosis**	**HIV/AIDS**	**Malaria**	**HIVAIDS**
Approved Funding (2 year)	$26,980,649 (Grant amount = $10,962,600)	$55,383,811	$37,875,211	$41,895,884
Principal Recipient	Federal Ministry of Health	HIV/AIDS Prevention and Control Office	Federal Ministry of Health	HIV/AIDS Prevention and Control Office
Local Fund Agent	KPMG	KPMG	KPMG	KPMG
Grant Agreement Signed	18 March 2003	09 October 2003	01 August 2003	11 February 2005
Grant Start Date	01 August 2003	01 November 2003	01 October 2003	01 March 2005
First Disbursement Date	06 August 2003	19 December 2003	19 August 2003	15 March 2005
Total Disbursed as of 1 May 2005 (% total)	$8,732,765 (80% of grant amount)	$40,444,917 (73%)	$32,600,733 (86%)	$19,390,093 (46%)

Activities for the first HIV/AIDS grant include training, social mobilization, drug and commodity procurement, and development of voluntary counseling and testing (VCT) infrastructure. By the end of 2004, most of the disbursed funds had been targeted toward training activities and procurement. Training interventions focused on VCT; HIV and sexually transmitted infection management; community home-based care; prevention of mother-to-child infection services; information, education, and communication; and monitoring and evaluation (M&E). Procurement activities were largely for HIV/AIDS-related drugs (ARV drugs, and drugs for opportunistic infections), as well as vehicles and equipment. The Round 4 HIV/AIDS grant is largely allocated to the purchase of ARV drugs, with some funds slotted for institutional strengthening and human resource development. (Note: While the Round 4 HIV/AIDS grant is substantial, and is likely to have significant impacts upon the broader health system, many of the potential effects are not documented in this report, as implementation began after the SWEF baseline data collection.)

The TB grant focuses on strengthening TB program management, supervision, and M&E, procurement of drugs, vehicles, and computers, the training of health workers and community DOTS (Directly Observed Treatment, Short-course) providers, establishing a structure for collaborative TB/HIV activities, and increasing health facility DOTS coverage from 30 percent (2002) to 75 percent (2005). Future plans include strengthening TB prevention and control, promoting HIV counseling and testing among TB patients, advocacy, communication and social mobilization, and increasing operational research in TB and TB/HIV.

The malaria grant supports national efforts for malaria control and prevention, human resource development, information systems development, education and communication, operational research, and the development of M&E capacity.

While many training activities have taken place, the procurement of drugs and commodities for all grants has been slow to date.

In addition to receiving funds from the GF, Ethiopia is also a PEPFAR recipient. PEPFAR has committed more than $130 million for HIV/AIDS prevention, medical treatment including antiretroviral therapy (ART), and care and support to Ethiopia for 2004-2005. Stakeholders include the MOH, HAPCO, regional officials, development partners, and other organizations, and objectives include averting new infections and treating thousands of new patients with ARV drugs. The World Bank MAP is also present in Ethiopia (with a grant of $59.7 million), through the Ethiopia Multisectoral AIDS Programme (EMSAP). EMSAP has been operational for more than five years, although there were severe delays in implementation during the first several years, resulting in a recent extension of activities for an additional 18 months.

2.3 Global Fund in Malawi

In February 2002, the Malawi GF Coordinating Committee submitted to the GF a proposal entitled "An Integrated National Response to HIV/AIDS and Malaria." Out of a total funding request of $267 million, $196 million was approved for the HIV/AIDS component over five years. A smaller grant of $39 million for malaria was also approved, although this malaria grant agreement had not been signed at the time of the research.[3] No TB proposal has been submitted to the GF as TB was considered well funded by other donors. Malawi was successful in its recently submitted round 5 proposal to the GF under the newly established health systems strengthening component. This grant proposal was in development at the time of the research.

The PR for the HIV/AIDS grant is the Registered Trustees of the National AIDS Commission Trust of the Republic of Malawi, and the LFA for both grants is PricewaterhouseCoopers.

Table 3. GF Grants in Malawi

	Round 1	**Round 2**
Component	**HIV/AIDS**	**Malaria**
Approved Funding (2 year)	$41,751,500	$20,872,000
Principal Recipient	National AIDS Commission Trust of the Republic of Malawi	
Local Fund Agent	PriceWaterhouse Coopers	PriceWaterhouse Coopers
Grant Agreement Signed	10 February 2003	Not signed
Grant Start Date	01 October 2003	N/A
First Disbursement Date	24 April 2003	N/A
Total Disbursed as of 1 May 2005 (% total)	$36,253,844 (87%)	0 (0%)

The HIV/AIDS grant has four components: (i) Voluntary Counseling and Testing; (ii) Prevention of Mother-to-Child Transmission; (iii) Community Home-Based Care; and (iv) Treatment and Management of Opportunistic Infections and Antiretroviral Drugs. In addition, there are two crosscutting components, namely health systems strengthening, and management and institutional support. The malaria grant, which addresses malaria prevention, has proceeded much more slowly. As

[3] The malaria grant agreement was finally signed in September 2005.

of June 2005, the grant had still not been signed, and dates for signing the grant had been postponed several times.

Malawi also receives substantial funding from a number of other global health initiatives (in particular, the World Bank's MAP, a $35 million project) currently being implemented. In addition, a number of other donors have HIV/AIDS-related programs coordinated by the National AIDS Commission (NAC) with support from the United Nations, U.S. Centers for Disease Control and Prevention, African Development Bank, Department for International Development, UK (DfID), Canadian International Development Agency, and the Norwegian Agency for Development Cooperation. Malawi is not a beneficiary of PEPFAR nor of the Clinton HIV/AIDS initiative.

3. Research Objectives and Methods

3.1 Research Objectives

The overall objective of the SWEF research is to document the effects that the processes involved in applying for and receiving a Global Fund grant and implementing GF-supported activities have on the health systems of recipient countries.

Findings from the research are intended to derive lessons for several audiences, including:

- Stakeholders within study countries, and other countries facing similar challenges and opportunities, so as to inform policies and implementation strategies for GF-supported activities;
- The GF Board and Secretariat, so as to help improve GF processes and guidelines in order to ensure that GF-supported activities enhance broader health care systems; and
- The broader donor and global community regarding how best to channel efforts to scale up substantially the assault upon AIDS, TB, and malaria and other diseases of poverty in low- and middle-income countries.

3.2 Research Approach

The conceptual framework underlying the research (Bennett and Fairbank 2003) suggests that GF-supported activities may have intended and unintended effects upon the broader health care system and that these effects may enhance health system performance (in terms of improving accessibility, sustainability, efficiency, and equity) or detract from it. Based upon the conceptual framework, there are multiple levels at which the effects of the GF upon the broader health care system could be measured. These include:

- Process effects upon the functioning of the health care system[4];

Box 3. Understanding Health Systems

Health systems in different countries aim to achieve similar goals: improved health (as equitably as possible), through systems that are also responsive and financially fair. And all health systems have to carry out the same basic functions regardless of how they are organized or which health interventions they are trying to deliver. These functions are the development of human and other key resources; service provision; financing; and stewardship (oversight and guidance). At its broadest, health system strengthening can be defined as any of a broad array of initiatives and strategies aimed at making improvements to one or more of the four functions of the health system that lead to better health through improvements in, for example, access, coverage, quality, and efficiency.

[4] The authors use the term 'process effects' to categorize those effects that reflect changes in how the health system operates or is managed, such as policymaking processes, staffing policies and approaches, procurement policies and approaches, and so on.

- Health system performance, such as equity, efficiency, access, quality, and sustainability of non-focal services;
- Impacts upon utilization of services and coverage of non-focal diseases; and
- The burden of disease from non-AIDS, TB, and malaria illness.

The SWEF research focuses upon identifying and measuring process effects within the health care system and measures of health system performance, and, to some degree, service utilization and coverage of non-focal diseases.

A common research protocol was developed and has been adapted to fit the context, policy, and information needs of each participating country. The SWEF common research protocol combines baseline and follow-up quantitative surveys of health facilities and health staff, with in-depth interviews of stakeholders at national and sub-national level. Where resources allow, researchers also conduct ongoing monitoring. The research aims to produce and share results in a timely fashion that allows course correction by decision makers.

The research protocol focuses upon four thematic areas, namely:

- ***Effects upon the policy environment***. By encouraging new and innovative partnerships among stakeholders within recipient countries, GF proposal and planning processes are designed to enhance the range of actors involved in informing policy and implementing disease control activities. The SWEF studies assess the extent to which this occurs. The development and implementation of GF-supported activities interfaces with other planning and aid frameworks such as sector-wide approaches (SWAps) and poverty reduction strategy papers, as well as other new financing mechanisms (such as MAP) targeted at HIV/AIDS. SWEF aims to assess the effects of GF support upon the broader pattern of health system funding, and the extent to which the policy and operations pursued by the GF are in alignment with existing structures.
- ***Effects upon the public/private mix***. The GF explicitly welcomes innovative approaches to expanding service coverage and approaches that draw private sector actors into the health care system; accordingly, a greater role for private sector actors may evolve. The SWEF studies aim to evaluate the effects of GF support upon the number, distribution, and organization of different types of providers (public, private for-profit, private non-profit) and relationships between public and private sectors (such as the number of public/private partnerships in non-focal areas, and the degree of trust and cooperation between sectors). In addition, the studies explore the implications of these changes for overall health system performance.
- ***Effects upon human resources***. Many GF proposals include training activities for health workers, and some address issues of staff retention and motivation. Where health workers are in short supply, GF-supported activities may overburden capacity. GF-supported activities may also affect the skills, motivation, and distribution of health workers and may cause shifts in the distribution of health workers from non-focal disease programs/functions. SWEF studies aim to evaluate the extent of these effects and identify the mechanisms through which they occurred.
- ***Effects upon pharmaceuticals and commodities***. Approximately 50 percent of GF money already committed will procure pharmaceuticals and commodities. This injection of funding

may affect procurement, supply and distribution systems, and the quality and prices of other drugs and commodities. The SWEF protocol considers issues of drug management (procurement, distribution, utilization/rational use, and monitoring and evaluation) as well as access (geographic access, physical availability, financial affordability, quality, and specific issues of pricing/subsidies) to investigate the effects of the GF upon pharmaceuticals and commodities within countries.

3.3 Study Design and Data Collection

The SWEF common research protocol uses a pre-test/post-test quasi-experimental research design without controls. Baseline data collection was conducted during 2004/2005, and this report synthesizes findings from the baseline studies. Follow-up surveys will be conducted in late 2005/early 2006.

3.3.1 Country Selection

This paper reports findings from PHR*plus*-supported studies in Benin, Ethiopia, and Malawi. These studies were coordinated with other participants in the broader SWEF research network (see preface).

Countries were selected for study on the basis that (i) they were early recipients of GF support (and therefore effects of GF support may be observed earlier), (ii) the amount of support which they were due to receive from the GF was significant compared to existing health budgets, and (iii) the SWEF network as a whole represented some degree of regional variation.

3.3.2 Data Collection, Processing, and Analysis

Three primary forms of data collection were used:

- Document review
- In-depth stakeholder interviews at national and sub-national levels
- Facility survey, with provider interviews

Sample selection, sample sizes, and implementation-related processes are described in more detail in Section 3.4 below. Individual country reports were built upon this primary data collection, but this synthesis report builds directly off the country reports. Quotes are used in this report to illustrate the points being made, but for a fuller substantiation of key points, the reader is advised to refer to the individual country reports.

While the full research protocol and approach is described below to orient the readers to the scale and scope of the studies, the majority of findings presented in later sections of this report are derived from the baseline qualitative findings rather than quantitative data. Additional focus will be placed on the quantitative data once the follow-up surveys are conducted, allowing for comparative analysis and more in-depth examination of changes between the baseline and follow-up.

In-depth Interviews

In each country, SWEF guides for in-depth interviews at the federal and regional levels were prepared, tested, and finalized. The guides were used to collect information on the four key thematic areas namely, policy environment, human resources, public/private mix, and procurement of drugs and commodities.

A list of key informants was prepared within each country, and interview guides were adapted to reflect the knowledge and experience of different sub-groups of key informants. Qualitative data collection included interviews with government officials at the national and sub-national levels, experts/heads of health programs, NGOs, bilateral organizations, multilateral organizations, and private sector informants. Certain key informants were interviewed more than once to obtain updates on the status of implementation of GF activities. Informed consent was obtained from all respondents.

All interviews were conducted by an experienced interviewer; a note taker took notes throughout the interviews. Interview notes were then transcribed (and translated into English when necessary) for analysis. Key themes were identified in the interview transcripts. Quotations from the interviews are used liberally in the report below. All findings reported have been triangulated, i.e., more than one respondent reported similar observations. It should be borne in mind that these quotations reflect the perspectives and opinions of the respondents, and may not necessarily coincide with facts.

Facility and Provider Surveys

In Benin and Ethiopia, facility surveys including provider interview modules were conducted as part of the baseline. No facility survey was conducted in Malawi. Research instruments from the Demographic and Health Survey Service Provision Assessment tool were adapted for use in the SWEF research. The questionnaires were then adapted to fit individual country needs, tested, piloted, and finalized on the basis of the pre-test results.

The facility survey included issues related to resources, staff, management, patient referrals, laboratory services, distribution of staff time, service availability and use, and case mix. The provider survey included questions on provider training, position and experience, supervision, motivation and job satisfaction, provider incomes as well as provider suggestions. Data were entered into SPSS (Statistical Package for Social Science) for analysis.

3.4 Status of SWEF Research in Benin, Ethiopia, and Malawi

Case studies were initiated in Benin and Ethiopia in late 2003 using the full SWEF protocol (Table 4). The Malawi study was implemented in early 2005. In Malawi, as the implementation of the study was delayed, it was agreed that a scaled-down version of the SWEF protocol should be undertaken and that this should focus primarily on a series of in-depth interviews at the national and district levels, and a review of relevant literature.

In Ethiopia and Malawi, official research/ethical clearance was obtained by the respective national bodies overseeing health research (Note: National stakeholders informed the Benin researchers that official research clearance was not required in Benin for this type of study).

Table 4. Timeline for SWEF Studies

Country	Initial Consultative Meetings and/or Workshop	Baseline Facility Survey	Baseline Qualitative Research	Interim Country Workshop on Baseline Findings
Benin	April 2004	August 2004	September 2004	March 2005
Ethiopia	December 2003	December 2004/ January 2005	November 2004–February 2005	October 2005
Malawi	August/September 2003*	N/A	May–June 2005	Under discussion

* Early discussions occurred in Malawi in 2003 with the Principal Secretary of the Ministry of Health, USAID, and other stakeholders to describe the research objectives and clarify questions about the scope of the study. At that time, an application for research clearance was also submitted to the Malawi National Health Sciences Research Committee. Delays were encountered in initiating the study due to some difficulties in identifying local research counterparts.

3.4.1 Sample Selection

In each country, researchers formulated sampling approaches for both the quantitative and qualitative data collection to ensure some degree of representation and to reflect a broad range of stakeholder perspectives. Due to budgetary constraints, full nationally representative surveys were not possible. In none of the three countries was it possible to identify control areas. While some of the GF-supported interventions (such as ART) may be being implemented only in specific geographical areas, given the number of grants going to each country, there were no regions which seemed 'untouched' by GF support.

Table 5 shows sample sizes for each country. Details of sampling approaches for the facility and provider survey are given in Annex B.

Table 5. Sample Sizes, Baseline SWEF Surveys

Country	Facility Survey	Provider Survey	In-Depth Stakeholder Interviews
Benin	40*	90	20
Ethiopia	60*	335	57
Malawi	N/A	N/A	44

* In Benin, only public facilities were include in the facility survey. In Ethiopia, both public and private facilities were surveyed.

Qualitative Survey Sampling Approach

In Benin, for the qualitative component of the study, 20 in-depth interviews were conducted in September 2004 with key actors in GF implementation and the health sector more broadly. In the public sector, these included interviews at the national level, with senior Ministry of Health officials and the directors of the national programs for AIDS, TB, and malaria; and at the sub-national level, with departmental and district health representatives and a provider involved in GF service delivery. Outside the public sector, interviews were conducted with representatives of domestic and international NGOs, the private for-profit sector; the PR (UNDP); and the World Bank MAP.

In Ethiopia the research team compiled a list of key informants, and adapted the SWEF interview guides to reflect the knowledge and experience of different respondent sub-groups. The researchers conducted 57 interviews with informants at the national and sub-national levels, including interviews

with: 34 government officials (including 22 at the regional level); 12 experts/heads of health programs; seven NGOs; two bilateral organizations; and two with multilateral organizations. Certain key informants were interviewed twice in order to get the latest information on GF activities. Four geographical regions (the same as those selected for the facility and provider survey) were selected for in-depth interviews, these were Addis Ababa City Administration, Oromiya National Regional State, Amhara National Regional State, and Somali National Regional State.

In Malawi, through discussions with PHR*plus*, the MOH, and USAID, a total of 44 informants were selected for interviews on issues relevant to their roles in GF-supported activities. These included staff from various sections and departments in the MOH, Ministry of Finance, Office of the President and Cabinet, National AIDS Commission, Malaria Control Programme, TB Control Programme, and the private sector (mainly the private non-profit actors).

3.4.2 Links to Local Stakeholders

To help ensure that the research is timely, objective, and sensitive to the complex policy environment within which initiatives such as the GF are operating, the broader SWEF Research Network agreed to the following principles:

- Engagement and establishment of a close relationship with key stakeholders (including CCMs and the GF Secretariat) to ensure that study findings feed into policy and implementation
- A country-driven approach reflecting (i) the importance of linking to ongoing processes incountry, (ii) the diversity of GF-supported activities across countries, and (iii) the principles of the GF itself
- A commitment to the timely dissemination of findings in order to influence country and global decision making regarding the GF
- Sensitivity to the complex environment within which the GF and countries supported by the GF operates.

SWEF research teams actively sought to engage key stakeholders, at the national and global level, in conceptualizing the research, interpreting study findings, and considering implications for policy. The process for engaging national stakeholders within each country is summarized below.

Benin. The research team formally launched the SWEF Benin study in April 2004 with a national stakeholder workshop in Bohicon. Approximately 25 stakeholder participated, representing district health zones, departmental health directors, the MOH, the national programs for HIV/AIDS, TB, and malaria, NGOs, and the UNDP. Initial discussions with key stakeholders suggested that all four of the key SWEF thematic areas were relevant in Benin. The workshop played an important function of introducing the scope/scale of GF activities to many actors outside Cotonou, where knowledge of the GF is quite low.

A second stakeholder workshop was held in late March 2005 to present and discuss the preliminary findings presented in the baseline report. A draft copy of the report was distributed to 35 participants from national and departmental levels. During the workshop, participants provided both comments on the report and ideas for improving systems strengthening in the context of the GF activities. The workshop resulted in a series of draft recommendations, which were to be reviewed and refined by a small committee nominated by the deputy minister.

Ethiopia. The research team in Ethiopia conducted a series of consultative meetings with the CCM/E and other stakeholders, including stakeholders at the regional level. On the basis of those discussions, the CCM/E agreed to respect the independence of the research and to cooperate with the research team. The research team agreed to regularly update the CCM/E on the research and allow the CCM/E to review research reports prior to general release. A special Study Steering Committee was formed with select members of the CCM/E.

The researchers have worked closely with the Study Steering Committee at important stages over the course of the study (such as review of the protocol, research instruments, sample selection, and draft baseline reports). A national dissemination of baseline findings took place in October 2005 in Addis Ababa, with approximately 100 invitees from the national and sub-national levels.

Malawi. In Malawi, early discussions were held with the Principal Secretary of Health about the scope and scale of the research. During this dialogue, the researchers explained the nature of the study, and the intent that research findings be relevant and applicable for decision makers in Malawi. The Principal Secretary expressed his support for the study and suggested the research proceed. Follow-up consultations were conducted with several other stakeholders to facilitate the process of fitting the study protocol and methods to the national context. Several stakeholders were also provided the opportunity to review and comment on the draft baseline report. The researchers are discussing plans for a national stakeholder workshop to disseminate the baseline findings in the coming months.

3.5 Study Limitations

In many countries, the implementation of GF-supported activities has been slower than anticipated and accordingly effects upon health systems are just beginning to emerge. The type of issues observed to date through the SWEF studies also reflects the relative infancy of GF implementation at the country level. More specifically, while funding may have been committed through an approved GF proposal, the process of signing grant agreements, disbursing funds to the country level, and initiating implementation of GF-supported programs has taken a considerable amount of time in most countries SWEF is studying. This delay in implementation has had a fundamental influence on the types of effects visible and measurable at this point in time, which results in the rather process-oriented nature of the observations discussed below. Once the follow-up surveys are conducted, it should be possible to undertake more quantitative analyses of impact of the GF.

The context within which the GF is operating – at both country and global levels – is becoming increasingly complex in terms of the numbers and scale of donors and new disease-specific initiatives. This not only makes it rather difficult to ascertain what the systemwide effects are of the Global Fund itself, but also complicates the environment that the GF and its supported programs are operating and can potentially further aggravate existing weaknesses within health systems. Particularly in countries where the World Bank's MAP and U.S. government's PEPFAR programs are also operational, the environment is extremely complicated. (In Benin and Malawi, the GF and MAP are currently present, while in Ethiopia, MAP, PEPFAR, and the GF are operating). The degree to which coordination occurs among these three vast programs differs from one country to another.

Lastly, it is important to note that the GF itself is rapidly changing, and has been learning as it goes. The information presented here is therefore time sensitive and some of it may already be out-of-date due to recent policy or procedural changes.

***

The following sections of the report focus on the findings from the baseline SWEF studies in Benin, Ethiopia, and Malawi. The findings are organized by the key thematic areas of the study, namely the effects on: policy processes, human resources, public/private mix, and pharmaceuticals and commodities.

4. SWEF Findings: Policy Processes

The structures and processes developed by the Global Fund to govern the design and selection of projects to be funded represent new approaches to development assistance. They are designed to expedite the transfer of fiscal resources and stimulate innovative approaches to program design and implementation (partly by engaging non-traditional policy actors in this process). Furthermore the GF strives to promote country ownership of GF-funded programs; for example, it states that "Programs underwritten by the GF build upon existing poverty-reduction strategies and sector-wide approaches that have been developed to improve public health."[5] In the policy process component of the research, the SWEF studies sought to examine these themes, as well as the extent to which the development and implementation of GF-supported activities were aligned with other plans and organizational structures. Finally, the research looked at the extent to which GF support to countries was harmonized with the support provided by other donors.

These themes – alignment, ownership, and harmonization – were prominent in The Paris Declaration on Aid Effectiveness (OECD March 2005), in which the GF was a participant. The Paris Declaration, signed by many ministers of developed and developing countries, and heads of development organizations, aims to improve the efficiency and effectiveness of development assistance. This section summarizes the evidence available from the study countries concerning how the GF's commitment to ownership, alignment, and harmonization, as well as other key policy-related issues, has translated in practice, on the ground.

4.1 Alignment with National Priorities and Plans

In principle, the majority of GF-supported programs in Benin, Ethiopia, and Malawi, appear to be in alignment with overall national health policies and plans. In general, the target diseases were identified as serious health problems within national health plans. Furthermore, during discussions, national stakeholders uniformly viewed the GF as an opportunity to improve countries' capacity to respond to these challenges. In each of the three countries, many informants noted that the GF was "gap-filling" – that is, it provided the financial support necessary to scale up activities as envisaged in national plans, and frequently proposals to the GF had been culled from existing, but unfunded, national plans. This was very clearly the case in Malawi, where a comprehensive and costed national plan to address HIV/AIDS and malaria had been developed prior to the launch of the GF. When the GF was initiated, Malawi used a scaled-down version of this national plan as the basis for its proposal.

Malawi was the only one of the three countries studied to have adopted a Sector Wide Approach for planning and programming in the health sector, although the SWAp was only signed in November 2004, after the GF HIV/AIDS grant agreement had already been signed. In general, the activities programmed with GF support at the program level are linked to the SWAp through the Essential Health Package – under which malaria, HIV/AIDS, and TB services are integrated at the service

[5] Downloaded from: http://www.theglobalfund.org/en/about/how/#3 24 September 2005.

delivery point with other health services. While planning for GF-supported activities is aligned with (and encompassed by) the National AIDS Commission (NAC) Integrated Annual Work Plan (IAWP), concern was expressed by respondents about the parallel planning processes for the development of the NAC IAWP and the MOH SWAp. While the GF is not the cause of this disconnect, the problem has clearly been exacerbated by the influx of GF funding. The majority of MOH respondents at the central level viewed the GF-supported program as a vertical program operating within a health system that was reforming to implement integrated health service delivery through the SWAp (see sub-section below on verticalization).

Furthermore, the GF will in the future be funding the HIV/AIDS component of Malawi's SWAp Program of Work, but GF funds will be channeled separately – not through the common SWAp pool into which other donors channel their funds in support of the SWAp plan of work. This separate financing channel is somewhat contrary to the rationale of a SWAp and creates a further parallel system. For the Malawi malaria grant, the MOH requested that the GF monies be channeled through the SWAp. According to local informants, the GF counter-proposed that the monies be channeled through a structure similar to the Financial Management Agent (used by the HIV/AIDS grant). The debate about how the funding should flow appears to have contributed to the extensive delays experienced in signing the malaria grant.

4.2 Alignment of Institutional Structures and Processes for Planning and Implementing GF Grants

The GF requires (apart from in exceptional circumstances) that all proposals submitted to it are reviewed and supported by the GF CCM (see Box 2). Although CCMs have often grown out of existing bodies (see Brugha et al. 2002) they constitute additional new actors in the policy and planning arena. A substantial body of literature on the functioning and representativeness of CCMs has developed (e.g., Brugha et al. 2004). By and large, the findings of the SWEF country studies coincide with the findings in the broader literature, and therefore are not reviewed in detail here. CCMs were commonly viewed to be rather disempowered (especially with respect to principal recipients) and were sometimes perceived as "rubber-stamping" bodies. Although the CCMs in the study countries abided by GF guidelines on CCM composition, knowledgeable respondents frequently described discussions to be dominated by government stakeholders. Private for-profit actors appeared to be particularly excluded. While CCMs generally had written terms of reference, their roles and responsibilities were still often unclear to a broader group of stakeholders.

In Malawi, for example, where the only signed grant was an HIV/AIDS grant, there were specific concerns about overlapping responsibilities between the Board of the National AIDS Commission and the CCM. More generally there was a concern about the proliferation of HIV/AIDS coordinating bodies, with eight different HIV/AIDS coordinating and policy bodies being identified at the national level.

While the CCMs are commonly known new entities associated with the GF, the country studies unearthed a surprising number of country-specific new entities that the planning and implementation of GF grants had brought about. This was particularly the case in Malawi. While the NAC had been selected as the PR for the HIV/AIDS grant, concerns about its financial management capacity had led the GF Secretariat to propose that the NAC engage an independent financial management authority to manage NAC finances for two years while the NAC builds the capacity of its own finance department. The FMA, which is an international accounting firm selected through international competitive tender, is housed in the same office block as the NAC and appears to have developed a very close working relationship with the NAC. In order to ensure that HIV funds are easily accessible

to district authorities, the NAC has also entered into a two-year contract with umbrella organizations (UOs) to disburse and manage NAC funds at the district level, while capacity to manage such funding is developed within district structures. The five organizations that have been selected to act as UOs are all international NGOs. To date, the UO appear to have focused mainly on supporting local community and faith-based organizations to prepare grant proposals to the NAC, and respondents expressed concerns that there was inadequate monitoring of whether they were accomplishing their primary job of developing the capacity of district AIDS coordinators.

In Malawi, the new entities constitute parallel structures that have been established with the aim of enabling timely implementation, while still building capacity for routine structures to ultimately take over these tasks. In Benin, because the CCM was perceived as unwieldy to deal with the many operational and technical issues that arrive, they created a technical committee made up of the three program heads, UNDP (the PR), and several major partners for these programs. In Ethiopia, entirely new structures, namely technical review panels, have been established. The Ethiopian TRPs mimic the GF TRP, and are used to evaluate proposals received from local organizations. An interesting observation was made in the Ethiopia study related to the development of new parallel structures for the implementation of GF-supported programs. While working with existing systems to improve them (in both efficiency and effectiveness) would be ideal, some respondents saw this way of approaching the GF as risky. Some government officials feared that the GF may not be a secure future source of funding, and therefore did not want to upset existing systems (such as hiring policies) to scale up activities if it were possible that such support might not be maintained in the future. Such fears limit the opportunities taken to improve the overall system, and contributed to a project mentality for implementation of GF activities in Ethiopia.

4.3 Decentralization

In all three of the study countries, decision-making authority for health is considerably decentralized. In Benin there is a long history of autonomy at the health facility level, linked to cost recovery under the Bamako Initiative. In addition, 1999 laws passed much formal responsibility for health sector planning and implementation to decentralized health zones. In Ethiopia, decentralization is even more marked given the federal nature of the state: The federal MOH is mandated with issuing policies, guidelines, and standards, as well as conducting procurement and major trainings, but implementation is the responsibility of the regions. In Malawi substantial responsibilities have been deconcentrated to district health authorities, who conduct their own planning processes which in turn feed into national-level plans.

GF guidelines do not stipulate what role sub-national level actors should play in developing or implementing GF proposals. However the planning processes which countries have adopted to apply for and implement GF support appear highly centralized, even in these rather decentralized contexts. This has led to problems as countries begin to implement GF-supported activities, due to lack of ownership at sub-national levels. This issue appears most critical in Benin and Ethiopia, where the functions within the health system are substantially decentralized (or in the process of becoming so). As noted previously, in Malawi there had been several extensive planning processes prior to the GF call for proposals, which had involved sub-national stakeholders. The Malawians were therefore in the fortunate position of being able to draw upon the products from prior planning processes to develop their GF proposal.

In Benin and Ethiopia, the GF and related processes have exposed tensions between centralized decision making and decentralized responsibilities. For example, in Ethiopia, regional stakeholders were not invited to participate in any consultations during initial proposal development, nor were GF

proposals and workplans vetted among regional authorities that would ultimately bear the responsibility for implementing them. A short turnaround time for proposal development was the most frequent reason provided for why regional stakeholders were not included or consulted.

> *We thought that meeting the deadline was more important. We did not consult regions. This was a shortcoming…* MOH official, Ethiopia

Further, regional respondents noted that, in most cases, the GF workplans did not always match the regional priorities or needs. All regional respondents in Ethiopia reported that they have been asked to implement GF-related activities that have been planned at the central level, irrespective of their existing regional strategic plans. One regional official highlighted that, while regions were asked to implement additional activities, no additional support or budget was provided for overall management.

The criteria used to allocate GF resources between different decentralized entities were unclear in both Ethiopia and Malawi, and this created suspicion amongst decentralized actors. Whereas routine government budgets are allocated based upon a clearly specified and transparent resource allocation mechanism (as in Malawi) or are at least subject to public review via published government budgets (as in Ethiopia), in neither country was the distribution of GF funding subject to such transparency or scrutiny.

Although some respondents in Ethiopia implied that the degree of consultation had improved, communication issues between the central level and regional levels continue to some degree.

> *GF is centralized and we have no say on it apart from implementing the activities set in the action plan… We have no ownership or say….. This has affected the effectiveness and quick implementation of the GF programs.* Regional respondent, Ethiopia

A similar dynamic emerged during early GF-related processes in Benin, where decentralization to departmental and district levels has been proceeding over the past decade. As in Ethiopia, no sub-national stakeholders were involved in the GF proposal development or early planning processes in Benin. Furthermore, there was confusion among many decision-makers at the central level about what decentralization really meant in the context of the GF. For example, while several central level informants (disease program managers) seemed to imply that decentralization was being supported (or at least not ignored) through GF processes in country, they were not able to support such claims with evidence that lower levels were involved in any of the related planning processes. In the meantime, most respondents at the sub-national level in Benin did not believe they had the power to make decisions or participate in the planning of GF activities.

> *We were not involved in the conception or planning of the Global Fund activities; to the contrary, we must just put up with it.* District health officer, Benin

While the research raises concerns about the alignment of GF processes with decentralized decision-making structures in-country, the underlying reasons for these problems are due at least in

part to rather fragile decentralization processes in the countries concerned. That is, while countries' own policy documents may allocate substantial decision-making powers to decentralized actors, the broader decentralization literature suggests that the decentralization of power is often contentious and contested – particularly by those actors whose power it diminishes (Brinkerhoff and Leighton 2002). Nonetheless it is clear that GF-related processes have in some cases exacerbated these tensions. This is for a number of reasons. First, the drive for rapid outcomes – in terms of proposal development, program planning, and implementation – can easily undermine fragile decentralization processes as it is simply so much quicker to centralize decision making. Furthermore the GF does not have any specific procedures or requirements that counter this tendency; for example, there is no requirement that actors from the regional or district levels are included on the CCM. Finally, the intrinsically disease-specific nature of GF support may also reinforce a shift towards greater centralization: whereas regional and district health officers are clearly responsible for the planning and implementation of the full range of health services provided within their region, PRs of GF grants are often heads of national disease control programs.

While centralized decision making may serve to speed up the development of plans and proposals, it can certainly (as witnessed in some of the study countries) undermine timely implementation because of mismatches between what the central level proposed and what is actually needed in the regions.

4.4 Vertical Programs within the Context of Integrated Service Delivery

Whil many regional and sub-national stakeholders felt disempowered by how the GF support to countries had been managed, many respondents perceived that national heads of disease control programs had been empowered by the considerable GF resources focused in their hands. This was often described as a "re-verticalization" of services. This "re-verticalization" is counter to the general trend in many countries, extending back to the 1970s, toward greater integration of health services.

For example, in Malawi, the majority of central-level respondents viewed GF activities as a vertical "program" operating within a health system that is reforming to implement integrated health service delivery through the SWAp. Similarly in Ethiopia, respondents expressed concern about the vertical nature of GF-supported activities.

> *You see, GF does not seem to be integrated with other services. It is vertical and focuses on three diseases, malaria, HIV/AIDS, and TB. However, these diseases are very much connected with other diseases. You cannot see one by isolating it from others. The system should work on developing the capacity to deal with associated illnesses too.* Donor representative, Ethiopia

> *HIV/AIDS is part of reproductive health. Today experts are talking about integrating HIV/AIDS and reproductive health activities. People that use family planning, especially condoms, are less vulnerable to HIV/AIDS. In family planning [in Ethiopia] there is a shortage of condoms and we do not have resources to buy condoms.* MOH official, Ethiopia

Specific concerns in all three countries were voiced about HIV/AIDS grants and their strong focus on treatment rather than prevention.

> *Under the GF, there is too much focus on ARVs, PMTCT [prevention of mother-to-child transmission]… and issues of prevention are not addressed.* Faith-based organization official, Malawi

In Ethiopia, respondents perceived that GF-supported activities in the country had strengthened the role of the MOH vis-à-vis the HAPCO, and that this was contributing to a "medicalization" of HIV/AIDS.[6]

In Benin, it appears that programming for malaria, TB, and HIV/AIDS have historically been quite vertical in their approach, indicating a disease-specific tendency even prior to the GF's arrival in country. The GF and the large influx of disease-specific resources has, however, contributed to further verticalization, with all conceptualization, planning, and implementation of GF-supported programs managed primarily within the three program offices.

Given the onus that the GF places upon country ownership and decision making, it would be unfair to attribute these shifts in the relative power of local stakeholders, and the subsequent implications for decentralization or verticalization, directly to the GF. Nonetheless, it should be recognized that in many cases, and particularly in countries such as the study countries where GF resources represent a significant amount compared to national budgets, control over GF resources represents a very real source of power and, if not governed carefully, can cause shifts in key policies.

4.5 Ownership

While alignment of GF-supported activities with the governments' plans should be conducive to a strong sense of country ownership, in practice, a number of respondents questioned the extent to which countries were able to make independent decisions regarding the funding made available by the GF. This sense of lack of ownership was most acute in Malawi, where informants provided several examples of the GF Secretariat providing advice or requesting procedures that were in conflict with the Malawian view or national policies. In most instances, these were relatively minor differences of opinion, but collectively they resulted in a sense of lack of ownership. For example, in Malawi's malaria proposal, the Malawi CCM indicated that the funds would be used in line with the SWAp; the GF Secretariat, however, wanted the funding to be channeled through a fiscal-management agency type structure. Further discord arose surrounding the selection of the PR, and the choice of malaria drugs (described in more detail in Section 7.2.2).

> *…this therefore raises the question – 'who makes decisions of a health system in a given country such as Malawi' – is it the MOH and national governments or someone sitting in the U.S.?…* MOH officer, Malawi

Similarly, the Ethiopia and Malawi studies identified strong perceptions about the inflexibility of the GF, particularly related to the use and allocation of funds. Informants noted that once GF annual workplans were approved, it was extremely difficult to reprogram funds, or make any funding

[6] The MOH, rather than HAPCO, was largely responsible for writing the early successful applications to the GF, and recently HAPCO has been shifted back under the Minister of Health, rather than reporting directly to the prime minister.

reallocations, even if there was adequate reason to do so (such as to support national priorities, etc.). Conversely in Benin, respondents praised the flexibility of the GF, but complained about a tendency for "micro-planning" and "micro-management" – which also serve to diminish the sense of country ownership.

4.6 Donor Harmonization

In all three countries, respondents typically believed that GF support was effectively harmonized with the support provided by other donors. For example, in Benin, direct cooperation between the GF and MAP was often reported to be good, although this was based on informal and independent coordination efforts rather than formal institutionalized links. In Malawi, all HIV/AIDS activities – including those supported by the GF and by other donors – are incorporated in the NAC's IAWP, which was perceived to be an effective way to coordinate efforts. In Ethiopia, MOH officials were universally of the opinion that there were no problems of harmonization; however, donor representatives did raise concerns about harmonization across different funding sources.

> *GF, PEPFAR, and EMSAP are not integrated. From my perspective the benefits are less than the side-effects when seen in relation to the way the funds are administered. Disjointed operation of the funds results in a waste of money, time, and energy.* Donor representative, Ethiopia

While most respondents perceived planning and implementation of GF-supported activities to be effectively harmonized with that of other donors, many respondents stated that there were enormous pressures upon them related to the GF. Much of this pressure in Benin appeared to be related to the production of quarterly reports that summarize progress:

> *We are subjected to a lot of pressure. It's too stressful. There's pressure from the GF and it's too much.* MOH representative, Benin

Respondents in the other two countries also cited immense pressure to achieve GF targets, primarily because of the performance-based nature of the grant agreements. Informants in Malawi pointed out the need to harmonize the M&E systems of the GF and the SWAp in order to take advantage of common information systems, and the limited skills in-country in M&E. In Ethiopia many respondents expressed concern about the weak capacity of the M&E system and wondered about how the country would be able to clearly prove that it had met its targets.

4.7 Additionality of Funding

The GF was developed as a new financing mechanism with the goal of mobilizing *new* resources, and distributing support where it is most needed in order to scale up responses to fight the three focal diseases. A fundamental principle of the GF is that of additionality: the GF has clearly stated its intent to "make available and leverage *additional* financial resources," and it states it will "only finance programs when it is assured that its assistance *does not replace or reduce* other sources of funding, either those for the fight against AIDS, tuberculosis and malaria or those that support public health more broadly." Featured prominently in many key GF documents, the concept of

additionality is clearly one of great concern to the GF in terms of its perceived effectiveness and impact. While preliminary concept papers have been developed by the GF Secretariat to further elaborate on additionality, there still lacks general agreement on how additionality will be measured or tracked.

The SWEF research aimed to ascertain to the extent to which the concept of additionality was understood at the country level, and to what degree it is being followed (although baseline information is based only on respondent perspectives and responses; no in-depth analysis has been undertaken to measure additionality). In general, the condition of additionality is not well understood at the country level (and many respondents were not aware of it as a condition of the GF grant), and there is a lack of understanding about how it is to be measured.

In Ethiopia, the government reports that GF monies are indeed additional to existing (or previous) funding levels, although for the three focal diseases, the majority of program funding in the country has historically been donor funding, with limited MOH support. In Benin and Ethiopia, respondents identified cases in which bilateral and international donors had decreased (or ceased) funding specific programs because of new GF support. In Ethiopia, a bilateral donor stopped providing support for the procurement of TB drugs, although the donor has implied that, should GF resources become insecure, it would again provide financing. Similarly, several program officials believed that specific international donors had reduced their funding level in Benin due to the GF. In practice, it is extremely difficult to establish the counterfactual regarding additionality to substantiate such concerns.

The researchers in Benin also sought to ascertain the degree to which the required additionality of GF resources was *desirable,* by indirectly asking senior MOH officials and planners whether they would have spent these funds exclusively on HIV/AIDS, malaria and TB were there no strings attached to how GF money was to be spent within the health sector. None of the respondents said that the resources would have been devoted *only* to the three focal diseases, and they cited other priorities within the health sector. Thus, despite the observation that GF-supported programs were generally in alignment with existing national plans and policies, there is some disconnect between the GF-supported programs and perceived national *priorities.*

> *If GF financing was not limited to these three programs, we would have expanded our support to other health activities as well.* MOH official, Benin

4.8 Summary

The GF has placed particular emphasis in its modus operandi in ensuring a country-driven approach. This is clearly a defining difference between the GF and some other donor-supported programs, and as a result there are wide variances in how countries are choosing to respond to GF requirements and processes, and how GF-supported programs are implemented at the country level. There do not seem to be any concerns about the alignment of GF-supported interventions with national health frameworks, as in the study countries (and many other recipient countries), the three target diseases represent serious health concerns. However, when decisions are made about *how* to implement – especially during the early proposal and workplan development processes – serious implications were identified regarding the mismatch between GF-related processes and existing national approaches. The most acute of these problems were those of decentralization and verticalization. While noted that these problems are not fully attributable to the GF, it would be

appropriate for the GF to take a more proactive approach to advocate that the processes adopted by CCMs and national stakeholders do not go counter to existing structures, and ensure that all decision makers – including those at the sub-national levels – are involved in GF program development.

Further, the issue of national ownership presents conflicts between what the GF intends – in terms of their country-driven approach – and what country stakeholders perceive. There are mixed perceptions about how much autonomy countries truly have in carrying out their GF-supported programs.

5. SWEF Findings: Human Resources

The crisis in human resources for health is increasingly recognized as one of the most important obstacles to scaling up priority health services in low-resource countries, especially sub-Saharan Africa (Joint Learning Initiative 2005). In many sub-Saharan African countries, there is an absolute shortage of health workers, and those who are available may be inequitably distributed, being concentrated in urban (rather than rural) areas and higher-level health care facilities. Moreover, unmanageable workloads, salaries that barely enable survival, a lack of complementary inputs (such as drugs and disposable gloves), and a lack of supervision, incentives, or support are commonplace and serve to corrode the motivation of health workers.

Shortages and maldistribution of health workers, as well as motivational issues, if not addressed, are likely to undermine GF-supported programs. More broadly, the GF may also have very direct effects on the health worker situation. On the one hand, it may exacerbate the problem of unmanageable workloads, and contribute to maldistribution of health workers by further concentrating health workers in higher level facilities, such as those where ART programs may be located. On the other hand, GF support may boost health worker incomes through allowances or salary top-ups, improve the availability of complementary supplies, and finance transport to allow more regular supervision.

This section reviews experiences to date in the three study countries, in terms of the capacity constraints encountered, the policy responses to these capacity constraints, and the impact of the GF upon health worker incentives, training, and activities.

5.1 Human Resources Capacity Constraints

To date in the three countries, the key human resource capacity constraint in dealing with the Global Fund appears to have occurred at the central level. This is largely attributable to the fact that the process of applying for, planning, and beginning to implement GF-supported programs has consumed a considerable proportion of the time of key country policy and decision makers. Given the large amount of resources involved and the use of performance-based grants by the GF, there was frequently great pressure upon policy and decision makers, from very senior ranks of government, to ensure timely implementation. This was reported in all three countries.

> *GF is a challenge as well as an opportunity. We are implementing huge money in TB with limited human resources. There were five experts in TB and three have already left and we are two.* MOH official, Ethiopia

> *There is a need for more senior staff members in the MOH to supervise and coordinate the implementation of HIV/AIDS activities in the public sector. Currently TAs outnumber full-time senior MOH staff, a situation which might lead to loss of local ownership.* MOH official, Malawi

The quotes above also allude to two related problems: first, issues of brain drain out of the public sector, which exacerbate the human resource crisis (and are discussed further in Section 5.3) and, second, the reliance upon foreign technical assistance.

Implementation of GF-supported activities was at a relatively early stage in all three countries and therefore the size and nature of human capacity constraints at the implementation level, was not yet fully apparent. However, many respondents, particularly in Ethiopia and Malawi, voiced concern about how the lack of human resources at all levels of the health system would influence successful implementation. Some respondents also expressed concerns about how implementation had already been delayed by human resource shortages, or the impact of new activities on workloads.

> *GF is very slow.…The main reason is the financial disbursement…The second reason is lack of capacity. There is a shortage of human resource and we could not employ new staff as per GF provision.* Regional official, Ethiopia

> *The ART clinic is overwhelmed with patients ….currently there is a waiting period of about three months for eligible patients to receive treatment. This is not because we have run out of ARVs but because we do not have enough clinicians to manage the patients. Gradually we have increased the number of clinicians working in the ART clinic from one to three, much to the detriment of the delivery of other hospital clinical services.* Health worker, Malawi

Some respondents in each country, particularly at the central level, stated that GF-related activities and responsibilities had distracted them from their routine activities. In Malawi, the MOH instituted a policy permitting non-medical health workers to conduct voluntary counseling and testing for HIV/AIDS. Since this policy shift, there is evidence that health surveillance assistants – employed by the MOH to implement health promotion and preventive health services at the community level – are "specializing" to become VCT providers. Concerns were voiced that this "specialization" could potentially weaken community-based health services for non-HIV/AIDS-related services. While not directly attributable to the GF, this shift has been augmented due to the rapid scale up of HIV/AIDS services under the GF-supported program. Although minor, some staffing shifts have also been observed in Malawi, from the MOH to NAC and NGOs involved in ART delivery.

> *The GF is taking away resources from diseases such as malaria to VCT where there are funds.* Donor representative, Malawi

Concerns about the lack of sufficient human resources to scale up programs were less marked in Benin, where respondents had mixed opinions as to whether GF activities represented a large additional burden on human resources. While many program representatives cited a heavy workload related to the GF, other individuals within the MOH (but outside of the three focal program offices) did not report any distractions or additional burden on them due to the GF support. This at least partially reflects the rather vertical nature of implementation in Benin.

> *Some of our other regular activities are falling behind. It is harder and harder to keep up with it all.* MOH official, Benin

5.2 Human Resource Policies

Despite the concerns which respondents voiced about the impact of human capacity constraints on successful implementation of GF-supported programs, in only one of the study countries (Malawi) were there overarching national-level strategies or plans to address human resource constraints to scaling up health services. In Benin and Ethiopia, plans did exist related to specific initiatives (such as PEPFAR) rather than the combined needs of all initiatives, and such plans do not typically take into account the potential implications of such scale-up on human resources for other programs within the health sector.

Malawi presents a unique example among the study countries of addressing the human resource crisis. As noted earlier in the report, Malawi's original proposal to the GF incorporated many systems strengthening aspects, in recognition of the weaknesses within the existing system that would constrain the implementation of GF-supported programs; this included specific emphasis on human resource and infrastructure development elements, both of which were cut from the funded program. In February 2004, however, nearly one year following the signing of Malawi's GF grant, the UNAIDS director and the DfID permanent secretary visited Malawi and noted that the human resource crisis in the public health sector would severely hamper the scaling-up of ART and other GF activities. Following this visit, the GF authorized the reprogramming of $40 million of the five-year approved budget to fund Malawi's Emergency Human Resource Programme (EHRP); this amount has now been added to the EHRP "resource envelope."

Without overarching human resource strategies many stakeholders at national and sub-national levels were experimenting with their own solutions to promote health worker retention and motivation. For example, in Ethiopia, there was an active debate about whether GF monies should be used to top up the salaries of key staff. While at the central level, salary top-ups were frowned upon, some regions had already employed them. While such experimentation has the advantage of allowing policy makers to learn about what does and does not work, it may create extremely distorted incentives. For example, remuneration packages in some regions may come to be much better than elsewhere, further skewing the distribution of health workers. In all cases a considered national policy on tackling the human resource challenge is needed.

5.3 Impact of the GF on Incentives for Health Workers

In the three countries, the majority of health workers were not provided with significant new incentives along with increased workload and/or responsibilities under GF programs. Because of already low pay, coupled with the reality that additional responsibilities of implementing GF-related activities do not necessarily correspond to increases in grade or salary, the most significant financial motivation for health workers remaining in their original posts in the study countries comes from additional benefits from training allowances.

> *The staff we have here in the district do not demand additional money for the additional activities. I think it's because they get some allowances for training….. We make sure that every staff, be it clinician or nurse, benefit from these activities.* District respondent, Malawi

While in most cases, financial incentives for health worker were absent from GF-supported programs, in Malawi, decision makers were able to make use of GF monies to facilitate the

implementation of a broader health sector program to increase all health worker salaries. The EHRP includes overall salary increases (50 percent increase above existing levels) for all health workers and strategies to improve the retention/recruitment of health workers, as well as other important elements. This program clearly has widespread potential benefits for the health sector as a whole, although there were concerns from informants that a 50 percent increase in salaries was not sufficient to retain and motivate staff. (Note: The salary increase was originally intended to be 100 percent under the original EHRP proposal developed by the Malawian government, but due to limited availability of donor support to the EHRP, the salary/allowance increase was scaled down to 50 percent.)

In all three countries additional staff to help implement GF-supported activities had been hired on short-term contracts. Frequently these employees were paid substantially more than regular government employees. For example, in Ethiopia, salaries for short-term hires or consultants were typically about three times the salary of regular government staff. Respondents had differing views about whether such insecure – but highly paid – contracts would encourage staff to quit their public sector jobs.

> *…but there is high risk in that the employment is at most one year, of course renewable if there is need and budgets available. The regular staff may feel the salary differentials, but they know the risk one entails to work in a project. The focal staff have top ups of their salaries.* Regional official, Ethiopia

While to some the risks of short-term employment may seem high, there has clearly been an exodus of technical staff from the MOH in Ethiopia, and many of these individuals are now working as consultants on GF-supported and other activities.

In Benin, the national program used GF support to hire individuals on a short-term, contract basis. This occurred outside of the influence or direction of the MOH director of human resources. The programs that have hired new personnel directly using GF money also reported that these individuals were being paid higher salaries than generally paid by the public sector. In both Benin and Ethiopia, however, the numbers of newly hired staff were low. In Malawi, most respondents also reported that there were no plans to hire significant number of new staff.

> *We have not recruited additional staff due to the GF, but we have allocated more responsibility to the same people. We would love to recruit more people, but the processes are long. As a district, we can not recruit on our own, even the lowest level of staff.* District respondent, Malawi

5.4 Impact of the GF on Training Opportunities and Working Environment

Virtually every GF proposal includes substantial allocations for training and other support to human resources – accounting for approximately 20 percent of total GF funding (GF 2005). However, in each study country, GF-supported training focused largely on clinical issues and much less on skills needed to develop and manage effective health services and systems. Very few GF-supported training efforts addressed skill needs in M&E, financial management and supervision.

In Benin, human resources and training represent 20 percent of GF expenditures. Many respondents emphasized training activities as a positive element of GF-related work in the country.

Furthermore, in Benin, some GF training programs also have applicability beyond the three focal diseases – a clear example of positive spin-off effects. National-level respondents spoke of the transferability of skills obtained through GF-supported trainings beyond HIV/AIDS, TB and malaria. For example, GF money is being used to support training in the Integrated Management of Childhood Illnesses (IMCI) – justified because of the emphasis on malaria prevention and treatment within IMCI. According to a district-level official, however, there remained many missed opportunities for using GF funding for broader applications, particularly related to improving generic skills such as M&E.

It is important to note that most of the training activities supported through GF programs in the three countries were for in-service training efforts, not to improve or extend basic pre-service training opportunities. The in-service training approach focuses largely on improving the capacity of existing health workers to do their jobs better (or to do *more* within their existing jobs). This type of training and capacity building, which does not include creating opportunities to train new health workers does not have implications for the overall – and longer-term – supply of health workers within each country.

Many respondents in Benin also noted the positive effects the GF were having on the capacity of health workers to perform their roles due to improvements in the supporting infrastructure. For example, the motorcycles provided under the TB program for supervision, and microscopes purchased for district hospitals, represent expenditures that could enhance human resource capacities beyond the three focal diseases.

> *In effect, these motorcycles from the TB program allow us to carry out other activities, such as vaccination and prenatal consultations.* Regional health official, Benin

In general, capital investments facilitated with GF support have the potential to support the health system more broadly, but this is largely dependent on the applicability of new equipment or infrastructure to non-focal disease work as well as how they are deployed geographically and across facility types. For example, the provision of training or equipment for a specialized facility dealing only with TB patients is less likely to have positive spin-off effects than the provision of training for lab technicians working within an integrated health facility.

Respondents in Malawi also underlined the significant impact of work environment upon health worker motivation, and lamented the very poor working environment in many of the country's hospitals. Some suggested that this issue was a very good example of why GF support should be broadened to encompass other elements of the SWAp – such as district-level strengthening – rather than focusing on HIV/AIDS alone.

5.5 Summary

While the three country studies did not find serious human resource constraints at the sub-national or service delivery level, this is likely due to the fact that implementation is still at such an early stage.

While most GF-supported programs have significant in-service clinical training components, managerial and planning skills critical to successful implementation of GF grants are rarely

addressed. Furthermore, GF support is focused upon in-service training, which will not address the problem of an absolute shortage of health staff that exists in much of sub-Saharan Africa.

More broadly, GF grants rarely adopt a systematic and holistic approach to human resource issues – addressing, for example, issues of motivation and retention. This is at least partly attributable to the fact that countries themselves do not have broad human resource policies, and therefore there is no clear consensus about how complex human resource challenges should be addressed. In the absence of broad strategies or central-level guidance, different national and sub-national stakeholders are developing their own measures to address human resource constraints, and this mishmash of approaches may skew incentives and exacerbate inequalities.

6. SWEF Findings: Public/Private Mix

One of the Global Fund's underlying principles is that it will "focus on the creation, development and expansion of government/private/NGO partnerships" (GF, *Framework Document*). The private sector – including both for-profit/commercial and non-profit entities outside of the government sector – is seen as an essential partner in the rapid scale-up of services, and increased private sector involvement is considered a means to strengthen civil society participation.

As the GF explicitly welcomes innovative approaches to expanding service coverage and approaches that draw private sector actors into the health care system, a greater role for private sector actors may evolve. The SWEF studies aim to evaluate the effects of GF support upon the number, distribution, and organization of different types of providers (public, private for-profit, private non-profit) and relationships between public and private sectors (such as the number of public/private partnerships in non-focal areas, and the degree of trust and cooperation between sectors). In addition, the studies explore the implications of these changes for overall health system performance.

6.1 Context and History of Public/Private Relationships

Relationships between public and private sectors are frequently characterized by a history of tension and lack of trust; this is particularly the case with respect to private for-profit providers (Gilson, Doherty, McIntyre et al. 1999). Previous studies have noted that this lack of trust between sectors may undermine the democratic functioning of CCMs (Brugha et al. 2004). The nature of the public/private relationship is unlikely to change quickly, and the country studies revealed several instances where tension between sectors had inhibited collaboration. For example, in all three countries, CCMs were very government dominated, and private for-profit actors often appeared sidelined from decision making. Furthermore, in Ethiopia, existing mistrust and tension constrained operational partnerships between the public and private sectors.

None of the three countries had specific policies concerning the role of the private sector. While broad policy documents and plans typically made fleeting references to the need to engage with private sector actors, these policy statements were rarely sufficiently specific to be useful. As a consequence, and this was particularly observed in Ethiopia, there was a lack of common understanding about the relative roles of public, private for-profit and private non-profit actors, or indeed what constituted a non-governmental organization. Private sector informants in Ethiopia largely welcomed the impetus the GF has given to new partnerships but said that, given the history in the country, it had proved difficult to make this work effectively.

> *There is tension between government and NGOs. It is all attitudinal… I think NGOs are not getting GF grants because government doesn't have a positive attitude towards NGOs and doesn't trust NGOs.* NGO/private sector respondent, Ethiopia

While it is probably too early to say, in both Benin and Ethiopia, some respondents felt that there was the prospect that the new forms of public/private partnership fostered by GF support might have a lasting impact, in terms of improved trust and cooperation between public and private sectors.

In Benin, several respondents reported that the GF had led to the creation of new partnerships with the private sector, especially with NGOs. On the government side, this was viewed in a very positive light, with most respondents recognizing the new collaborations. They said they would like to continue these relationships if the GF were no longer present, and worried about the sustainability of such partnerships post-GF due to a "lack of money, not will." However, it appears that the collaboration took place at the central level and excluded the district level.

> *For the GF activities, collaboration and arrangements happen between the three programs and the NGOs, without any involvement of us in the district.* District health official, Benin

A senior official in the MOH noted the new partnerships would also have benefits for other health priorities since the same NGOs were involved in them (giving the example of onchoceriasis). An NGO representative also noted the improved and increased collaboration with the government. This respondent talked of the new competencies acquired by many NGOs through GF-supported trainings that would benefit their other work as well (such as improved management and financial management).

6.2 Private Sector Participation in GF Planning Processes

The GF requires that some private sector stakeholders are represented on the CCM. However, in countries where there was a lack of trust between public and private sectors, government-dominated CCMs had been reluctant to include strong private for-profit stakeholders. This was particularly the case in Ethiopia, but in both Benin and Malawi some private sector representatives felt that it was difficult to make their voice heard within the CCM. Outside of the CCM, many private sector actors interviewed knew little of the GF, except what they had read in the newspapers.

While CCMs had approved the final proposals submitted to the GF, it was typically a much smaller group, often without private sector representation, that had been closely involved in proposal development. Malawi constituted a notable exception to this. The plans which had been previously drafted in Malawi, and which were later adapted to meet GF requirements, had been through an extensive consultative process as part of their development, and as a consequence had been aired and discussed within the private sector. Of the 10 GF grants approved in the study countries, only one was to a non-government PR (excluding the grants to UNDP in Benin).

For reasons of mutual accountability, it is important for private sector actors to be engaged as part of CCMs; however, government respondents in Ethiopia, and to a lesser degree Malawi, expressed some skepticism about the motives of NGOs and believed it to be important for government to retain a stewardship role within the health sector. This notion would be compatible with government playing a strong role within CCMs.

6.3 Forms of Collaboration between Public and Private Sectors for GF Implementation

GF monies have stimulated new types of collaborations between public and private sectors, both in planning for the use of monies and in the execution of funded programs. In Malawi, the GF has served to stimulate an existing, but new, public/private collaboration. Quite recently, Malawi has instituted the use of umbrella organizations to help implement HIV/AIDS activities. These UOs were contracted by the National AIDS Commission to support district- and community-level HIV/AIDS interventions. The UOs work with community-based organizations and faith-based organizations to support them in making applications to the NAC for small grants. This UO structure was originally established at the request of the pooled donors. While not created by or for the GF specifically, the UO structure may be strengthened through increased funding under the GF program. Many respondents in the SWEF study viewed the role of the UOs to be particularly innovative. The UOs – all five of which are international NGOs – have a two-year contract with NAC to build and strengthen the capacity of the district assemblies such that each district assembly is capable of coordinating district-level responses to HIV/AIDS. This function was seen as a very significant contribution to the public/private mix in the country.

While most respondents in Malawi felt the government's view of the private sector was changing, and that the government was increasingly recognizing that the participation of the private sector would be crucial to achieving national targets, they also noted that most of the time the government does not fully engage the private sector. One interesting explanation, provided by several respondents, was that the government might be reluctant to use the private sector because it does not want to be perceived as having inadequate capacity to implement activities proposed in their GF proposal.

> *The option of referring patients to other private facilities or CHAM [Chrisian Health Association of Malawi] hospitals to receive ARVs is a non-starter, government would not allow it. Government does not want to show that it is not capable of delivering HIV services with the current resources in the hospitals.*
> MOH official, Malawi

Rather than using the GF as an opportunity to fully scale up services, this perception and fear among certain MOH stakeholders limits the country's potential for achieving broader targets.

In Ethiopia, NGOs complained about the GF funding process, citing instances of its taking over one year to get funding from the National HAPCO, while government entities were able to get funds more readily. This, coupled with a sub-contracting approach in Ethiopia that provided small disbursements every few months ("piecemeal fashion"), discouraged long-term activities and ultimately made the GF an unreliable and somewhat unattractive source of funding for private sector actors.

Given the history of mistrust between public and private sectors, transparency in dealings is of the utmost importance. Many NGOs in Ethiopia had heard from some (unspecified) source that NGOs would get 30 percent of GF funding. This had dramatically raised their expectations about what the GF could mean for them. Failure to actually receive this level of funding had led to disillusionment and a degree of cynicism within the NGO community. While PRs explained to the researchers that much of the GF funding was tied up in procurements, and that they did aim for NGOs to receive 30

percent of the funding available for some activities, this had not been clearly communicated to the NGO community.

In Benin, an NGO UO has become a vocal participant in the CCM and is also currently managing sub-grants to NGOs, both within its network and outside for HIV/AIDS activities.

6.4 Growth in Non-profit Private Sector

In Malawi and Ethiopia, there has been a rapid growth in the number of NGOs within the health sector. Many respondents perceived that the GF, among other large donor programs, had stimulated this growth in the private non-profit sector (although it is clear that significant civil society involvement, especially for HIV/AIDS, preceded the establishment of the GF). In several instances, country stakeholders expressed concern about the rapid growth of the NGO sector, believing that many new NGOs (sometimes referred to elsewhere as "briefcase NGOs") had limited capacity and were only weakly accountable.

In Benin, as mentioned above, many respondents noted the positive development of improved public/private collaboration under the GF-supported programs. An NGO respondent emphasized that, with this new collaboration, the range of actors and especially activities in which NGOs were participating in the health sector had grown considerably. This trend was expected to continue, as means were sought to further include traditional healers and religious groups. The informant did not believe that the influx of GF funds had led to the creation of many new NGOs, but had perhaps led to more NGOs officially registering with the local NGO network body. Finally, the representative noted that the NGO members were benefiting from the new partnerships, acquiring new competencies through various seminars and trainings as part of the participation in implementing the GF-supported program. Improved management capacities, in particular, will have more widespread positive effects on NGO capacities to implement non-GF-related activities. On the other hand, in Benin, some private manufacturers of mosquito nets noted being left out of the GF-related processes, as all nets were acquired through the U.S.-based NGO Population Services International (see Section 7).

In the study countries, very little attention had been paid to ensuring adequate regulation or quality control in the private sector. Respondents in Malawi had concerns about the capacity of private sector organizations (non-profit and for-profit) to implement activities. According to respondents, such organizations typically do not have adequate staff – in terms of numbers or training – to implement all of the activities outlined in their proposals to the PR to receive GF support. Further concerns were noted in Malawi about the ability of these NGOs (particularly new ones, which surfaced in response to the new availability of funds) to account for funding received. Several informants noted the critical importance of monitoring the implementation and accounting of these new entities, to ensure that funds were managed and spent appropriately, and that activities were implemented according to satisfactory standards.

In both Ethiopia and Malawi, respondents mentioned that poor coordination within the private sector contributed to difficulties in establishing public/private partnerships. Such coordinating mechanisms were in the process of being established when the studies were undertaken. For example, in Ethiopia, there was a nascent private practitioners association and, in Malawi, a couple of new networks and a forum for private sector organizations working in the health sector were being established. Such organizations or networks may both help empower private sector actors (by enabling them to speak with one voice) and may also reduce the transaction costs of doing business with the private sector.

6.5 Migration of Staff between Public and Private Sectors

In countries where there are shifts in the balance between public and private sector participation in carrying out activities, there is a risk of triggering a migration of health workers from one sector to another. For example, if the private sector is involved extensively in a large scale-up of HIV/AIDS services, there is the potential for public sector workers to leave their public posts to seek employment within the private sector, often for higher salaries. During the baseline studies, this trend was not widely evident. In Malawi, some small insignificant shifts of health staff from the public sector to NGOs involved in implementing the GF program (ART activities, specifically) were observed. To date, no significant shifts were noticed in Benin or Ethiopia, where the number of additional posts created is still limited.

6.6 Summary

The history of mistrust between public and private sectors in the study countries, combined with the lack of a clear policy framework or common understanding of the relative roles of government, private for-profit and private non-profit actors has to some extent undermined the GF's original vision of stimulating innovative partnerships between the sectors. However, despite the problems that clearly exist, there have also been some successes and according to the respondents interviewed, these successes may have ripple effects in terms of beginning to change the way in which the different sectors relate to each other.

What constitutes an appropriate role for the private sector to play should surely depend upon, on the one hand, the capacity, accountability, and democratic structures of government, and, on the other the capacity and comparative advantage of the private sector. These starting points vary between countries. The GF, but more broadly the donor community, need better tools to assess these dimensions, and map the private sector so that the approaches used to program funds and provide oversight to grants can be adapted to different circumstances.

7. SWEF Findings: Pharmaceuticals and Commodities

Approximately 50 percent of Global Fund money committed across the globe is intended to procure pharmaceuticals and commodities. This injection of funding may affect procurement, supply and distribution systems, and the quality and prices of other drugs and commodities. The SWEF protocol considers issues of drug management – such as procurement, distribution, utilization/rational use, and monitoring and evaluation – as well as geographic access, physical availability, financial affordability, quality, and specific issues of pricing/subsidies, to investigate the effects of the GF upon pharmaceuticals and commodities.

There had been delays in procurement processes in all three countries, but these had been most acute in Ethiopia, where, at the time of the research, almost two years after the signing of the first grant, very few drugs procured with GF finances had yet arrived in country. In that country, there were several instances where procurement delays had adversely affected the successful implementation of other program components; for example training in new treatment protocols could not be applied due to lack of drugs. Given the fact that few drugs or commodities procured with GF support had yet reached health facilities, this interim report is not able to analyze effects upon the availability, affordability, or use of drugs. The planned follow-up surveys will cast more light on this.

7.1 Alignment with Existing Pharmaceutical Supply and Distribution Systems

Table 6 provides an overview of drug and commodity procurement and distribution responsibilities for GF grants in the study countries. In Benin and Malawi, existing procurement and distribution systems were bypassed for the implementation of GF programs. This presents serious concerns about the sustainability of programming, as well as missed opportunities to strengthen the existing procurement and distribution systems within the countries.

Table 6. Procurement and Distribution Responsibilities for GF Grants in Study Countries

	Malawi ARVs	Malawi Other drugs	Ethiopia All drugs	Benin ITNs	Benin ARVs
Procurement	UNICEF	UNICEF	Pharmaceutical Administration & Supply Services (PASS)	Population Services International (PSI)	UNICEF
Distribution	UNICEF	Central Medical Stores (CMS)	PASS	PSI	AIDS program within MOH

In Benin, following the assessment of the government procurement agency (*Centrale d'Achat des Médicaments Essentiels,* CAME) by the LFA, procurement responsibilities for GF-related programs were given to UNICEF (for ARVs) and the NGO Population Services International. The reason for bypassing the government system was stated to be the need for rapid scale-up. However

many respondents in Benin expressed concerns that bypassing might undermine the sustainability of GF-supported programs and also complicate coordination of different procurements. While the principal recipient agreed to concurrently strengthen the government procurement channels, there was no clear agreement about what needs to be done or how this should be done (and nothing has happened to date). Some respondents perceived the existence of parallel structures for procurement and the lack of any single entity with an overarching view of procurement processes as potentially damaging. Furthermore, at the time of the baseline, no clear mechanism had been established to ensure dialogue between the PR and CAME on issues of procurement. (Although following the release of baseline findings in country, this issue has since been discussed more openly).

A similar situation emerged in Malawi. Following the approval of Malawi's HIV/AIDS grant, the LFA conducted an assessment of the Central Medical Store (CMS) capacity to procure drugs and medical supplies for the GF program. The assessment concluded that CMS lacked adequate capacity, and the GF requested that the MOH identify a procurement agent by either going through a "lengthy" international tendering process or by directly engaging a member of the U.N. family (prequalified). To expedite things, the MOH/CMS recommended that UNICEF be contracted to procure drugs and medical commodities on behalf of the MOH. As part of the memorandum of understanding between the MOH/CMS and UNICEF, UNICEF was tasked with building the capacity of the CMS specifically in the area of procurement and medical supply management. The MOH further envisioned that CMS would gradually take over tasks from UNICEF in a phased manner.

Ethiopia provides a contrast to the other two countries. Here, the Pharmaceutical Administration and Supply Service (PASS) (a branch of the MOH) took on responsibility for all procurement. Procurement had been extremely slow, and respondents at all levels of the health system complained about this. PASS appeared to be understaffed and frankly overwhelmed by the quantity and complexity of GF procurements. However during the study period, PASS made a number of changes to its mode of operation – including renting more warehouses, hiring more staff on short-term contracts, and contracting out specific elements of the procurement and distribution chain – which appeared to be having very positive effects upon the efficiency of procurement.

In Benin and Malawi, it is clear that the decision to bypass existing systems was meant to be a "quick fix" solution. The establishment of such parallel, external, procurement systems for the target diseases are likely to lead to inefficiency and duplication of efforts within the country: health staff at the facility level need to manage multiple mechanisms for ordering drugs, more sophisticated information systems need to be put into place to handle the various sources of products, and there may be straightforward duplication of warehouses and distribution systems. Moreover, bypassing existing procurement and distribution systems reduces the potential for the large quantities of GF procurements to motivate changes in the primary procurement and distribution systems.

7.2 Alignment with Existing Policies

Two main areas of concern were noted in the studies about alignment with existing pharmaceutical and commodity-related policies and processes, namely (i) pricing strategies used for drugs or commodities purchased with GF monies, and (ii) the selection of drugs to be purchased with GF support.

7.2.1 Cost Recovery and Pricing Policies

An important element of Benin's existing health system is a cost recovery mechanism at the health center level, following the Bamako Initiative approach. It is generally viewed as a well-functioning system, through which funds are generated to ensure continuing stocks of drugs and other supplies while engaging local communities in health-related decision making. When asked about how well the drugs and supplies procured under the GF program in Benin fit into the existing cost recovery approach, several senior MOH officials stated that the policy applied equally to the GF. However, in further discussions the researchers discovered otherwise, specifically regarding pricing of insecticide-treated nets – see Box 3. Bed nets purchased with GF support were being sold at a lower price than those purchased through the regular system. This was not a consequence of explicit targeting of GF-purchased bednets to poorer segments of the community, but simply separate funding sources and decision-making authorities. Moreover, there were also different policies regarding use of revenues from the sale of ITNs. As both GF-purchased nets and other nets were often present in the same facility, this created substantial confusion and extra work for health staff who had to account for funds separately.

Box 3. Cost Recovery and Pricing of ITNs in Benin

ITNs purchased through GF

ITNs are sold for 1,500 CFA each, with all revenues returned to a special account of the national malaria program to support the sustainability of the activities.

ITNs purchased through health system

ITNs purchased through normal channels within the health system are priced at 2,500 CFA, of which health centers retain 100 CFA for community financing and 50 CFA for community-based health workers.

Some respondents acknowledged that these parallel approaches could pose problems, and suggested that there were plans for harmonization of prices and policies. It should be noted, however, that in Benin there are in fact multiple pricing strategies for ITNs – depending on various donor mechanisms – and that the GF was one more divergent approach on top several preexisting ones.

During the baseline studies, GF-supported ART programs were still in their infancy in the study countries. Malawi was in the process of taking steps to align the price of ART between mission and government health facilities (by using GF support to cover consultation fees charged at mission facilities), and was also seeking to subsidize care in the private for-profit sector requesting in return that ART services be charged at a fixed and agreed price. As ART programs get underway in other countries, the issue of differential pricing and cost recovery could become more substantial. If attention is not paid to this issue, then there is the danger of parallel cost-recovery systems developing within a country, with different prices for ARV drugs depending on the funding/donor source. This may create both inequity and confusion.

7.2.2 Drug Selection Policies

Issues were also identified in Malawi regarding the selection of drugs to be procured with GF support. Several respondents in Malawi expressed serious concerns about the GF Secretariat "interfering" with the independence of the MOH in terms of their existing antimalarial drug policy (this 'obstacle' was noted even though the malaria grant was not yet signed). Since early 2004, the GF has been going through a process of determining how to best facilitate the scale-up of artemisinin-based combination therapies (ACT) as the first-line malaria treatment in appropriate contexts (that is, where other treatments are no longer effective). In January 2004, in a letter to all CCMs, the GF noted:

> *Treatment using chloroquine (CQ) and sulfadoxine-pyrimethamine (SP) will be approved if there is evidence that these interventions are effective. If, following a grant approval or signing, a recipient gathers evidence that these treatments are not effective due to resistance to these drugs, we encourage and expect such recipients to contact the Global Fund and to alter the terms of the approved program to allow the use of a more effective treatment protocol including artemisinin-based combination therapy (ACT).* The GF, January 2004 (GF website)

Based on a multi-country assessment carried out for the GF, Malawi was found to have high sulfadoxine-pyrimethamine (SP) failure rates, and Malawi was included in a list of countries for which ACT was recommended as the first-line treatment by the assessment team (Vestergaard 2004). The Malawi Malaria Control Committee – the national malaria policy-making body – has however made a recent decision that SP should continue to be the first-line antimalarial treatment in Malawi, and that it should be purchased for GF-supported malaria activities.

Some respondents were frustrated that the GF advocated for a change to ACT treatment policies in Malawi, despite the national policy decision.

> *….the same Global Fund stated that countries are free to make their own malaria policy, but on the other hand they insist that we should procure ACTs as first-line treatment instead of SP… our Malaria Control Committee decided to continue using SP [as first-line treatment] based on local experiences and realities, but the Global Fund would like to impose ACTs on us.* MOH official, Malawi

In Benin, national policy was changed to make Coartem the first line malaria treatment. Interestingly, in this context respondents cited the GF's support to this new policy as a good example of its flexibility and desire to support country decision making.

7.3 Summary

The GF and local stakeholders face complex choices about under what circumstances the need for speed should trump the need for sustainable solutions that build country capacity and self-reliance. This is particularly acute with respect to bypassing existing national systems in order to ensure rapid implementation and outcomes, as demonstrated for the procurement of pharmaceuticals and commodities. If routine procurement and distribution systems are to be bypassed, then it seems important that explicit and agreed strategies are in place to strengthen these systems so that at a fixed point in the future they can take over. Given the amount of GF resources allocated to drugs and supplies, support to the development of nationally owned, strong, and transparent procurement and distribution systems would seem to be a very logical use of the GF's new health systems strengthening facility. In many cases clearer country plans for strengthening procurement and distribution systems are needed to guide strategy in this area.

The issue of differential pricing strategies and cost recovery mechanisms is likely to become an increasingly important topic, especially as other large health initiatives, such as PEPFAR, support the scaling up of ART programs at the same time as the GF. Country decision makers should pay particular attention to this issue as such programs are rolled out to ensure that the complexities of

multiple approaches does not impact equity or access to services, or effect the efficiency of service delivery by placing excessive management responsibilities on health staff in negotiating the varying approaches. Advocating for better coordination of donor programming at the country level is one way of avoiding such complexities.

Finally, the example of drug selection dilemmas demonstrates the complexities inherent in supporting high quality and responsible drug procurement processes. While the GF needs to try to ensure that the drugs procured with its resources are appropriate and effective (and in line with World Health Organization recommendations), and to respond to the concerns of many about the efficacy of the pharmaceutical regimens it supports, there remain a disconnect, as demonstrated in Malawi, between advocating the "best approach" and deferring to the autonomy of national policymakers.

8. Conclusions and Recommendations

The health system barriers that the Global Fund is encountering at the country level are predictable and other studies have highlighted how a weak human resource base, lack of experience in working with the private sector, and poor drug supply management create considerable barriers to scale-up (Oliveira-Cruz, Hanson, and Mills 2003). The constraints encountered by the GF thus far are not necessarily unique to the GF but rather reflect existing weaknesses in underlying health systems. While the preliminary research findings presented here, and in other SWEF reports, suggest that although the GF may not have led to widespread negative effects upon health systems thus far (which some feared), neither has GF support yet materialized as a means to strengthen health systems. In this respect the GF's recent policy shift – explicitly inviting proposals for health system strengthening in its Round 5 application process – appears essential to the achievement of its specific disease-related objectives.

This concluding section identifies five broad areas to which countries, the GF, and the broader international development community should pay attention in order to increase the prospects for beneficial effects upon health systems. While it is important that all three of these stakeholder groups are aware of the range of issues identified, some issues may best be addressed by a particular stakeholder group. Where possible we identify which stakeholder groups are most suitable to take forward a specific agenda item.

8.1 Do No Harm

As the GF begins to engage more in health system strengthening, it needs to be aware of how its own policies and procedures, and particularly its quest for speed, may potentially undermine health system strengthening goals. The GF is under much pressure to move fast – its speed in expending resources and delivering impacts affects its ability to raise additional resources, and ultimately the chances of securing its own survival. But an excessive focus upon fast implementation and rapid results may undermine health system strengthening and ultimately sustainability, as well as inhibit participation and inclusiveness.

The country studies illustrated a number of ways in which GF policies and procedures may damage country health systems:

By-passing of routine systems, such as drug procurement and distribution systems, or information systems. This may enhance speed, but create duplication and inefficiency, which will have a particularly adverse effect upon staff at the facility level, who are often already over-burdened.

Creating planning processes that differ from standard practice in country. Overly centralized approaches to GF planning in many countries undermine decentralization initiatives. Creating overly powerful disease programs detracts from government policies to develop integrated service packages. These problems are not fundamentally GF problems, but rather arise with fragile development processes (decentralization and integration) on the ground. Nonetheless, they have been exacerbated by GF support.

Not abiding by existing government policies or practices in implementation, such as allowing the development of alternative user fee structures and systems for revenue collection.

The development of parallel systems, or bypassing of existing systems is commonly due to perceived inefficiencies or sluggishness of existing systems. Given the pressure upon the GF (and similar initiatives) to act fast, it may sometimes be necessary to implement programs through temporary structures that bypass existing systems. However, the sustainability of the parallel structures created is often dubious and the GF should ensure that adequate measures are developed and implemented to strengthen routine systems so that programs can eventually be implemented through these more sustainable mechanisms. As described earlier, omitting key implementation actors (such as regional- or district-level stakeholders) from planning processes may save time in the short run, but can potentially lead to long delays in implementation, as plans are found not to reflect local needs or capacities.

While adhering to the GF's core principles that it is not an implementing agency but a financing one, the GF Secretariat could and should take measures to address problems such as these. With regard to the bypassing of systems, for example, GF proposal formats could clearly ask whether existing systems will be bypassed and, if so, require that plans to be build capacity in existing systems be specified. If, as appears to be more commonly the case, existing systems are bypassed at the suggestion of LFAs, then LFAs could be required to broker agreements about how capacity should be built. With respect to the issues of centralization and verticalization, changing the composition of the CCMs, in particular to require more representation on CCMs of implementing agencies and stakeholders from regional and district levels may help redress the balance of power. An additional strategy that the GF or other stakeholders could support would be to develop simple checklists or guides for recipient countries to use in identifying effects that GF (and other disease- or service-specific) support may have upon health systems.

8.2 Health System Strengthening to Achieve GF Goals

The three country case studies discussed here highlight many different ways in which health system strengthening is needed in order for the targets specified under GF-supported programs to be met. Among the many health system strengthening needs, specific examples discussed in the report include:

- There is a need for more health workers, and more motivated health workers to help deliver focal services;
- The working environment for health workers – in terms of the availability of complementary drugs and supplies, supervision, etc. – needs to be improved;
- There need to be clearer agreements about how to work with private sector actors;
- Procurement and distribution systems need to be strengthened to respond to increased demands associated with GF procurements.

This report has also identified examples where GF support is already contributing to health systems strengthening (such as the adoption of innovative ways of working with the private sector, or improved availability of transport for supervisory and logistical purposes). However, the contribution of GF support to health system strengthening to date appears to be small. What more needs to happen

to empower countries to move forward on health systems strengthening and make good use of the new GF health system strengthening component?

For many elements of the health system, there is no clear vision or agreed strategy for how to strengthen them – this is true both at the global and the country levels. Very few countries have broad policies or plans on human resource development, or the role of the private sector, or pharmaceutical policy. As a consequence, different stakeholders in country have different views about what needs to be done and progress is slow. This is mirrored at the global level, where, in many instances, there is a lack of evidence and consensus about which health systems strengthening strategies work and which do not. Both of these gaps need to be addressed.

The development of policies and strategies for health systems strengthening is not a task that the GF alone can or should take on. Rather, in-country processes must be led by government actors and engage a broad range of stakeholders including health workers, civil society, in-country donors, and local representatives of global health initiatives (such as CCMs). At the global level, greater clarity is needed as to which health system strengthening strategies are effective. The GF, along with GAVI (Global Alliance for Vaccines and Immunization) and other global health initiatives, have a stake in this debate and should be active participants, but the primary responsibility for pursuing does not lie with them. The 2005 Montreux Challenge meeting[7] constituted an initial step in this direction but much more remains to be done.

8.3 Promoting Mutual Accountability and Transparency

A distinguishing characteristic of the GF has been its efforts to engage a broader range of civil society actors in decision making, and its attempts to promote transparency through, for example, the detailed information provided on its website, and the open manner in which it has addressed controversial issues. While this ethos of mutual accountability and transparency has clearly affected GF-supported activities and GF planning at the country level, much more still needs to be done in this area at the country level. The CCM in particular, but also other country-level stakeholders such as ministries of health should bear responsibility for action in this area.

In both Benin and Ethiopia, outside of the small group of stakeholders directly involved in the CCM or implementation activities, there was very limited knowledge of what the GF was and how it operated. In the absence of clear information, there were often rumors and misinterpretation of what was going on. CCMs need to be encouraged to play a more active role in communicating the nature and results of GF-supported activities within countries. This may also help the CCM break out of the "rubber stamping" mold in which some are currently stuck. CCMs should gain authority and legitimacy if they can become better conduits for information about the GF to a range of civil society and government stakeholders.

Transparency in GF dealings within a country is also critical. CCMs and PRs need to consider making GF budgets and workplans more publicly available, and perhaps adopt resource allocation criteria to distribute GF resources between different regions or districts.

[7] "The Montreux Challenge: Making Health Systems Work" meeting was held in Glion-sur-Montreux, Switzlerand, 4-6 April 2005.

8.4 Sustainability

In an era of high HIV/AIDS prevalence and a commitment to scaling up services, definitions of sustainability that emphasize the ability of government to take over from external sources of financing are outdated.

It is imperative that GF financing is perceived by country stakeholders to be, and, in reality is, secure. The country case studies revealed several instances where country policymakers hesitated to undertake major reforms of existing systems, or adopt new treatment regimes, primarily because they were uncertain that they could depend upon the GF as a reliable source of finance into the future. The large amounts of money now flowing into countries via the GF and similar mechanisms hold the prospect of not just strengthening specific health systems (such as drug procurement or information systems) but really changing the bureaucratic culture and way of doing business. However, these more significant reforms will not occur unless the GF is perceived to be here to stay. This is a challenge for the international donor community as a whole – it needs to do more to ensure the financial sustainability of what has already been set in process.

8.5 Learning from Doing

The GF has a strongly country-driven approach, reflected in the freedom that it gives PRs and CCMs in defining how best to make use of GF resources. With respect to new forms of public/private partnerships, arrangements for drug procurement and supply, and incentives for human resources, a thousand flowers are blooming as a result of GF support to countries. This diversity of organizational arrangements, together with the GF's unique ability to learn from past experience and adapt its procedures and policies accordingly, raises the importance of timely evaluation and cross-country transfer of knowledge. It is heartening that the GF has learned from its experience to date and realized that health systems strengthening is critical to the achievement of its own goals. It is now important to ensure that structured learning – through different types of monitoring and evaluation studies continue and inform not just the GF Secretariat and Board, but also country processes and the broader donor community. All stakeholder groups – including country actors, the GF, and the broad international development community – have critical roles to play in ensuring that there is effective evaluation and learning from GF experiences.

8.6 Next Steps

The context within which the GF is operating – at both country and global levels – is becoming increasingly complex in terms of the numbers and scale of donors and new disease-specific initiatives. It is therefore critical that independent evaluation efforts, such as SWEF, continue to track the effects of these massive resources on the health systems in recipient countries.

Follow-up SWEF surveys are planned in the three study countries, allowing for more in-depth consideration of systemwide changes related to the influx of resources from the GF. This will enable comparative analysis, and assessment of the impacts upon utilization for non-focal disease services such as immunizations or family planning, time allocation of health workers, and resource availability. Findings and final reports from these studies will be available in June 2006.

Interim updates on the status of SWEF activities will be posted to the PHR*plus* website at www.phrplus.org/swef.php.

Annex A. Facility Survey Sampling

Benin Facility and Provider Surveys. Three health zones (districts), representative of the different geographical regions of the country (north, central, south) were selected – all of which were intervention areas for GF-supported activities. Cotonou, Benin's main urban center, was also included in the sample. The study zones included: (i) Zone 6: Come/Bopa/Grand-Popo/Houeyogbe; (ii) Zone 17: Dassa-Zoume/Glazoue; (iii) Zone 31: Malanville; and (iv) Cotonou Ville. The sampling frame included all facilities (census) within selected health zones.

After assessing the range of likely effects of the GF in Benin, the research team decided to include only public facilities in its sample, as there are very few private facilities outside of Cotonou, and the majority of GF activities are implemented in the public sector. The health center level was selected as the facility level of focus for the study. Several health providers were interviewed from each study health center.

Ethiopia Facility and Provider Surveys. Given limited resources, a nationally representative sample was not possible in Ethiopia. It was therefore necessary to select representative regions for the study. Four geographical regions were selected for the facility and provider surveys, including Addis Ababa City Administration, Oromiya National Regional State, Amhara National Regional State, and Somali National Regional State. The regions were selected based on population densities (we include both densely populated and remote pastoralist areas), disease prevalence, and presence of GF (and in some cases PEPFAR) activities. (The Study Steering Committee of the CCM/E offered their endorsement on the appropriateness of the sampling approach).

The number of health facilities selected from each region was roughly proportional to the total number of health facilities within that region, by type of facility. Given the size of the country, the selection of facilities within the selected regions was purposeful (convenience sampling). The research team traveled first to the regional health offices to conduct interviews with regional health staff to consult with local informants to ascertain urban/rural breakdowns and other information about the health facilities in the locale. In the first three GF grants, nearly all activities are focused at the primary health care level; all types of primary health care units (health posts, health stations/clinics, and health centers; public, private for-profit, and NGO) were included in the sample. In each facility surveyed, all health providers present at a selected facility at the time of the interview were asked to participate in the provider survey. (The research team did not attempt to interview those who were not present at the time of the survey.) The facility and provider surveys were conducted between December 2004 and January 2005.

Annex B: Bibliography

Banteyergu H, Kidanu A, Bennett S, and Stillman K. Forthcoming 2005. *The Systemwide Effects of the Global Fund in Ethiopia: Baseline Study Report*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

Bennett S and Fairbank A. 2003. *A Conceptual Framework for Analyzing the System-wide Effects of the Global Fund*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

Brinkerhoff, D and Leighton, C. 2002. *Decentralization and Health Sector Reform*. Insights for Implementers series. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

Brown, Adrienne. 2001. *Integrating vertical health programmes into sector wide approaches: Experiences and lessons*. Paper prepared for the Swiss Agency for Development and Cooperation. London: IHSD.

Brugha Ruairí, Donoghue Martine, Starling Mary, Ndubani Phillimon, Ssengooba Freddie, Fernandes Benedita, and Walt Gill. 2004. The Global Fund: managing great expectations. *The Lancet* 364: 95-100

Brugha R, Starling M, Walt G. 2002. GAVI, the first steps: lessons for the Global Fund. *The Lancet* 359 (9304/February): 435-438

Country Coordinating Mechanism (CCM)/Ethiopia. 2003. Structure and Functions of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Country Coordinating Mechanism of Ethiopia. Updated draft, 14 May.

Freedman L, Waldman R, de Pinho H, and Wirth M. 2005. Who's got the power? Transforming health systems for women and children. Task Force on Child Health and Maternal Health. New York: UN Millennium Project.

Gilson L, Doherty J, McIntyre D, Thomas S, Brijlal V, Bowa C et al. 1999. *The dynamics of policy change: health care financing in South Africa 1994-1999.* Monograph No 66, Johannesburg, Centre for Health Policy, University of Witwatersrand/Cape Town, Health Economics Unit, University of Cape Town.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). 2005. *Global Fund Grant Status Report*, as of August 15, 2005. Downloaded from GF website. http://www.theglobalfund.org/en/files/grantsstatusreports/44-GrantsStatusReport-31August2005.xls

GF. 2005. *Progress Report* – January 21, 2005. Geneva.

GF. 2002. *Proposal from the Federal Democratic Republic of Ethiopia (FDRE).* Addis Ababa, Ethiopia. March.

GF. n.d. The Framework Document of the Global Fund to Fight AIDS, TB and Malaria. Geneva. http://www.theglobalfund.org/en/files/publicdoc/Framework_uk.pdf

Government of Malawi. 2004. Human Resources in the Health Sector: Towards a Solution. Ministry of Health.

Government of Malawi. n.d. Integrated National Response to HIV/AIDS and Malaria: Submission to the Global Fund. Malawi Global Fund Coordinating Committee (MGFCC).

Joint Learning Initiative. 2005. *Human Resources for Health: Overcoming the Crisis* Global Equity Initiative, Cambridge, MA: Harvard University.

Mtonya B., Mwapasa V., Kadzindira J, Bennett S. Forthcoming 2005. *The Systemwide Effects of the Global Fund: Malawi Baseline Report*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

Oliveira-Cruz V, Hanson K and Mills A. 2003. Approaches to overcoming constraints to effective health service delivery: a review of the evidence. *Journal for International Development*, Special issue 15(1): 41-66.

Organization for Economic Cooperation and Development (OECD). 2005. Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability. Paris: High Level Forum.

Smith, O, Gbangbade S, Hounsa A, and Miller-Franco L. July 2005. *Benin: Effects of the System-wide Effects of the Global Fund*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

Vestergaard, Lasse S. June 2004. *Review of Anti-Malarial Treatment Choices for the Global Fund Approved Grants Rounds 1-3*. A report of a consultation convened by The Global Fund to Fight AIDS, Tuberculosis and Malaria Geneva, Switzerland, 2 May 2004 Geneva. Centre for Medical Parasitology, Copenhagen University Hospital and University of Copenhagen, Denmark. http://www.theglobalfund.org/pdf/report_malariagrants_rounds1to3.pdf

World Health Organization. 2004. *World Health Report 2004: Changing history*. Geneva:

World Bank. 2004. *World Development Report 2004*. Washington, DC: Oxford University Press.