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# Effects of the Global Fund on Reproductive Health in Ethiopia and Malawi: Baseline Findings

*September 2005*

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*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.*

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# Abstract

This report is part of the Systemwide Effects of the Fund (SWEF) research initiative, which aims to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the activities it supports on reproductive health and family planning programs in Ethiopia and Malawi. The main research objectives are to consider the effects of GF activities on the policy process, human resources, the public/private mix, and pharmaceutical and commodity procurement and management with relation to reproductive health and family planning services. Findings are that reproductive health players have not participated extensively in GF planning processes, and GF activities are not integrated with reproductive health, family planning, or other preventive care services. Health workers have increased responsibilities with GF activities and work in resource-constrained environments. In Ethiopia, health workers are shifting out of the public sector in search of better working conditions at non-governmental organizations (NGOs), bilateral aid agencies, and international organizations, and, in Malawi, there is evidence of resource shifts away from community health programs like reproductive health and family planning in favor of activities related to the three focal diseases of AIDS, tuberculosis, and malaria. While both public and private facilities offer reproductive services, they are available in almost all public health facilities, but in fewer private facilities. The number of private NGOs has grown, while the involvement of the private nonprofit sector remains limited. Systems for commodity procurement and disbursement have improved in Ethiopia, while fewer improvements to the system have occurred in Malawi as GF activities have been implemented. In order to bolster reproductive health and family planning services in future GF activities, reproductive health advocates and providers should make a case for integrating services for these focal diseases with reproductive health and family planning, and become more involved in the planning process for GF activities.

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# Acronyms

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Antiretroviral
<b>BLM</b>	Banja La Mtsogolo, Malawi
<b>CBO</b>	Community-based organization
<b>CCM</b>	Country Coordinating Mechanism
<b>CCM/E</b>	Country Coordinating Mechanism in Ethiopia
<b>CDC</b>	U.S. Centers for Disease Control and Prevention
<b>CHAM</b>	Christian Health Association of Malawi
<b>CHBC</b>	Community home-based care
<b>CMS</b>	Central Medical Stores, Malawi
<b>CRDA</b>	Christian Relief and Development Association, Ethiopia
<b>CSO</b>	Civil society organization
<b>DFID</b>	Department for International Development (UK)
<b>DHS</b>	Demographic and Health Survey
<b>DHTSS</b>	Department of Health Technical and Support Services, Malawi
<b>DOTS</b>	Directly observed treatment short-course
<b>DTP3</b>	Diphtheria, tetanus, and pertussis
<b>EHP</b>	Essential Health Package, Malawi
<b>EHRP</b>	Emergency Human Resource Program, Malawi
<b>EMSAP</b>	Ethiopia Multisectoral AIDS Program
<b>FMOH/E</b>	Federal Ministry of Health/Ethiopia
<b>GF</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HAPCO</b>	HIV/AIDS Prevention and Control Office, Ethiopia
<b>HIV</b>	Human immunodeficiency virus
<b>HSDP II</b>	Health Sector Development Program, Ethiopia
<b>IEC</b>	Information, education, and communication
<b>LFA</b>	Local Fund Agent

<b>M&amp;E</b>	Monitoring and evaluation
<b>MACRO</b>	Malawi AIDS Counseling Resource Organization
<b>MOH</b>	Ministry of Health
<b>NAC</b>	National AIDS Commission, Malawi
<b>NGO</b>	Non-governmental organization
<b>OI</b>	Opportunistic infection
<b>PASS</b>	Pharmaceuticals Administration and Supply Services, Ethiopia
<b>PEPFAR</b>	Presidential Emergency Plan for AIDS Relief
<b>PHR<i>plus</i></b>	Partners for Health Reform <i>plus</i> project
<b>PLWHA</b>	Person living with HIV/AIDS
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>PR</b>	Principal Recipient
<b>STI</b>	Sexually transmitted infection
<b>SWAP</b>	Sector-wide approach program
<b>SWEF</b>	Systemwide Effects of the Fund
<b>TB</b>	Tuberculosis
<b>TRP</b>	Technical Review Panel
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary counseling and testing
<b>WDR</b>	World Development Report
<b>WHO</b>	World Health Organization

# Preface

The Systemwide Effects of the Fund (SWEF) Research Network<sup>1</sup> 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 to Fight AIDS, Tuberculosis and Malaria affect the broader health care systems of recipient countries. The network was launched in 2003, following consultations with the Global Fund 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<sup>2</sup> (PHR*plus*), a USAID-funded project, 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 specific to reproductive health and family planning from the Ethiopia and Malawi studies implemented by PHR*plus*. A separate report has been written on the broader health systemwide effects of the Global Fund, and will be available on [www.phrplus.org](http://www.phrplus.org).

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<sup>1</sup> Further information about SWEF is available at <http://www.phrplus.org/swef.php>

<sup>2</sup> 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.



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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 surveys, and analyze the data whose results are described within. The authors wish to thank Tania Dmytraczenko for her technical review and comments on previous drafts of the report. They also thank Pauline Hovey, Linda Moll and Maria Claudia de Valdenebro for their assistance with the production of this report. We are grateful for the support of the Government of Ethiopia's Ministry of Health and the Government of Malawi's Ministry of Health for supporting this work. Special thanks to USAID for funding this activity, especially Karen Cavanaugh and Joan Robertson of USAID/Washington Bureau of Global Health; Holly Fluty Dempsey and Omer Ahmed of USAID/Ethiopia; and Mexon Nyirongo of USAID/Malawi, all of whom provided invaluable support to the studies.

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



# Executive Summary

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## Background and Objectives

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) was established in 2002 to leverage donor funds in support of interventions to mitigate the impact of these three major causes of morbidity and mortality in developing countries. Providing no broad policy prescriptions, the GF emphasizes government ownership, while requiring measurable results.

As large sums of money are funneled into developing country health systems, amounts that often surpass government health budgets, GF support is likely to have effects not only on the target diseases, but also on non-focal programs. This report is part of a study to assess the effects of GF support on health systems as part of the Systemwide Effects of the Fund (SWEF) Research Network, a collaborative group of research organizations seeking to understand how GF support can affect broader health systems. In particular, this report examines the effects of GF-related activities on reproductive health and family planning in Malawi and Ethiopia. The specific objectives are to determine the effects of GF-related activities on reproductive health and family planning in the following areas:

- ▲ Involvement in the policy dialogue and planning processes
- ▲ Human resource shifts among focal and non-focal interventions
- ▲ Composition and changes in the public/private mix
- ▲ Pharmaceutical and commodity procurement and distribution

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## Methodology

The study relies on in-depth interviews with 44 informants in Malawi and 57 stakeholders in Ethiopia, along with document review and a quantitative facility survey in Ethiopia. A survey of 60 facilities in Ethiopia encompasses questions about service provision and the availability of services and commodities, and a survey of 335 providers in Ethiopia provides information on health worker time allocation to various services and training activities, as well as health worker motivation. This study is a baseline study, and a follow-up study will offer richer analysis. At the time this study was conducted, GF activities were still at their early phases, so many of the findings are early impressions of the potential impact of GF activities.

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## Findings

Overall, the findings suggest that GF support has caused a range of different types of effects on health systems and on reproductive health programming. 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 (particularly for HIV/AIDS). 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.

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## Policy Processes

Reproductive health and family planning advocates and providers were not involved in the Country Coordinating Mechanism decision making or planning of GF activities in Malawi and Ethiopia. Instead, planning and implementation of GF activities has been dominated by disease-specific agencies. Few of the planned GF activities integrate interventions to combat AIDS, tuberculosis, and malaria (herein after referred collectively as “focal diseases”) with other basic health activities, such as family planning, antenatal care, and other reproductive health services.

While both Malawi and Ethiopia have the strategic objective of strengthening their health systems to benefit focal disease services as well as reproductive health services, the direction of funding has taken a relatively vertical approach due to the structure of the funding mechanism. As a result, many informants feel that major health systems challenges to reproductive health and other programs, such as severe human resource constraints, stock-outs of contraceptives, and problems of access, have not been addressed thus far with GF support. Instead, interventions have focused largely on disease-specific interventions, such as training and commodity procurement.

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## Effects on Health Workers

Both Malawi and Ethiopia face severe human resource crises, poor working conditions for staff, and resource-constrained facilities. In Malawi, the majority of districts have fewer than two nurses per health facility, and many districts have no doctor at all, according to a Japan International Cooperation Agency study. Workers both at the central policy level and at the facility level have taken on GF activities in addition to their own responsibilities and many feel more staff is needed. There have been no efforts to hire new permanent staff, and workers are not compensated for their additional responsibilities. There are reports that, in Malawi, GF activities have attracted some health workers trained for preventive services in the community to provide voluntary counseling and testing (VCT) and other services, diminishing the human resources available to provide reproductive health and family planning services.

In Ethiopia, the physician-to-population ratio was 1:34,000 in 2003 (Kombe et al., 2005), and physicians are rarely available in health centers. In areas where there is significant GF work pressure, high-level human resources are in short supply. A large number of qualified staff has been lost to the private sector, where salaries are higher in non-governmental organizations (NGOs), bilateral aid agencies, and international organizations. Many have also left the country to work abroad. In an attempt to attract highly qualified individuals to implement GF activities, the government has hired several consultants at rates that are three times the salary of an equivalent permanent position, tempting some high-level individuals to resign and take up consulting.

According to a provider survey conducted in Ethiopia in 2004, providers reported that they spend the most time on general outpatient services, followed by child health and maternal health services. While only 10 percent of providers stated that they offer HIV/AIDS testing, 29 percent offer maternal health services and 27 percent offer family planning. Similarly, health providers spent the

most time on those services, and did not spend more time on focal diseases than they did on reproductive health and family planning services. It will be important to monitor how health workers spend their time as more GF activities are implemented.

Staff in both countries have been trained in VCT, PMTCT (prevention of mother-to-child transmission), ART (antiretroviral therapy), IEC (information, education and communication), and other GF activities, often receiving an allowance for their participation, a form of providing incentive to employees working in difficult environments. According to the provider survey in Ethiopia, the highest percentage of staff received training in HIV/AIDS counseling and testing and child health over the last year. A comparable portion of staff is also receiving training in family planning and maternal health. Health workers in both countries work in resource-constrained environments and feel they are not compensated for the work they do. GF activities planned thus far have done little to deal with human resource constraints, though some money has been reprogrammed toward this end, and future rounds of GF may address the human resource crisis.

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### Effects on Public/Private Mix

While both Ethiopia and Malawi have seen an increase in the number of NGOs in recent years, the private for-profit sector remains relatively small. Some NGOs have expanded their mission to include GF activities, raising questions about whether resources have shifted away from non-focal services such as reproductive health and family planning. In Ethiopia, NGOs that traditionally focused on family planning now plan to provide VCT and other services, and, in Malawi, some NGOs have already expanded their scope of work in order to take on GF activities. In Ethiopia, the private for-profit sector has had limited involvement in the focal diseases and private for-profit implementation of GF activities in Malawi remains limited. The relationship between the private and public sectors in both countries was already somewhat strained even prior to the GF, with a lack of trust and communication challenges possibly exacerbating relations.

In Ethiopia, all public facilities and the majority of private facilities offered family planning and antenatal care, according to the facility survey. While 100 percent of public facilities offered family planning services, 60 percent of private facilities provided family planning. GF activities include the rehabilitation and construction of public health centers in Ethiopia, efforts that have the potential to improve services for reproductive health and family planning as well. Although the survey revealed that most facilities offered reproductive health and family planning services, relatively few offered HIV/AIDS care and support at the time of the survey. Rapid scale-up of GF activities could cause additional strains on facilities working with old equipment and a lack of basic supplies and drugs. It will be important to monitor how the provision of these services evolves, as GF activities are scaled up.

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### Effects on Drug and Commodity Procurement

According to the facility survey in Ethiopia, the majority of health centers and a significant portion of health posts and private providers experienced stock-outs in oral and injectable contraceptives and condoms at the baseline. Much of the initial GF support went toward the procurement of drugs and commodities in Ethiopia, exposing weaknesses in the procurement and distribution system run by the Pharmaceutical Administration and Supply Service (PASS). PASS recognized its shortcomings, however, and took action to improve its systems, hiring additional procurement officers, purchasing vehicles, renting warehouses, and establishing a computer system. Despite initial delays, drugs and commodities have started arriving at facilities. Although PASS may

emerge from GF activities substantially strengthened, the intense focus on GF activities may be to the detriment of other commodities and pharmaceuticals. It will be important to monitor the procurement and distribution system as further rounds of GF support are disbursed.

In Malawi, the local procurement mechanism for drugs and supplies, Central Medical Stores (CMS), was deemed to have inadequate capacity for GF drugs and supplies. Instead of having CMS operate GF procurement, the GF requested that the Ministry of Health (MOH) identify an alternative agent. The MOH opted for a contract with UNICEF to procure drugs and commodities, with the understanding that capacity building would take place and CMS would eventually take over the process. However, it appears that, due to a misunderstanding, substantial capacity building did not take place. Instead of GF funds going to build the capacity of CMS, a parallel procurement and distribution system was created, causing duplication and inefficiency. Although an opportunity to strengthen CMS was missed, the overall drug management system has benefited to some degree from GF funds for greater safeguarding of drugs and supplies, updates of national drug policies, support to the pharmacy school, and utility trucks for the distribution system.

Any improvements in the availability of supplies at the facility level may improve the working conditions of health workers in reproductive health and family planning as well as the quality of service provided to their patients. Further monitoring of the overall changes to procurement and distribution implemented with GF support will help to determine whether improvements spill over to reproductive health and family planning.

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## Recommendations

While the massive amounts of funding made possible through the GF represent an opportunity to reduce morbidity and mortality from some of the most deadly diseases affecting individuals in Malawi and Ethiopia, it also has the potential to shift resources away from basic and preventive health services, such as reproductive health and family planning. If advocates and providers of reproductive health can make an effective case for the integration of reproductive health and family planning services with focal disease interventions, then planners may be more apt to include such activities in future funding requests. Such an approach may lead to further involvement of reproductive health and family planning programs in the GF activity planning process, and could enhance the integration of these services into GF activities.

# 1. Background and Objectives

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) was established in 2002 to leverage donor funds in support of interventions to mitigate the impact of these three major causes of morbidity and mortality in developing countries. As a mechanism designed to mobilize and channel large volumes of resources toward the three diseases, the GF sought to ameliorate the overwhelming effects of these deadly diseases. Since its first call for proposals in 2002, the GF has approved more than \$3.6 billion in grants to fund health interventions for these diseases, with the latest round of proposals bringing new requests from 95 countries of another \$3.5 billion over a two-year period (GF 2005).

While financial support from the GF is likely to fundamentally impact the morbidity and mortality caused by these three diseases, this surge of financing into resource-constrained health systems is also likely to indirectly affect other facets of health systems. For example, scaling up treatment for HIV/AIDS within a context of health worker shortages could unintentionally result in fewer staff available for routine health interventions, such as family planning or immunization. At the same time, strengthening the drug distribution system for the purposes of scaling up antiretroviral therapy (ART) programs benefit those same routine health programs in need of vaccines or contraceptives.

Development professionals and country experts alike have expressed concerns about vertical approaches of targeting specific diseases, which tend to place less emphasis on issues affecting the broader health system, such as health worker availability, drug distribution systems, and equitable access to health services. While some of the indirect effects of the GF may be positive, interventions may only be sustainable if they are well integrated into the overall health system, and simultaneously they will only be successful if introduced into a health system that is functional.

To understand the effects of the GF on health systems, the Partners for Health Reform<sup>plus</sup> project (PHR<sup>plus</sup>) is leading a research initiative to implement country case studies. This collaborative research network comprised of research organizations from the South and the North, called the Systemwide Effects of the Fund (SWEF) Research Network, is conducting a series of country studies to assess changes in the health system as a result of the influx of GF resources. PHR<sup>plus</sup> has been implementing studies in Benin, Ethiopia, and Malawi. While these studies focus on the health system overall, the studies in Ethiopia and Malawi also included specific modules to look at the effects of GF support to recipient countries on reproductive health- and family planning-related issues. This report is focused largely on the findings specific to reproductive health, while additional reports are available to describe the broader baseline findings in each country. While HIV/AIDS, one of the three diseases targeted, may be considered a part of reproductive health, this report will focus on the effects of the GF on routine reproductive health issues, such as family planning, sexually transmitted disease prevention, and maternal health.

In particular, the objective of this component of the SWEF study is to identify the effects of GF-supported activities on reproductive health- and family planning-related issues within the four thematic areas of the overall SWEF research:

- ▲ **Effects on policy processes:** The GF planning process is designed to enhance the range of actors involved in informing policy and implementing disease-control activities. This thematic area concerns the impact of GF processes and activities on policy actors and GF alignment with existing structures and priorities.
- ▲ **Effects on human resources:** Many GF proposals rely on training and capacity-building activities, and address issues of retention and motivation. This thematic area relates to capacity building, the shifting of human resources among focal and non-focal diseases, and the distribution of health staff.
- ▲ **Effects on public/private mix:** The GF encourages developing innovative approaches to service delivery and expanding coverage, and drawing private sector actors into the health system. This thematic area addresses the distribution and organization of different types of providers (public, private for-profit, private nonprofit), and the relationship among these types of providers.
- ▲ **Effects on pharmaceuticals and commodities:** A substantial amount of GF support is targeted toward bolstering procurement and distribution systems. This thematic area considers the drug and commodity procurement and distribution systems, and the availability of commodities and pharmaceuticals at health facilities.

As a baseline study, this report provides important preliminary information on these thematic areas. Once the follow-up study has been conducted as part of the SWEF research program, a much richer assessment of the impacts of scaling up services for the focal diseases will be available.

Following this introduction, Section 2 presents the methodology used to gather information for this study, Section 3 discusses characteristics of the health systems in Malawi and Ethiopia, and Section 4 outlines the status of GF activities in order to provide the context for the following discussion. Section 5 reviews the findings of the study within each thematic area and the final section contains concluding observations and some preliminary recommendations.

## 2. Research Methods

The Malawi and Ethiopia country studies followed a common research protocol developed for all of the SWEF studies, which was adapted to fit the policy context and information needs of each country. The common research protocol calls for baseline and follow-up quantitative surveys of health facilities and staff when possible, complemented by a series of in-depth interviews with stakeholders at national and subnational levels, as well as literature review. The reproductive health-specific components of the study were incorporated into the broader SWEF research instruments. Time constraints prevented the implementation of a facility survey in Malawi, and thus the Malawi findings are based chiefly on qualitative findings. The Ethiopia findings are based on both qualitative and quantitative data.

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### 2.1 Qualitative 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 subgroups of key informants. Qualitative data collection included interviews with government officials at national and subnational levels, experts/heads of health programs, non-governmental organizations (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.

In obtaining the informed consent of the respondents, all informants were told that any information they provided would be confidential and used only for the purposes of the study, and that participation in the study was entirely voluntary. Respondents were advised that statements would not be attributed to specific individuals in the reports, but rather identified by broader stakeholder groupings (such as government, donor, or NGO respondent).

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 that follows. 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.

In Malawi, discussions with *PHRplus*, the Ministry of Health (MOH), and the U.S. Agency for International Development (USAID) helped to identify stakeholders, of which 44 from various sections of the MOH, the Ministry of Finance, the Office of the President and Cabinet, National AIDS Commission, the Malaria Control Program, the Tuberculosis (TB) Control Program, and the (mainly nonprofit) private sector were interviewed. Interviews were conducted between May and June 2005.

In Ethiopia, four regions were selected for the study: Addis Ababa City Administration, Oromiya National Regional State, Amhara National Regional State, and Somali National Regional State. Somali was selected because it contains pastoral communities and has a high malaria presence, and is meant to represent remote regions and pastoralist communities. The other three regions were selected because they are large, densely populated areas with large urban settlements, which have a high prevalence of HIV/AIDS, TB and malaria, and have voluntary counseling and training (VCT) and prevention of mother to child transmission (PMTCT) activities. In all, 57 stakeholders were interviewed in Ethiopia between November 2004 and February 2005, with some key informants interviewed twice for updated information. Table 1 shows a list of the respondents by category for both Malawi and Ethiopia.

**Table 1. Respondents by Category**

Category of respondents	No. interviewees Malawi	No. interviewees Ethiopia
Central government officials	16	12
Regional government officials		22
Health staff	5	12
Donor community	10	4
Private sector	10	7
Other (professional councils, local fund agent)	3	
Total	44	57

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## 2.2 Facility and Provider Survey Data

In 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 (DHS) 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 pretest results.

The facility survey included issues related to resources; staff; management; patient referrals; laboratory services; distribution of staff time; health services availability, use, and case mix including inpatient care, outpatient consultations, sexually transmitted infections (STIs) and HIV/AIDS services (such as VCT services and other HIV/AIDS services), and priority services such as immunizations and family planning. The provider survey included questions on provider training, position and experience, supervision, motivation and job satisfaction, provider incomes, and provider suggestions. Data were entered into the Statistical Package for Social Science for analysis.

The number of health facilities selected from each region is approximately proportional to the total number of health facilities within that region, by type of facility. Convenience sampling was employed to select facilities within regions, based on minimized travel time, while representing both urban and rural areas. A total of 60 facilities were surveyed. Table 2 shows a breakdown of the number of surveyed health facilities in each region.

**Table 2. Rural and Urban Breakdown of Sample Facilities, Ethiopia**

Facility type	Location	Addis Ababa	Oromiya	Amhara	Somali	Total
Health center	Rural	0	5	4	1	10
	Urban	3	2	1	1	7
Health post, health station, or clinic	Rural	2	11	10	1	24
	Urban	1	3	2	1	7
Private	Rural	1	1	1	1	4
	Urban	3	2	2	1	8
Total		10	24	20	6	60

Participant selection for the provider survey was based on being present at the time of the facility survey. A total of 335 respondents completed the provider survey, of which 33.5 percent were from Oromiya, 33.7 from Amhara, 24 percent from Addis Ababa, and 6.6 percent from Somali. Of the providers interviewed, 58.8 percent worked in health centers and 41.2 percent worked in health posts and clinics. As much as 71 percent of providers worked in government facilities, 17.9 percent in private for-profit, and 11 percent in NGOs. Of the respondents, 51.3 percent were male and 48.7 percent were female; 94 percent had permanent positions and 6 percent worked on a temporary basis.

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## 2.3 Limitations

Researchers collecting data for the Ethiopia and Malawi studies focused on the broad, systemwide effects of the GF, exposing important information on how GF-supported activities have affected reproductive health and family planning services in particular. This report piggybacks on those studies, paying particular attention to reproductive health and family planning issues within the context of broader GF activity impact. While researchers analyzed all of the information collected for those studies, this report is not an exhaustive presentation of all stakeholder views on changes in reproductive health and family planning services, but rather reflects the principle issues raised by interviewees.

In both Ethiopia and Malawi, the implementation of GF-supported activities has been slower than anticipated and, accordingly, the effects on health systems are just beginning to emerge. The type of issues observed to date thus reflects the relative infancy of GF implementation at the country level. Such delays in implementation have 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 in this report. While this baseline report is crucial to identifying and anticipating some of the effects of GF-supported activities, the follow-up study will serve to bolster early findings and reveal longer-term impacts that may have been masked during the early phases of implementation.



## 3. Health System Context in Ethiopia and Malawi

### 3.1 Health Status and Systems

Malawi and Ethiopia are two of the poorest countries in the world, ranking 83 and 92, respectively, on the United Nations Development Program (UNDP) Human Poverty Index scale. Ethiopia has the second largest population in sub-Saharan Africa, at 71 million inhabitants, with 85 percent living in rural areas (Federal Ministry of Health, Ethiopia 2004). A quarter of the population of Ethiopia lives on less than a dollar per day, while over 40 percent of Malawi's 11 million people live on less than a dollar a day (World Bank 2004). While Malawi is prone to droughts and floods (World Health Organization 2004a), Ethiopia has suffered from civil wars, repeated droughts, and famines (Banteyerga et. al. 2005).

Given these social, economic, and geographic challenges, it comes as no surprise that health indicators for Malawi and Ethiopia remain extremely poor. The average life expectancy in Malawi is 38 years, while for Ethiopia it is only 42 (World Bank 2004). In part, low life expectancy in Malawi can be attributed to the HIV/AIDS pandemic, with a prevalence rate among adults of 14.4 percent (Malawi National AIDS Commission, 2004). In Ethiopia, HIV/AIDS has also taken its toll, affecting 1.5 million individuals (UNAIDS 2004), with a prevalence rate in urban areas close to 13 percent (FMOH/E 2004). TB and malaria are also major causes of morbidity and mortality in both countries. While HIV/AIDS and infectious diseases have hit hard,<sup>3</sup> some basic indicators have improved over the last several years. For example, childhood immunization has improved, with DTP3 coverage in Ethiopia up to 66 percent in 2004, up from 42 percent in 2000, and in Malawi, at 89 percent in 2004, up from 75 percent in 2000 (WHO/UNICEF 2005). Table 3 shows some development indicators for both countries.

Key reproductive health indicators in Malawi and Ethiopia demonstrate there is much room for improvement. Table 3 shows that contraceptive prevalence in both Malawi and Ethiopia is low, at 33 and 23 percent, respectively. While the United Nations Children's Fund (UNICEF) calculates that a skilled attendant was present at delivery for 61 percent of births between 1995 and 2003 in Malawi, the same was true for only 6 percent of births in Ethiopia.

In both Malawi and Ethiopia, access to health systems remains a challenge. In Malawi, only 54 percent of the rural population is estimated to have access to formal health services within a 5 kilometer radius (Mtonya et al., 2005), while in Ethiopia, only 60 percent of the population is estimated to live within walking distance to a health facility (WHO 2005a).

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<sup>3</sup> For a more in-depth discussion of the impact of HIV/AIDS, malaria, and tuberculosis, refer to the country studies.

**Table 3. Key Development Indicators**

Indicator	Malawi	Source	Ethiopia	Source
Total population	11.0	WDR, 2005	71.1	FMOH/E, 2004
Infant mortality rate per 1,000 live births	112	WB, 2003	112	WB, 2003
Life expectancy at birth	38	WDR, 2005	42	WDR, 2005
DTP3 coverage	89	WHO-UNICEF, 2004	66	WHO-UNICEF, 2004
Maternal mortality rate per 1,000 live births	1,800	WHO, 2001	871	FMOH/E, 2004
Total fertility rate	6.0	DHS, 2004	5.9	FMOH/E, 2004
Contraceptive prevalence	33.0	DHS, 2004	23.0	FMOH/E, 2004
Skilled attendant at delivery (%)	61	UNICEF, 1995-2003	6	UNICEF, 1995-2003

Sources: World Development Report, 2005; Federal Ministry of Health, Ethiopia, 2004; Malawi Data Profile, 2003, World Bank; Ethiopia Data Profile, 2003, World Bank; Demographic and Health Survey, Ethiopia, 2004; WHO-UNICEF Joint Reporting Form, Country Estimates, 2004; UNICEF, At a Glance: Malawi, 2003; UNICEF, At a Glance: Ethiopia, 2003.

Total expenditures on health were \$13.50 per capita in Malawi in 2002, and \$3.30 per capita in Ethiopia in 2001 (WHO 2005b, WHO 2005c). Issues of access to health services among the poor are raised when considering the heavy out-of-pocket contributions to health services. Of the total private sector expenditures on health (which include NGO disbursements), out-of-pocket payments constitute 85 percent of expenditures in Ethiopia and 42 percent of expenditures in Malawi (WHO 2005b, WHO 2005c).<sup>4</sup> Both countries are heavily reliant on donor resources to fund the health system; in Malawi, 30 percent of funding came from donors in a 2001 analysis of 1998–1999 data, compared to 25 percent of expenditures from government coffers (Ministry of Health and Population, Malawi 2001).

The main players in the health system in Malawi apart from the government include the Christian Health Association of Malawi (CHAM), nonprofit providers, the Malawi AIDS Counseling Resource Organization (MACRO), and the private, for-profit sector. The health infrastructure includes clinics, health centers, and community, district, and central hospitals, which are linked by a referral system. The MOH accounts for about two-thirds of all facilities, CHAM operates 26 percent, a nonprofit NGO focusing on family planning known as Banja La Mtsogolo (BLM) operates about 5 percent, and the Ministry of Local Government another 5 percent. The remaining facilities are operated by the private sector (Mtonya et al., 2005).

The health system in Ethiopia is decentralized, and although the MOH issues policies and guidelines, the regional health bureaus hold responsibility for service delivery. In addition to government facilities, NGOs and private for-profit entities also deliver health services (Banteyerga, et al., 2005). According to MOH data, there were 126 hospitals, 519 health centers, 4,696 health stations and health posts, and 1,299 private clinics in 2004. Nearly 200 NGOs provided about 10 percent of health services in Ethiopia in 2000 as part of the umbrella organization known as the Christian Relief and Development Association (CRDA), and the private sector has grown in recent years (WHO 2002). Of the pharmacies, drug shops, and rural drug vendors located in Ethiopia, 95 percent were privately owned in 2000 (WHO 2002).

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<sup>4</sup> Private sector expenditures include health-related expenditures by insurers, household out of pockets, NGO and nonprofit disbursements, and employer and other private entity expenditures. Since the insurance sector and employer expenditures are extremely small in both countries (insurance programs make up less than 2 percent of private expenditures in both countries), nonprofit disbursements appear to make up the bulk of private expenditures in Malawi.

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## 3.2 Health Strategy and Administration

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### 3.2.1 Malawi

In Malawi, the primary government planning document for the health sector is the Fourth National Health Plan (1999–2004), which focuses on the priority areas of 1) reproductive health (including HIV/AIDS); 2) child health; 3) health promotion, prevention, and rehabilitation (including malaria and TB); 4) diagnostic and treatment services; and 5) environmental health services. Major strategies to confront these areas include the strengthening of primary health care, development of a sector-wide approach, decentralization of health care management, cost recovery, and strengthening of policy formation, information systems, and human resources.

Following on the national health plan, several other broad programs work toward improving the health sector in Malawi. The Malawi Poverty Reduction Strategy was launched in 2002, within which the centerpiece is the Essential Health Package (EHP). The EHP addresses the major causes of morbidity and mortality among the general population and focuses on medical conditions and service gaps that disproportionately affect the poor. Strategies include developing human resources, increasing availability of drugs, rehabilitating infrastructure, and strengthening management. In addition, the sectorwide approach program (SWAP) outlines a program of work for 2004–2010, including a strategy to increase the availability of health staff, improvement of procurement of medical supplies and pharmaceuticals, and further infrastructure and systems strengthening activities.

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### 3.2.2 Ethiopia

In Ethiopia, the main health strategy document is the Health Sector Development Program (HSDP II), emphasizing access, equity, and quality, with a focus on promotion and prevention as well as curative services. The plan strives to provide a primary health center for every 25,000 people, a district hospital for every 250,000, a zonal hospital per 1 million, and specialized referral hospitals. Health facilities and human resources remain limited, however, and the system has not yet been fully implemented.

Ethiopia, unlike Malawi, is a federal state with extensive responsibilities devolved to regional governments, and increasingly lower level *woreda* (or district) authorities. Ethiopia is comprised of nine regional states and two city administrations. While the federal MOH issues policies, guidelines, standards, major training efforts, and other initiatives, the implementation of health policy is decentralized. Regional health bureaus lead service delivery and management, which will be further devolved to the *woreda* level as part of the implementation of HSDP II (Banteyerga et al., 2005).

In addition to government activities, the HSDP II includes the recognition of NGOs and private for-profit organizations as partners in service delivery; capacity building as a major objective; integration of other national policies and programs, such as the Sustainable Development and Poverty Reduction Program, into health sector plans; and integration of the principles of the Civil Service Reform Program regarding administrative processes. Ethiopia is also implementing an increasing number of activities led by global public/private partnerships, particularly in the area of drugs and vaccines.

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## 3.3 Reproductive Health Context

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### 3.3.1 Malawi

The state of reproductive health in Malawi is meager. A woman born in Malawi faces a lifetime risk of maternal death of one in seven, ranking only behind Afghanistan and Angola in maternal mortality risk per birth.<sup>5</sup> DHS data show that 33 percent of teenagers have begun childbearing, and that the average age at first sex for women is 17 years of age (DHS 2000a). Given the high fertility rate combined with a high maternal mortality rate, women in Malawi are at increased risk for maternal death over their lifetimes.

Although the percentage of married Malawian women using any method of family planning has increased substantially from 1992, only one-quarter of married women used some modern method of family planning in 2000 (up from only 7 percent in 1992) (DHS 2000a). Moreover, while the number of women who reported having an unmet need for family planning decreased in 2000 from the amount reported in 1992, as much as 30 percent of women said they were not able to get the resources they needed (DHS 2000a).

These statistics highlight the great need for reproductive health and family planning services to be available and accessible to men and women in Malawi. According to a reproductive health official in Malawi, the main barriers to improving reproductive health in Malawi are 1) the long distance to facilities, 2) critical shortage of staff, 3) lack of essential utilities such as electricity, water, and communications, and 4) financial resources.

The MOH remains a major provider of reproductive health and family planning services, with 700 facilities offering family planning, safe motherhood, and other reproductive services, while the private NGO BLM has about 29 sites offering family planning, VCT, and information, education and communication (IEC), as well as other basic services such as immunization.

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### 3.3.2 Ethiopia

Ethiopia had the fourth highest number of estimated maternal deaths in the world in 2000, with 24,000 women estimated to have lost their lives during childbirth. The lifetime risk of maternal death is one in 33 (WHO 2004b). The average age at first sexual relation is 16 years, and 16 percent of teenagers have begun childbearing (DHS 2000b). Only 5 percent of all live births were estimated to have been delivered at a health facility in 2000. Women delivering children face extreme risks, and are exposed to these risks from a young age.

Many women facing the risk of maternal mortality have an unmet need for family planning. Among married women, 35 percent report not having access to the counseling or supplies that they need to prevent unwanted births (DHS 2000b). Only 6 percent of married women currently use any modern method of family planning. A summary of these statistics for Ethiopia and Malawi may be found in Table 4.

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<sup>5</sup> The lifetime risk of maternal death takes into account both the probability of becoming pregnant and the probability of dying as a result of that pregnancy, cumulated across a woman's reproductive years (WHO 2004).

**Table 4. Key Reproductive Health Indicators**

<b>Indicator</b>	<b>Malawi</b>	<b>Ethiopia</b>	<b>Source</b>
Lifetime risk of maternal death: 1 in	7	33	WHO, 2004
Number of maternal deaths	9,300	24,000	WHO, 2004
Percentage of teenagers who have begun childbearing	33.0	16.3	DHS, 2000
Percentage of married women currently using any modern method of family planning	26.1	6.3	DHS, 2000
Percentage of married women with an unmet need for family planning	29.7	35.2	DHS, 2000
Percentage of live births delivered at health facility	55.3	5.0	DHS, 2000
Median age at first birth for women age 25–29 years	19.2	18.5	DHS, 2000
Median age at first sex for women age 25–29	16.8	16.0	DHS, 2000

Sources: WHO 2004, "Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, and UNFPA"; Demographic and Health Survey, Ethiopia, 2000; Demographic and Health Survey, Malawi, 2000.

Given the pre-existing challenges to reproductive health and family planning in both Malawi and Ethiopia, GF support has the potential to both benefit and worsen the current situation, depending on whether activities address or aggravate these challenges.



## 4. The Global Fund in Ethiopia and Malawi

The GF was designed to attract and disburse resources to mitigate the impact of the three focal diseases: HIV/AIDS, TB, and malaria. The GF was not created, however, to be an implementing agency, but rather a financial mechanism, and the programs it supports are meant to reflect national ownership rather than any particular global approach to the diseases. In the guidelines for GF funding, particular emphasis is placed on the use of public/private partnerships, the achievement of clear, measurable results, and efficient processes for programming and utilizing resources. Given the largely country-driven nature of GF programming, for the most part, the effects of GF support will be defined by the way in which countries have interpreted GF rules and regulations, and how they have programmed activities to meet these requirements as well as their own goals. Some important terms related to GF-related entities, referred to throughout the following sections, are included in Box 1.

### Box 1. Global Fund Related Terms

**Country Coordinating Mechanism (CCM).** Countries are required to have a country-level partnership that develops and submits grant proposals to the GF, monitors their implementation, and coordinates with other donors and domestic programs. The CCM is intended to involve government agencies, NGOs, private sector institutions, individuals living with the focal diseases, and bilateral and multilateral agencies.

**Technical Review Panel (TRP):** An independent panel of disease-specific and crosscutting health and development experts that provides a rigorous review of the technical merit of applications. The TRP may recommend to the board that proposals be funded without condition, approved conditionally, resubmitted, or not approved.

**Principal Recipient (PR):** A local entity nominated by the CCM and confirmed by the GF to be legally responsible for grant proceeds and implementation in a recipient country. Disbursements are made to the PR based on the achievement of measurable results. There may be more than one public and/or private PR in a country.

**Local Fund Agent (LFA):** Independent organizations contracted by the Secretariat to assess a PR's capacity to administer funds and provide ongoing oversight and verification of grantee-reported data on financial and programmatic progress. Through a global competitive tender process, 10 organizations are qualified to provide LFA services, often international, private accounting firms or public agencies.

Source: Global Fund, <http://www.theglobalfund.org/en/faq/>

### 4.1 Malawi

The GF approved \$196 million in funding over five years for a first round HIV/AIDS grant submitted by the Malawi Coordinating Committee in February 2002. The first disbursement of \$314,000 arrived in Malawi in June 2003 to support preparatory program activities, and \$7.6 million was received in January 2004 to support scaling up of activities in VCT, PMTCT, community home-based care (CHBC), and treatment and management of opportunistic infections (OIs) and antiretroviral (ARV) drugs. In addition, the grant included a component for health systems strengthening and management and institutional support. Malawi won a second grant in round 2 for work on malaria prevention, for a total of \$39 million, though this grant has not yet been signed. By mid-2005, Malawi had received \$36 million in support of HIV/AIDS scale-up efforts.

It is important to note that Malawi's original proposal included a substantial component of health systems strengthening, reflecting a national priority of developing the health system as a precondition to effective disease-specific interventions. Such systems strengthening might have benefited reproductive health and family planning in Malawi along with other health programs. Malawi was required to scale back its first grant agreement, however, with the majority of health systems strengthening elements removed. Some informants perceived that the GF assumed that a functioning health system with adequate human resource capacity and infrastructure was already in place. While policy officials remained committed to implementing systems strengthening activities, they found themselves without the necessary resources to implement them. As a result, GF support was focused on specific HIV/AIDS interventions during initial implementation of GF activities.

In addition, in round 5, the GF expanded its call for proposals to encompass health system interventions for all countries. According to the MOH in Malawi, GF support for systems strengthening activities was a welcome development, as it will not only assist in the implementation of GF activities but also the delivery of health services for other non-focal diseases. Malawi's round 5 GF proposal includes activities to further strengthen the human resource capacity of the public health sector. As this example illustrates, GF funds targeted toward specific activities have the potential to focus attention on those particular activities above others, while important priorities of the MOH may be overlooked if they are left without GF financial support.

Progress toward implementing the GF grant includes the following achievements:

- ▲ Development of a free ARV program, to be scaled up to cover 59 health facilities by December 2004, including MOH and CHAM hospitals, Malawi Defense Force and Police Hospitals, and private sector health facilities meeting eligibility laid out by the MOH. Although in May 2005 there were only 34 activities providing ARVs, a press release from June 2005 held that the target of 59 facilities had been reached.
- ▲ An increase in the number of patients receiving ARVs to 17,000 by March 2005 and to 23,000 by the end of June 2005. The objective is to reach 55,000 by December 2005.
- ▲ Development and printing of various guidelines and manuals to facilitate scaling up of VCT, PMTCT, CHBC, and OI management
- ▲ Training of more than 300 health workers in OI management and provision of ART
- ▲ Development of IEC materials for targeted activities for print, television, and radio
- ▲ Development of CHBC model for Malawi piloted in Salima, Thyolo, and Mzimba districts, with subsequent roll-out planned
- ▲ Awarding of grants worth \$10 million to institutions including MOH; Ministry of Gender; Child Welfare and Community Services; College of Medicine; NGOs; Medical Council of Malawi; Nurses and Midwives Council of Malawi; Pharmacy, Medicines and Poisons Board; and community-based organizations (CBOs) for HIV/AIDS-related interventions.

The PR for the HIV/AIDS grant is the Registered Trustees of the National AIDS Commission Trust of the Republic of Malawi. A GF malaria grant agreement was signed in late September 2005, but funds had not yet been disbursed at the time this report was written. The PR for the malaria grant is the MOH of the Republic of Malawi. The LFA for both grants is PricewaterhouseCoopers.

Malawi also receives substantial funding from a number of other global health initiatives currently being implemented. In particular, the World Bank's Multi-Sectoral Project is a \$35 million project with the objective of reducing HIV transmission and mitigating the impact of HIV/AIDS. 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 (CDC), African Development Bank, Department for International Development, UK (DFID), Canadian International Development Agency, and Norwegian Agency for Development Cooperation. Note: Malawi is *not* a recipient country of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

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## 4.2 Ethiopia

The GF has approved \$645 million over five years for two HIV/AIDS grants (submitted in rounds 2 and 4), one TB grant (submitted in round 1), and one malaria grant (submitted in round 2). Activities for the first HIV/AIDS grant include training, social mobilization, drug and commodity procurement, and development of VCT infrastructure. By the end of 2004, \$20 million had been disbursed, which went mostly toward training and procurement. Training targets were partially achieved for VCT, HIV and STI management, CHBC, PMTCT services, IEC, and monitoring and evaluation (M&E); and drugs for opportunistic infections, ARV drugs, and vehicles and equipment were in the process of being distributed. For the round 4 HIV/AIDS grant, most of the funds were allocated to the purchase of ARV drugs, with some funds slotted for institutional strengthening and human resource development. The scale of GF grants combined is substantial, and will likely have spin-off effects on broader areas of the health system.

Of the \$11 million disbursed for the TB grant, funds have gone toward the following activities: strengthening program management; providing supervision and M&E; procuring drugs, vehicles, and computers; training health workers and community directly observed treatment short course (DOTS) providers; and establishing a structure for collaborative TB/HIV activities. In addition, under this grant, health facility DOTS coverage increased from 30 percent in 2002 to 75 percent in 2005, with 165,000 people receiving DOTs by March 2005 (Banteyerga et al., 2005). Not only were more people receiving DOTS, but the number of new cases diagnosed and treated also increased, and health workers received training in TB/HIV collaborative activities. Future plans include strengthening TB prevention and control; promoting HIV counseling and testing among TB patients; strengthening political and community support through advocacy, communication, and social mobilization; and increasing operational research in TB and TB/HIV.

Finally, \$38 million has been disbursed to the malaria program in support of malaria control and prevention, human resource development, information systems development, education and communication, operational research, and the development of M&E capacity. Under this grant, training activities have started, although the procurement of drugs and commodities has been slow.

The National HIV/AIDS Prevention and Control Office is the PR of the HIV/AIDS grants, while the Department of Disease Control within the MOH is the PR for the TB and malaria grants. The LFA for all grants is KPMG based in Nairobi.

In addition to receiving funds from the GF, Ethiopia is among the 15 recipients of PEPFAR, which has allocated more than \$100 million for HIV/AIDS prevention and medical treatment including ARV and care and support to Ethiopia. Rather than channeling funds directly through government ministries, PEPFAR is implemented by a group of U.S. government agencies, including the Department of State, the Department of Defense, CDC, and USAID. PEPFAR's objectives

include averting new infections and treating thousands of new patients with ARV. The World Bank Multisectoral AIDS Project (MAP) program is also present in Ethiopia, through a program called Ethiopia Multisectoral AIDS Program (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.

## 5. Findings: Effects of the Global Fund on Reproductive Health and Family Planning

The mobilization of resources through the GF has the potential to impact reproductive health and family planning service provision both positively and negatively. On one hand, scaling up services for the three focal diseases has resulted in increased training, strengthening of health infrastructure, and the procurement of needed drugs and supplies. Such improvements can have positive spillovers to other health areas, including reproductive health and family planning services, to the extent that these services are also offered in strengthened facilities or by health workers who have received relevant training. Improvements made to drug procurement and distribution systems could also benefit reproductive health services if contraceptives and other supplies for maternal health and family planning become more readily available and stock-outs become a less frequent occurrence.

On the other hand, as reproductive health and other basic services are facing severe human resource crises in both Ethiopia and Malawi and capacity in drug procurement and distribution is limited, the demands of scaling up services could divert the attention of health workers away from the provision of broader reproductive health and family planning services in favor of meeting the goals and objectives of scaling up services for focal diseases. As more resources become available for these services, NGOs could shift their focus away from general reproductive health and family planning services in favor of ART, the provision of insecticide-treated bednets (ITNs), or other services for these focal diseases. In addition, if higher salaries are offered for the provision of GF-supported services, health workers may be attracted to providing such services, shifting their availability away from the public sector or from some reproductive health services.

Not only is the GF likely to affect service delivery, but the massive funding provided through the GF also raises concerns about the equity, quality, and sustainability of the health system. In particular, if services are targeted to scaling up services for the three focal diseases, then national resource allocation may shift as well, leaving areas in which other services are needed with comparably scant resources. In addition, given that the funds provided through GF to support activities related to focal diseases are enormous, yet time-limited, questions about the sustainability of scaling up health services are inevitable. Without careful planning and consideration, many opportunities to improve the broader health system, including improvements to reproductive health and family planning services, may be missed.

The following sections present the main findings of this baseline study, including the effects of GF-supported activities on policy and processes, human resources, the public/private mix related to reproductive health and family planning, and pharmaceuticals and commodities.

It is important to note that GF activities are continuously evolving, and that only a relatively short period of time has elapsed since the first funds began to flow into Malawi and Ethiopia in mid-2003. The data collected for this analysis, however, reveal areas for potential benefits and concern resulting from the influx of funds for spending on HIV/AIDS, malaria, and TB affected by the GF.

Findings from the baseline studies are presented below within each of the key thematic areas of the studies.

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## 5.1 Effects on the Policy Process

This section considers the effects of GF-related activities on the policy processes in Ethiopia and Malawi, with particular attention paid to the implications for reproductive health. In particular, the studies assess the GF planning process and the extent to which reproductive health planners were involved, the degree to which reproductive health and family planning services may have been integrated with the focal diseases, and questions of whether stakeholders are concerned about issues of access and sustainability.

The findings suggest that reproductive health planners and providers were not extensively involved in planning for GF activities, and that the influx of GF resources has drawn attention to services for specific diseases rather than to broader health system improvements and integrated care. Stakeholders are also concerned about the sustainability of GF-supported activities.

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### 5.1.1 Participation in GF-related Planning Processes

GF support has the stated intention of increasing coordination and collaboration among various stakeholders in the implementation of activities. This implies the potential for involving providers and advocates of reproductive health services across sectors. It appears, however, that reproductive health advocates have played a relatively minor role in the CCM and activity planning thus far. In both countries, reproductive health officials had little power in planning GF-supported activities as they were largely left out of the GF planning process.

In Ethiopia, the CCM was established to facilitate and coordinate the management of GF-supported activities. According to a document approved by the body, it is mandated with strengthening national involvement and commitment to scaling up interventions, improving coordination across government ministries, public and private entities, and civil society. Among the members of the CCM in Ethiopia (CCM/E) are government entities, bilateral agencies, civil society, and the private sector (Box 2). While several high-level MOH officials hold seats on the CCM/E, reproductive health and family planning are not represented among the government divisions. The government leadership on the CCM/E is made up of the Minister of Health, the head of planning, the head of the Disease Control Division, and the head of the HIV/AIDS Prevention and Control Office (HAPCO), none of whom represent the broader needs of reproductive health and family planning.

CRDA, an NGO providing many reproductive health and family planning services, is a member. While a number of other non-governmental groups are represented on the CCM/E, many of them suggested that government stakeholders dominate the CCM/E. Several respondents suggested that the CCM/E is not an active leader and coordinator of GF-supported activities, but rather the MOH plays such a role. Given the current structure and climate of the CCM/E, coordination across entities may be hampered and it may be difficult for reproductive health advocates, whether within or outside the government, to be heard.

## Box 2. Composition of the CCM in Malawi and Ethiopia

Malawi	Ethiopia
Composition of the MGFCC is as follows (as of June 2005):	- Minister of Health – Chair of Committee (govt.)
Principal Secretary for Health (Chairman)	- Head of Planning, MOH (govt.)
NAC Board Chairman	- Head of Disease Control Division, MOH (govt.)
NAC Director	- Head of HAPCO (govt.)
One member from each of the following:	- Christian Relief and Development Agency (NGO)
State/Faith Taskforce	- Representative of People Living with HIV/AIDS organization (civil society)
Ministry of Finance	- Chamber of Commerce (private for-profit sector)
Salima AIDS Support Organization – representing CBOs and civil society organizations (CSOs)	- The Ethiopian Health and Nutrition Research Institute (govt.)
John Hopkins Research Group (for technical advice on HIV/AIDS)	- UNAIDS (U.N.)
College of Medicine – Malaria Research (TA on malaria)	- WHO (country representative, U.N.)
College of Medicine (representing academic institutions)	- WHO (policy advisor, U.N.)
HIV/HIV Activists/PLWHAs	- UNICEF
Embassy of Norway – representing foreign missions/donors	- USAID
Chief – representing traditional leadership	- The Netherlands Embassy
Project HOPE – representing international NGOs	- Ethiopian Public Health Association (civil association)
UNAIDS	- Ethiopian Interfaith Forum for Development
CHAM	
TB Program	
National Youth Council	

In Malawi, the CCM evolved from a technical working group that had been previously established as a subcommittee of the National Technical Working Group on HIV/AIDS. Members include government entities as well as representatives from bilateral programs, NGOs, and civil society. While numerous members sit on the CCM, none of them represents reproductive health or family planning *specifically*, but instead specializes in the three focal diseases (or health services in general). In fact, several respondents expressed concern about the bias toward HIV/AIDS over malaria and TB, suggesting non-focal programs may not receive sufficient emphasis in the CCM, and noting that they may not be well represented. Most of the key informants involved with the CCM or aware of its operations, however, viewed it as being fairly representative, with discussions rated as democratic and open. (It is important to note that respondents may have been reflecting on the representativeness of membership as per the focal disease needs, not necessarily about broad health concerns including reproductive health and family planning).

With the Department of Disease Prevention and Control and HAPCO as the principal recipients in Ethiopia, disease-specific areas of the MOH have dominated the implementation of GF-supported activities, so that coordination with other areas of the MOH may be challenging. For example, one reproductive health official said that the Department of Family Health was left out of the planning process, forgoing the ability to influence the direction of GF activities:

The Department of Family Health wanted to be included in the GF program because we have a shortage of funds. Moreover, HIV/AIDS is part of reproductive health... There should have been emphasis on 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... The majority of the Ethiopian population is in the reproductive health age. We need to strengthen family planning. Knowledge of reproductive health and family planning means knowledge of reproductive health and this would have a positive effect on HIV/AIDS prevention.

In part because reproductive health officials were not included in the planning process in Ethiopia, GF-supported activities relating to AIDS, TB, and malaria have not been integrated with reproductive health and family planning services. Moreover, respondents reported little coordination with regional level officials, and communication between the center and regions was insufficient, according to several respondents. This was particularly problematic in Ethiopia, where the health sector is quite decentralized. With activity planning taking place at the central government level under a tight deadline, little information was shared with the regions and with many relevant stakeholders. The workplans developed for GF-supported programs often did not match the priorities already identified at the regional levels. Furthermore, not only were reproductive health advocates in various levels of government and NGOs not able to express their needs, but they were not very well informed of GF activities. One reproductive health official stated that the Planning Department planned activities “in a closed office,” “without consulting us and other departments.”

In Ethiopia, some view the GF as both a missed opportunity and a future hope for improving reproductive health and family planning. In the development of Ethiopia’s GF proposals, the Department of Family Health was not given consideration as a recipient because it already had an external source of funding. According to one informant, however, a shortage of condoms and commodities could have been eliminated with support from GF. As PMTCT and HIV/AIDS are also reproductive health issues, GF support for these necessities would have been within the scope of GF objectives. Despite having missed the opportunity to equip reproductive health centers with supplies, the GF still offers the future potential of supporting reproductive health and family planning programs. In particular, planned activities targeting youth with information and education regarding HIV/AIDS could result in increased demand for reproductive health and family planning services and information.

In Malawi, the principal recipient of GF funds is the NAC, suggestive of the vertical attention to HIV/AIDS issues in Malawi. The NAC was chosen by the CCM, without competitive bidding, because it was considered to be the only organization with sufficient financial and administrative capacity to manage the grant. The only reproductive health services included in the GF grant, according to a reproductive health official, were activities for safe motherhood. As one official stated, “there is too much focus on ARV and PMCT, while issues of prevention are not addressed.” Though not indicated by this respondent, reproductive health and family planning issues beyond prevention were also overlooked.

While the GF presents the potential to improve coordination among stakeholders, it does not appear that reproductive health advocates and providers have been able to participate extensively in the formulation of plans for utilizing GF resources. In both countries, GF funds disbursed for HIV/AIDS went mostly to training and ART scale-up, drug procurement, and PMTCT. According to informants, there has been little emphasis placed on STI prevention thus far, and in the implementation of GF activities, other reproductive health issues such as family planning, antenatal

services, and maternal health, were largely passed over. In both Malawi and Ethiopia, reproductive health and family planning activities continue to be funded largely by other donors.

As activities supporting the GF focal diseases are scaled up significantly while reproductive activities remain relatively stable, the comparative importance of reproductive health and family planning in terms of total resource allocation may be somewhat diminished. This type of concern has been documented previously, noting the risk that increased funding (for HIV/AIDS particularly) and policy shifts can detract focus from reproductive health and family planning programs (USAID 2003; Shears, 2004). Furthermore, such priority shifts can result in competition for already scarce national resources, such as health workers who are already in short supply.

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### 5.1.2 Vertical Approaches versus Integration

The GF has injected unprecedented amounts of funding into government coffers for the provision of services for the three focal diseases. As grants are primarily managed by principal recipients that are focused on specific diseases, the potential for a vertical approach to service delivery could easily overshadow efforts to strengthen overall health systems through a more horizontal or integrated approach. In Ethiopia, the \$645 million HAPCO and the Department of Disease Prevention and Control are programmed to receive over five years is the equivalent of almost three times what Ethiopia spent on health in 2001. With such substantial sums of money flowing into disease-specific agencies, these government entities, often made up of individuals who approach diseases in a relatively vertical way, are given a new degree of power and influence over the direction of health services in their countries.

In Ethiopia, many officials stated that strategic planning was developed in advance of GF, that GF merely provided an opportunity to fund activities that were already planned, and that a major shift in priorities was not undertaken. Several respondents in Ethiopia expressed concern that the mode of planning and implementation of GF was contributing to a more vertical approach than the country had envisioned as part of its strategic plan. One international aid respondent stated:

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.

Various reproductive health respondents in Ethiopia called for a more integrated approach to reproductive health and family planning than has been taken by GF activities. One official called for HIV/AIDS to be integrated with reproductive health and family planning interventions, taking advantage of the opportunity to deliver contraceptives and sensitization activities in reproductive health when targeting HIV/AIDS patients:

HIV/AIDS needs a lot of social mobilization and sensitization... The cultural practices expose people to HIV/AIDS. The funds should be channeled to teaching the community. The culture of the people is oral-dominated, and IEC/BCC [behavior change communication] activities need to be developed in line with the culture of the people. Moreover, HIV/AIDS has to be integrated with reproductive health... The impact of GF up to now is minimal and difficult to tell...

An NGO respondent in Ethiopia stated that if GF is to achieve the Millennium Development goals, a more integrated response is needed for reproductive health:

Problems related to family planning, poverty, and unwanted pregnancy should be given due attention. The GF does not focus on prevention activities. At present, GF is giving support for HIV, malaria, and TB separately, but in my view, it would have been better if it supported integrated health delivery service.

While it is too early to suggest that GF funds in Ethiopia have diverted attention toward a more vertical approach to disease control and eradication, it is clear that several respondents have concerns that GF support could lead to such an approach, while the systems supporting these GF activities receive less attention. For many of these individuals, the concern is that health interventions for the three focal diseases will neither be effective nor sustainable if commodities are not properly managed, health workers are not available, or interventions are not designed appropriately for the community.

Similarly, in Malawi, there exists concern that GF-supported activities may not take a broader health systems approach, but instead focus on specific diseases. Reproductive health experts indicated that they have creative ideas about how to confront the focal diseases in a way that also strengthens health systems; which is in their view, an approach that would be more sustainable in the long run. One reproductive health respondent said that the GF should not focus on HIV/AIDS alone, but also on issues of family planning, safe motherhood, and breast and cervical cancer. Another said HIV/AIDS should be integrated with family planning services, testing pregnant women for HIV/AIDS, and then giving them referrals for PMTCT. Reproductive health officials and advocates are concerned that focal diseases be integrated with reproductive health and family planning, and they suggest that they have seen attention diverted from these areas under GF activities. As one government official stated,

GF does affect reproductive health and PMCT, as HIV counseling diverts attention.

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### 5.1.3 Systems Weaknesses and Sustainability

In addition to the concerns of numerous respondents about a perceived vertical approach of GF funding, several individuals expressed that other weaknesses in health systems persist at the service delivery level. With the various new players involved and activities taking place in HIV/AIDS, respondents in both Malawi and Ethiopia underlined the need for quality control and better monitoring and evaluation systems. Furthermore, problems of equity and access continue to challenge both countries, as the percentage of individuals without access to health facilities remains high, and GF funding has not addressed these issues specifically. In particular, GF activities do not address many of the major barriers to reproductive health, such as distance to care, staff and supply shortages, and lack of financial resources.

Issues of sustainability are frequently raised by the huge injection of GF funds. The future of these resources is unclear, and the capacity of governments to absorb such large sums of money remains to be seen. One respondent in Malawi pointed out that the GF has forced the government to improve its financing system, while another held that the absorptive capacity of the public health system is limited. In both countries, individuals expressed concern that there is no guarantee that funds will be extended into subsequent grant periods, questioning the sustainability of activities

supported by GF. If future funding is withdrawn, government budgets may be left to cover the cost of new activities introduced under the GF. Given the enormity of GF support in comparison to overall government health budgets, government sources are not only likely to fall short from covering these activities alone, but are even less likely to cover GF activities in combination with other routine health interventions. Without future GF support, GF activities and other government health programs would likely suffer to some degree, and some programs might be entirely eroded. How well these countries will absorb funds and to what extent they are used effectively and efficiently may be seen in the follow-up study.

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## 5.2 Effects on Human Resources

In both Malawi and Ethiopia, serious crises of human resources have existed within the health sector even prior to the GF. Severe staffing and commodity shortages and a poor work environment have resulted in staff turnover, shifts of human resource capacity away from the public sector and away from reproductive health and family planning, and even emigration of highly capable staff. Staffing and human resource problems are so severe that they hamper the implementation of GF activities and threaten reproductive health as well as other facets of the health system. Many anticipate that as GF activities are scaled up, there will be further shortages of counselors, physicians, nurses, and lab technicians.

Malawi faces chronic human resource shortages and the inequitable geographic allocation of workers in the public health sector. Between 1999 and 2004, staff shortages worsened, particularly among nurses, with 64 percent vacancy rates, and specialist doctors, with vacancy rates ranging from 71 to 100 percent (Mtonya et al., 2005). In 2002, a joint MOH and Japan International Cooperation Agency facility survey revealed that 15 of the 26 districts had fewer than 1.5 nurses per health facility, while five districts had fewer than one nurse per facility (MOH, Malawi 2002). In addition, 10 districts had no MOH doctor, while four districts had no doctor at all.

According to a government study, the major causes of the human resource crisis in Malawi are the resignation of skilled workers from the public sector due to poor salaries and poor working conditions, inadequate output from training institutions to meet the staff requirements of the health care sector, and high death rates among health workers (up to 2.0 percent per year) (Harries 2002, Government of Malawi and U.N. Development Program/Lilongwe 2002). As mentioned earlier, a national human resources strategy was developed, the Emergency Human Resource Program (EHRP), and has been partially funded, to address the human resource crisis.

In Ethiopia, staff shortages and attrition hinder the provision of reproductive health, family planning, and other services. In 2003, the physician population ratio was 1:34,000 (Kombe et al., 2005), and a significant number of qualified staff has shifted from the public sector to the private sector, NGOs, and bilateral and multilateral organizations. According to the facility survey, most health posts and centers have no physician or health officer, and there is often only one nurse at the post. Most health centers have only two nurses, and a physician is rarely available. Private facilities (including for-profit facilities and NGOs) have the highest number of physicians on average. In Somali, there are 40 posts without a provider, and most facilities lack equipment. Donors, private organizations, and NGOs attribute the human resource problem in part to poor management, a lack of incentives, and poor working conditions.

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### 5.2.1 Human Resource Capacity Constraints

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. Despite this, many respondents in both Ethiopia and Malawi were already voicing 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.

Malawi presents a unique example 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 DfID permanent secretary and director for Africa visited Malawi and noted that the human resource crisis in the public health sector would severely hamper the success of GF-supported activities among other HIV/AIDS related programs.

Following this visit, the GF authorized the reprogramming of \$40 million of the five-year approved budget to fund Malawi's EHRP; this amount has now been added to the EHRP "resource envelope." The EHRP was a national strategic plan developed in 2004 for the purpose of securing donor funding for improvements in human resources retention, attracting health workers to the public system, and other approaches. This EHRP demonstrated proactive strategic planning on the part of the Malawian government to address the human resource crisis affecting the country. Support to the EHRP (from the GF as well as DFID) has enabled a 50-percent increase in health worker salaries — this applies to all health workers, not only those involved in GF-related activities. These GF resources will support the overall delivery of health services, including reproductive health.

In Ethiopia, the round 4 proposal contains a substantial component for health provider mobilization. While this GF support has the potential to attract large numbers of workers due to the financial incentive it provides, questions of sustainability and the effect on reproductive health and family planning remain. If GF funding is withdrawn and government budgets are not able to cover the new positions created by GF activities, any progress made in ameliorating the human resources crisis may be undone.

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### 5.2.2 Health Worker Resource Shifts

In both Ethiopia and Malawi, officials have chosen not to hire permanent staff for GF-funded activities, but instead have implemented GF-supported programs by either increasing the responsibilities of current staff or hiring short-term consultants. As a result, there has been an increase in the demands on existing employees and some evidence of minor shifts in resources among and within sectors.

In Malawi, workers at the central policy level and at the facility level perceive a need for more manpower, but there are no plans to hire extra clinicians or planners. As one MOH official stated,

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.

At the service delivery level, ART clinics are overwhelmed with patients. According to one health worker in Malawi,

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.

Some respondents in each country, particularly at the central level, stated that GF-related activities and responsibilities had distracted them from their routine activities. Specifically, some respondents in Malawi have raised concerns about the effects of scaling up HIV/AIDS activities on non-focal diseases. For example, the MOH recently instituted a policy that permits 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. This could divert attention away from regular community outreach activities, which likely include safe motherhood messages. 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.

An MOH official in Malawi also said that GF activities have affected services such as reproductive health and family planning by diverting attention and human resources. These human resource shifts may potentially weaken community-based and other activities in reproductive health and family planning. Some respondents also anticipate that the NGOs currently scaling up their HIV/AIDS services will be in need of trained health workers, thus attracting them from the public sector. While there has been no massive shift of health workers out of the public sector following GF implementation in Malawi, some staffing shifts have been observed, 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

In the past (and even prior to the GF), Ethiopia lost a significant number of highly qualified staff to the private sector, NGOs, and bilateral and multilateral organizations, and highly skilled individuals have left the country to work abroad. At the planning level, according to an MOH official,

The workload of GF created a problem on other activities...in departments like procurement office, finance and liaison office, the staff is sharing a big burden.

In particular, respondents in Ethiopia pointed to shortages of (or excessive burden on) high-level staff in areas in which there is significant GF work pressure: planning, M&E, data and information processing systems, procurement, and financial management and auditing. In both Ethiopia and Malawi, the most serious human resource constraints thus far have been seen at the central levels, where high-level decision makers have been inundated with added responsibilities and tasks related to planning for the GF. That the constraints to date have been largely at the central level is related to the fact that GF-supported activities are at a relatively early stage of implementation, and thus the majority of GF-related tasks, including proposal development, workplan development, and planning,

were borne by higher level decision makers as opposed to health workers themselves. This trend may shift as activities are rolled out and services are scaled up, placing additional tasks in the hands of health workers themselves.

In order to deal with these human resource constraints, the MOH in Ethiopia has hired consultants on a short-term basis, with salaries that are sometimes triple those of civil serviced employees. As a result of the salary disparity, some permanent employees are reluctant to cooperate with consultants, and high-level employees are tempted to resign from their permanent positions in order to be hired at a better salary. The MOH believes they have “no other option apart from hiring staff on a short-term basis,” because salary increases for regular staff in focal departments would create “huge discontent on staff working in other departments.”

Overloaded staff in Ethiopia have not been financially compensated for their additional work for fear of creating disparities and ill will among public sector employees. According to several respondents, the work burden results in burnout and drives many to leave the public sector in search of better conditions at NGOs and bilateral or multilateral organizations. The Department of Family Health has lost several experts due to low salary, its staff work with little incentive, and high turnover plagues the department:

The department has lost many experts because of the poor salary we pay them. We have projects and some senior staff are paying sacrifices to run the projects. We have been refused to top up the salaries of staff doing extra work because of the nature of the projects.

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### 5.2.3 Training Opportunities

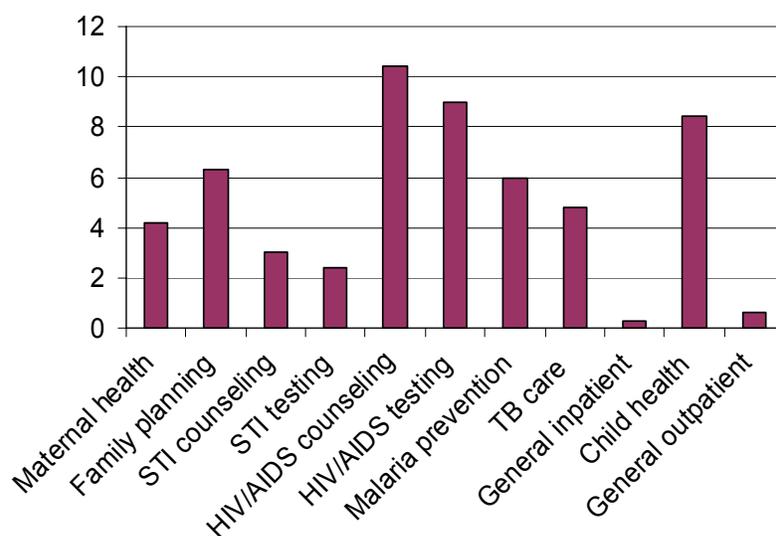
In the two countries, the majority of health workers will not be provided with significant new incentives along with the increased workload and/or responsibilities they face to implement GF-supported activities. Because of already low pay, coupled with the reality that additional responsibilities of implementing GF-related activities do not necessarily correspond to increases in grade or salary, one of the most significant *financial* motivations for health workers to remain in their original posts in the study countries comes from additional benefits from training allowances. Under GF-supported programs in Malawi and Ethiopia, health workers have been trained in VCT, PMTCT, ART, IEC, and other GF activities, often receiving a small stipend for their participation.

Not only is training a part of GF activities, but it can also serve as a broader motivational incentive to health workers. In Malawi, one respondent said that they make sure every staff member may benefit from training activities, and in Ethiopia, both technical staff and support staff are provided with training.

The baseline provider survey in Ethiopia reveals that staff have received training in a number of areas over the past year, with the most training hours spent in HIV/AIDS counseling, HIV/AIDS testing, and child health. Figure 1 shows the percentage of staff training in the various types of

activities, as reported by the providers interviewed.<sup>6</sup> While there appears to be a focus on HIV/AIDS, malaria, and, to some extent, TB, providers also report receiving training in family planning and maternal health.

**Figure 1. Percentage of Staff Receiving Training in Past Year**



#### 5.2.4 Worker Motivation

Overall, worker motivation is low in both countries, as salaries are dismal, working conditions are poor, and facilities lack basic supplies. In Ethiopia, the public sector cannot attract and retain the best workers in such an environment, and in Malawi, a recent salary increase<sup>7</sup> still leaves salaries at extremely low levels. As one respondent in Malawi stated,

The 52 percent increase in staff salaries is unlikely to help retain staff in the public health sector because the base salaries were so small that staff needed a 300 percent increase. To compound this problem, the 52 percent increase has been heavily taxed. It is also unclear what will happen to the salary increase after six years (the expiry of current funding source). In addition, the working conditions in the hospital are pathetic. There is no basic equipment such that even gloves are always in short supply.

<sup>6</sup> Note that for Figures 1–3, all information was collected through a provider questionnaire and is self-reported. The information presented demonstrated how providers perceive their time is spent. The data in the figures have not been fully triangulated with other national data sources to validate accuracy or comparability with other existing data. Where possible, the authors have noted the limitations of these data. In addition, it is important to recall that this is baseline data, which will be enriched subsequent to follow-up surveys that will allow for comparative analysis.

<sup>7</sup> As noted earlier in the report, the GF, along with DFID, has provided support to Malawi’s EHRP. This has enabled a 50-percent increase in all health worker salaries (not only those involved in implementing GF-supported activities). The original plan for the EHRP indicated the need for the salary increase to be 100 percent above existing levels, but given limited donor support, the actual increase was 50 percent, with the result that salaries are still very low.

The work environment for health workers in hospitals in Malawi includes chronic shortages of basic medical supplies and drugs. In such an environment, workers find it difficult to conduct their tasks, and their own safety may be at risk. As one respondent said,

Workplace safety is a real issue. There are no latex gloves or other protective equipment available for nurses. MOH has to be informed that incentives are not just monetary but also workplace environment.

Similarly, in the Department of Family Health in Ethiopia, poor conditions contribute to poor and inefficient service, according to one respondent:

Our staff bring us resources, but we make them work more with no incentive. This is affecting our staff and there is high turnover. Most of the staff we have now are not willing to stay even a minute to do additional work after the office hour. The problem is that our leaders think in terms of poverty not in terms of motivation... This problem makes our service inefficient and poor.

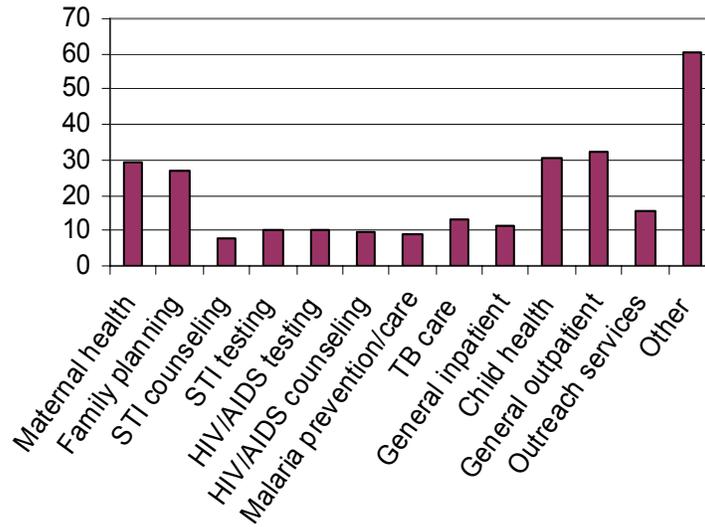
Although health workers deal in very resource-constrained environments and feel they are not financially compensated for the work they do, the majority enjoy and feel pride in the services they provide to the community. Of the 335 Ethiopian respondents to the provider survey, 71 percent believe they are not paid according to the service they render to the community, and 68 percent believe that the pay is not enough to meet their family needs. Over 60 percent complain that the lack of medical supplies and equipment prevents them from rendering quality service to the community. Positive findings of the survey are that 75 percent agree that the facilities where they work have a good reputation in the community, 59 percent say they were proud to obtain a position in the facility, and 71 percent express pride in the services they render to the community.

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### 5.2.5 Health Worker Time Allocation

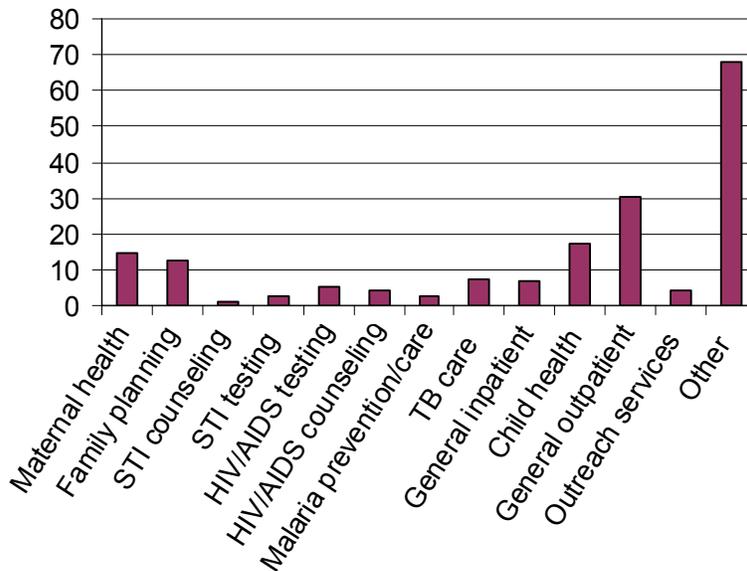
Based on the baseline provider survey conducted in Ethiopia, providers reported that they spend most of their time on general outpatient services, followed by child health and maternal health services (Figure 2). While only 10 percent of the 335 providers surveyed offer HIV/AIDS testing and counseling and malaria prevention and care, 29 percent offer maternal health and 27 percent offer family planning. It is interesting to note that despite very low levels of coverage, among the providers surveyed for this study, more providers report that they offer reproductive health services than they do HIV/AIDS services. This finding may be the result of previous donor-supported vertical funding for reproductive health and family planning. With the scaling up of HIV/AIDS and other GF activities planned, there may be a shift in focus in the follow-up survey, as more providers offer HIV/AIDS, TB, and malaria support and care.

**Figure 2. Percentage of Staff Offering Type of Service**



Overall, the 335 health workers in Ethiopia spent the majority of their time on general outpatient care, followed by child health and maternal health, similar to same-service provision trends (Figure 3). Although the majority of provider time is reported to be spent on other, unspecified activities, it is worth noting that neither HIV/AIDS testing and counseling nor TB and malaria care appear to take up much more provider time than maternal health and family planning. GF activities have the potential to alter this scenario, and the follow-up survey should reflect such changes if they occur.

**Figure 3. Average Hours Spent on Type of Service per Month**



It is important to note that since the data collected in Figures 1–3 is self-reported from providers, it is possible that in Figures 2 and 3, some focal disease services, such as malaria treatment, are captured under the “general outpatient,” “general inpatient,” “child health,” or “other” categories. This is also possibly the case for the treatment of opportunistic infections, or other HIV-related services, when the status of the client is unknown (and thus the service is not necessarily considered to be HIV/AIDS related). If this has occurred, the balance of focal disease-related services versus non-focal disease services might be slightly different than appears in the data.

Aside from the funds reprogrammed in Malawi to support the EHRP, GF activities planned thus far in the two countries have done little to deal with human resource constraints, other than offering health worker training in the focal diseases. While reproductive health and family planning services are widespread and workers allocate a substantial portion of their time to provide them, working conditions are poor in both countries and issues of staff motivation are significant. As subsequent GF activities are implemented, it will be important to monitor how health workers allocate their time and whether they may shift attention away from reproductive health and family planning services.

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### 5.3 Public/Private Mix

The GF places particular emphasis on the participation of a wide variety of actors in the implementation of GF activities, and one of the GF’s underlying principles is that it will “*focus on the creation, development and expansion of government/private/NGO partnerships.*” The private sector, including both for-profit/commercial and not-for-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.

Though a number of new nonprofit organizations (NGOs) appear to have stepped in to participate in the implementation of GF activities, the participation of the for-profit sector remains quite weak. In both countries, GF-supported activities appear to be quite government dominated, and private sector respondents feel they have little voice in GF-related decision making or planning.

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#### 5.3.1 Public-Private Mix and Reproductive Health and Family Planning Services

In Ethiopia, all public facilities offer family planning and antenatal care, and the majority of private facilities offer those services. Most health centers, clinics, and private facilities also offer STI and delivery services. Of the facilities surveyed, 100 percent of health centers and clinics and 60 percent of private facilities offer family planning. Similarly, 100 percent of health centers, 96 percent of clinics, and 80 percent of private facilities offer antenatal care. In comparison, 85 percent of health centers offer VCT, compared to only 4 percent of clinics and 53 percent of private facilities. PMTCT is offered at 57 percent of health centers, 45 percent of clinics, and 40 percent of private facilities. Table 5 shows a selected list of the range of services available at each type of facility at the baseline.

**Table 5. Selected Services Available in Study Facilities**

Percentage of facilities offering service	Health center	Clinic/ post	Private	All
Curative inpatient	57.1	0	40.0	30.0
VCT	85.7	4.2	53.3	45.4
PMTCT	57.1	45.8	40.0	48.3
ART	38.1	45.8	46.6	43.3
Family planning	100.0	100.0	60.0	90.0
Antenatal	100.0	95.8	80.0	93.3
Delivery	90.5	79.2	66.7	80.0
STI	100.0	75.0	39.3	88.3
Number of facilities:	21	24	15	60

While most health facilities surveyed in Ethiopia offer reproductive health and family planning services, relatively few offered HIV/AIDS care and support at the time of the baseline. If some of the surveyed facilities benefit from GF support for improving the health infrastructure to facilitate provision of services for the three focal diseases, such improvements may also have positive spin-off effects for reproductive health and family planning services. For example, in Ethiopia, GF scale-up plans include augmented government services for HIV/AIDS through the rehabilitation and construction of health centers, health posts, and hospitals that may be used for HIV as well as other services. As one respondent stated,

If a laboratory service is to be established [with GF funds], it is not only clients who come for an HIV test that can access the services, but it can be used for delivering other services.

In Malawi, health facilities have been renovated and plans include improving the procurement and laboratory systems, both of which may also benefit activities in reproductive health and family planning in the public sector.

On the other hand, it is also possible that as HIV/AIDS, VCT, and PMTCT services are scaled up, resources could shift away from reproductive health and family planning services. Rapid scale-up could place considerable pressure on facilities working with old equipment, poor facilities, a lack of basic supplies, and drug stock-outs, a concern mentioned by several respondents. According to one hospital respondent in Ethiopia,

We have poor facilities, old medical equipment, shortage of medical supplies, overcrowded wards, even patients sleeping in the corridors, overworked staff...We are going to start ART and that would make our work very complex. The potential clients for ART are high.

It will be important to monitor the availability of family planning, prenatal care, and other reproductive health services in both public and private facilities in the follow-on study.

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### 5.3.2 Relationship between Public and Private Sectors

While the involvement of private sector actors in the provision of health services has increased slightly (particularly for nonprofit organizations) as described in more detail below, the relationship between the public and private sectors remains somewhat tenuous. In Malawi, for example, the government remains somewhat reluctant to use the private sector. Many respondents reported a lack of trust between the two entities. One explanation for government reluctance to employ the private sector more extensively, as suggested by an MOH official, was concern for its own image as a major provider:

The option of referring patients to other private facilities or CHAM 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 hospital.

In addition to this concern, several respondents in Malawi pointed out that infrastructure is limited and the private sector is not always able to access the necessary resources for its work. In addition, private sector organizations may lack sufficient staff, as many well-educated private sector workers are emigrating in search of better opportunities. In addition, there is fear that private practitioners may not be sufficiently trained to provide services such as ART, and it is difficult to ascertain the quality of services provided by this sector.

In Ethiopia, respondents in the private sector and donors suggested that the relationship between the public and private sectors also lacks trust. One NGO respondent stated, “There is tension between government and NGOs,” and another said, “Government’s negative attitude might be the main obstacle for lack of involving the private sector because they are blamed for squandering funds.” Indeed, some government respondents have raised questions about NGOs and private providers, suggesting they were unreliable or focused only on money. In addition, there appears to be a lack of communication between the sectors. As one government respondent stated:

At the initial stage we were asked to make all providers aware of the GF. However, the plan did not include all these stakeholders as promised. This has created a conflict with NGOs in particular. The MOH is promising to include all stakeholders in the planning process for the next GF round.

It appears that GF may have exposed or even exacerbated an existing tension between the public and private sectors in both Ethiopia and Malawi, with respondents on both sides raising concerns about the optimal public/private mix. To the extent that relations between the sectors may have become more strained, the ability of stakeholders to work collaboratively across sectors is challenged, which may affect non-focal services as well as services for focal diseases.

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### 5.3.3 Growth in Nonprofit Private Sector

GF support has spurred a burgeoning of both new and existing NGOs to serve HIV/AIDS patients, but new GF activities may be shifting the focus away from family planning and reproductive health among these organizations. In Malawi, almost all respondents perceived a growth in new CBOs and NGOs since the start of GF funding. They have focused activities on behavior change interventions, care and support, and impact mitigation. According to the informants, some NGOs that

were already in existence have changed their mission objectives or expanded their scope of work in order to take on new activities (particularly for HIV/AIDS activities). This shift in scope, however, raised questions of quality control for some respondents, and there is a concern that attention may be shifted from family planning and reproductive health as the local organizations expand (or shift focus) to take on these new roles.

Similarly, in Ethiopia, NGOs that may have traditionally focused on family planning now plan to expand to provide VCT and other services. As one respondent stated,

The GF grant will have an impact on the quality, range, and volume of service offered by NGOs... The objective of [the] Global Fund is to scale up services. Some donors forced NGOs to work with the same staff and office space. But Global Fund allows NGOs to increase manpower to provide better service.

As the private nonprofit sector grows to offer more services in Ethiopia, it will be important to monitor how any shift in focus affects reproductive health and family planning services.

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#### 5.3.4 Involvement of For-Profit Private Sector Actors

In Malawi, most respondents indicated that private for-profit partners have been left out of decision-making processes. GF activities include plans for some qualified medical practitioners to provide ARVs at a highly subsidized price and to extend this service to some private medical aid schemes. In addition, some private employers will launch ARV programs for their employees and their families. Private, for-profit implementation of GF activities remains limited, however, and may not have had a clear effect on reproductive health and family planning services.

In Ethiopia, the private, for-profit sector has historically had limited involvement in HIV/AIDS, TB, and malaria. The public sector manages TB programs and virtually all malaria activities, and only a few private clinics have begun to offer VCT services. Informants in the private, for-profit sector did not anticipate being largely affected by GF support for drugs and services for the focal diseases; however, according to one private provider,

Private providers have no idea about how to access information about the GF. There is a very big information gap. NGOs have much better access to the GF, but the for-profit sector is not invited in.

To the extent that changes have not yet occurred in the private for-profit sector, changes to reproductive health and family planning services provided in the private for-profit sector resulting from GF-supported activities might be minimal.

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### 5.4 Effects on Contraceptive Availability

Approximately 50 percent of GF 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.

Although it is likely too early to determine whether GF support to pharmaceutical and commodity procurement and distribution may not have had a clear, direct or indirect effect on the availability of contraceptives and other supplies for reproductive health and family planning services, it has substantially affected the overall pharmaceutical commodity procurement and distribution systems in both countries, albeit in different ways. Table 6 provides an overview of drug and commodity procurement and distribution responsibilities for GF grants in the study countries.

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

	<b>Malawi ARVs</b>	<b>Malawi Other drugs</b>	<b>Ethiopia All drugs</b>
<b>Procurement</b>	UNICEF	UNICEF	Pharmaceutical Administration & Supply Services (PASS)
<b>Distribution</b>	UNICEF	Central Medical Stores (CMS)	PASS

Although existing national procurement and distribution capacities were limited in both countries, in Ethiopia, the local government procurement entity PASS was selected to manage all pharmaceuticals and commodities efforts for the GF grant. As a result, any improvements to PASS may ultimately improve availability of contraceptives and other supplies; on the other hand, focus on GF commodities may have diverted attention away from other important commodities in the early phases of implementation. Meanwhile, in Malawi, the local procurement entity was bypassed, creating a dual commodity procurement system which will likely result in duplication of efforts. This bypassing of the national system presents many missed opportunities to address existing limitations within the local procurement and distribution capacity, and raises serious concerns about sustainability.

#### 5.4.1 Utilizing Existing Systems in Ethiopia

At the facility level, shortages of contraceptives can aggravate health outcomes. According to the facility survey conducted in Ethiopia, the majority of health centers and a significant portion of health posts and private providers in Ethiopia had experienced shortages in oral and injectable contraceptives in the six months prior to the survey. As one respondent pointed out, these shortages, particularly of Depo-Provera, a popular method of contraception, can result in unwanted pregnancies, and expose women to the risk of maternal death. Many public facilities and a large portion of private facilities also faced condom stock-outs, limiting protection from both pregnancy and sexually transmitted diseases. Table 7 outlines these shortages. In addition, protocols or guidelines for reproductive health were available in less than 35 percent of the facilities.

**Table 7. Drug Stock-outs at Study Facilities**

<b>Item</b>	<b>Percentage of facilities with stock-outs during past six months</b>			<b>Percentage of facilities currently without drugs</b>		
	<b>Health center (N=21)</b>	<b>Clinic/ Health post (N=24)</b>	<b>Private (N=15)</b>	<b>Health center (N=21)</b>	<b>Clinic/ Health post (N=24)</b>	<b>Private (N=15)</b>
Oral pill with estrogen	52.2	35.1	10.0	13.0	16.2	10.0
Injectable (3 monthly)	69.6	40.5	10.0	21.7	21.6	10.0
Condom (male)	21.7	21.6	40.0	8.7	16.2	20.0

In Ethiopia, 85 percent of GF monies were requested for the purchase of drugs and commodities, and the round 4 HIV/AIDS grant has a large allocation to ARVs.

Ethiopia provides an interesting example of how local capacities can be built with GF resources. PASS (a branch of the MOH) took on responsibility for all procurement under the GF grant. While PASS was expected to accomplish all procurement within six months of the first year, limited human resources and lengthy bidding processes prevented the timely procurement of drugs and commodities, and procurement processes dragged on two years after the first grant agreement was signed. Respondents at all levels of the health system complained about the significant procurement delays encountered during the early period of GF implementation. PASS appeared to be understaffed and frankly overwhelmed by the quantity and complexity of GF procurements.

As PASS became overburdened with the procurement of so many GF commodities, weaknesses were revealed. PASS has handled nearly all procurement for the GF, including drugs, supplies, vehicles, and computers; however, it lacked knowledge to make specifications of the items purchased, and had difficulty finding reliable partners in procurement. As one PASS official stated,

The problem regarding HIV medical equipment arose because GF wrote the lists of items that we should buy. We also lacked knowledge to make specification of the items to be purchased. Besides, after the bid process, checking equipments was our responsibility. We had to hire experts from EHNRI [Ethiopian Health and Nutrition Research Institute] to help us with the specification of HIV medical equipments, and all these took time.

While the use of a local procurement mechanism for GF pharmaceuticals and commodities exposed weaknesses in the system, stakeholders are now working to strengthen PASS' procurement and distribution systems.

Recognizing its limitations, PASS noted it has developed a new system to make procurement faster and more effective. During the study period, the changes that PASS made to its mode of operation included renting more warehouses, hiring more staff on short-term contracts, purchasing additional vehicles, and establishing a computer system. In addition, PASS is now outsourcing and giving bids to companies and bilateral and multilateral organizations to procure drugs and commodities, though GF regulations have prevented PASS from purchasing drugs locally. Despite initial delays, drugs and commodities have started arriving at facilities. These changes appear to be having very positive effects upon the efficiency of procurement, and have the potential for positive offshoot effects on other procurement and distribution needs within the country, such as the need for contraceptives.

PASS officials suggest that the procurement and distribution system will be further strengthened under round 4 of GF, where the proposal is more focused than earlier ones, which were completed "in a hurry." Funding is requested for strengthening the distribution network, and the government has also considered sustainability issues. For example, under round 4 of GF support, new staff will be hired at government rates, rather than at inflated salaries.

Although it appears that the procurement and distribution system has the potential to emerge from GF funding substantially strengthened, GF-supported activities have taken up much of staff time at PASS, possibly to the detriment of other services. In the first phases of GF activity implementation, there was significant pressure on the agency to focus on GF, because future funding depends on the efficient and effective use of previous rounds of funding. The head of PASS estimates that he spent 80 percent of his time on procurement during the initial phases of implementation of GF activities,

mostly due to GF grants. In addition, the delivery of supplies to regions was almost exclusively for GF-related activities initially, raising concerns about whether contraceptives and other critical drugs and supplies were made available to regions during that time:

Up till now PASS has been making GF-specific deliveries to the regions. However, this is because they have been delivering in bulk, and each delivery easily fills a truck. If there were smaller deliveries, then GF and non-GF supplies would be mixed.

The GF challenged PASS to be more responsive and look for innovative procedures to speed up procurement. Decision making has improved and the procurement process is reportedly better; however, the initial focus on GF may have squeezed out the procurement and distribution of other important commodities and pharmaceuticals to regions and health facilities. It will be important to monitor the short- and long-term effects of the intense focus on GF-supported commodities. There is the potential that, in the long run, improvements in the procurement and distribution system will spill over to other areas of service provision, and that the availability of contraceptives and other commodities will be improved.

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#### **5.4.2 Bypassing National Systems in Malawi**

In Malawi it is clear that the decision to bypass the existing national systems was meant to be a “quick fix” solution. The establishment of such parallel, external, procurement systems for the target diseases is likely to lead to inefficiency and duplication of efforts within the country.

Following the approval of Malawi’s HIV/AIDS grant, the LFA conducted an assessment of the capacity of the CMS 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 directly engaging a prequalified member of the U.N. family. To expedite the process, 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 to help build the capacity of CMS, with the objective of CMS gradually taking over procurement and distribution. The MOH further envisioned that CMS would gradually take over tasks from UNICEF in a phased manner. The Department of Health Technical and Support Services (DHTSS) and CMS had reservations, however, regarding the procurement decision, finding the assessment unfair and inaccurate. While the DHTSS and CMS see the inefficiencies as resulting from human, material, and financial resource shortages coupled with facility management problems, the LFA consultant placed emphasis on a need for reform.

In practice, the capacity-building exercise UNICEF was to undertake was unsatisfactory, according to the DHTSS and CMS. Rather than laying down a program of work and milestones for capacity development, according to CMS and DHTSS, UNICEF has undertaken only one activity, a visit of CMS officials to the UNICEF procurement division in Copenhagen. Furthermore, they view the UNICEF system as a parallel drug procurement system. According to UNICEF, however, the only capacity activities required of UNICEF are the preparation of international tendering, supplier identification, and the identification of the best products at lower prices, holding that other aspects of capacity building were not assigned to UNICEF. In their view, DfID previously invested a lot of resources in an attempt to reform CMS, but failed, in part due to the complex problems resulting from linkages between CMS and the Ministry of Finance and MOH.

Despite these issues, the GF has provided support to the following areas related to pharmaceuticals and commodities:

- ▲ Strengthening operations in safeguarding the quality of drugs and supplies in Malawi
- ▲ Supporting the school of pharmacy, which should help to alleviate capacity constraints at CMS
- ▲ Allowing the MOH to regularly update national drug policies and treatment guidelines
- ▲ Supporting the CMS distribution system with utility trucks

While these improvements may indirectly improve the distribution of contraceptives to reproductive health facilities, it may also be that the focus on GF has diverted attention from the provision of contraceptives to facilities. Further research in the follow-up study is needed to determine the effects of GF funding on contraceptive availability. It is apparent, however, that GF funding has missed an opportunity to strengthen local capacities — in pharmaceutical management, procurement, forecasting, distribution, and policy — which, if collectively improved, would have led to a greater likelihood for also helping to improve contraceptive security.



## 6. Conclusions and Recommendations

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### 6.1 Concluding Remarks

The GF has mobilized substantial resources and released them to a greater number of players in an effort to combat HIV/AIDS, TB, and malaria. With the surge in funding brought about by GF comes opportunity to scale up efforts to improve health, as well as challenges in absorbing funds and using them efficiently and effectively.

Improvements have been made in areas such as increasing the actors involved in service provision, enhancing infrastructure, and increasing availability and capacity of health services. The GF, however, has also led to an increasing focus on the three focal diseases, rather than increased attention to broader health systems strengthening. As a result, existing health system challenges have been overlooked in many cases, and to some extent, other health priorities have been overshadowed. Opportunities that have arisen to strengthen health systems while implementing GF activities have often been missed, as in the case of the drug procurement system in Malawi. Furthermore, significant issues of sustainability remain.

While the CCM and other GF-related planning mechanisms may not currently provide a forum for discussions of integrating GF activities with reproductive health and family planning services, they may not be averse to considering new ideas on ensuring better coordination of GF-supported activities with other non-focal services. If appropriate to the national contexts, GF activities can be successfully integrated with other basic health services such as preventive care, family planning, and childhood immunization, thus potentially increasing the impact of GF-supported interventions<sup>8</sup>. Country-level stakeholders must weigh the potential benefits and risks of integrating services and determine if it makes sense within the national context to advocate for integration.

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### 6.2 Recommendations

In order to encourage the strengthening of reproductive health and family planning programs through the implementation of GF-supported activities, reproductive health programs could coordinate and collaborate more (and better) with GF structures, such as the CCM. Reproductive health programs can make an effective case for their sustained involvement in GF-related planning processes and their participation in the implementation of activities through the clear articulation of how reproductive health and family planning programs are linked to supported activities.

By promoting a message of how reproductive health and family planning objectives fit into those of proposed GF activities, the MOH and other stakeholders may come to a better understanding of

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<sup>8</sup> There is some documented risk that the integration of HIV/AIDS and reproductive health services can in fact result in a diminished focus on reproductive health priorities, especially family planning (USAID, 2003). Careful assessment of the country context is necessary prior to advocating for an integration of GF-related services (especially HIV/AIDS) and reproductive health and family planning services.

how focal disease interventions may be linked with reproductive health services and vice versa. Such an approach may lead to further involvement of reproductive health programs in the planning process and enhance the integration of reproductive health services into GF activities.

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### 6.3 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 two 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 (with specific attention to reproductive health and 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](http://www.phrplus.org/swef.php).

# Bibliography

- Banteyerga, H., A. Kidanu, S. Bennett, and K. Stillman. 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 A. Fairbank. 2003. A Conceptual Framework for Analyzing the Systemwide Effects of the Global Fund. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.
- Central Statistical Agency and ORC MACRO. 2001. Demographic and health survey (DHS) Ethiopia, 2000. Addis Ababa, Ethiopia and Calverton, Maryland, USA.
- 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.
- Demographic and Health Survey (DHS). 2000a. Malawi.
- DHS. 2000b. Ethiopia.
- Federal Ministry of Health, Ethiopia. 2004. Health and Health Related Indicators. Addis Ababa, Ethiopia: FMOH Planning and Programming Department.
- Global Fund. 2005. Preliminary Round Five Information.  
[http://www.theglobalfund.org/en/apply/call5/submission\\_stats](http://www.theglobalfund.org/en/apply/call5/submission_stats).
- The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2002. The Framework Document of the Global Fund to Fight AIDS, TB and Malaria, Global Fund, Geneva.
- Government of Malawi and U.N. Development Program/Lilongwe. Impact of HIV/AIDS on Human Resources in the Malawi Public Sector. Lilongwe.
- Harries A.D. 2002. High death rates in health care workers and teachers in Malawi. *Trans Roy Society Tropical Medicine & Hygiene* 96: 34-37.
- Kombe G., D. Galaty, R. Gadhia, and K. Decker. 2005. The Human and Financial Resource Requirements for Scaling Up HIV/AIDS services in Ethiopia. Bethesda, MD, USA: Partners for Health Reform*plus*, Abt Associates Inc.
- Lush, Louisiana. Integrating HIV/STI and Family Planning Services. *Service Integration: An Overview of Policy Developments. International Family Planning Perspectives*, 2002, 28(2):71-76.
- Malawi National AIDS Commission. 2004. "Integrated Annual Work Plan 2004-2005"

- Ministry of Health and Population, Malawi. 2001. National Health Accounts (NHA): A Broader Perspective on the Malawian Health Sector. Planning Department.  
[http://www.who.int/nha/docs/en/Malawi\\_NHA\\_report\\_english.pdf](http://www.who.int/nha/docs/en/Malawi_NHA_report_english.pdf)
- Ministry of Health and Japan International Cooperation Agency. 2002. Malawi Health Facility Survey 2002 Report.
- Mtonya, B., V. Mwapasa, and J. Kadzandira. 2005. The Systemwide Effects of the Global Fund: Malawi Report. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.
- Shears, K.H. Family Planning and HIV Service Integration: Potential synergies are recognized. *Network*, 2004, 23(3): 4-6. Family Health International.
- Smith, O., S. Gbangbade, A. Hounsa, and L. Miller-Franco. 2005. Benin: Effects of the Systemwide Effects of the Global Fund. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc. July.
- The World Bank. 2004. World Development Report 2005: A Better Investment Climate for Everyone. Washington, DC.
- UNAIDS. 2004. UNAIDS/WHO Epidemiological Fact Sheet – 2004 Update: Ethiopia. UNAIDS Geneva.
- United States Agency for International Development (USAID). 2003. Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs. Washington, DC: USAID.
- World Health Organization (WHO). 2002. WHO Country Cooperation Strategy: Ethiopia, 2002-2005. Regional Office for Africa, Brazzaville. [www.who.int/countries/en/cooperation\\_strategy\\_eth\\_en.pdf](http://www.who.int/countries/en/cooperation_strategy_eth_en.pdf)
- WHO. 2004a. Country Profile, Malawi, Context. <http://www.who.int/countries/mwi/en/>.
- WHO. 2004b. Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA. Geneva.
- WHO. 2005a. Country Profile, Ethiopia, The Present Context. <http://www.who.int/hac/crises/eth/en/>.
- WHO. 2005b. WHO NHA estimates, 1998-2002, Malawi. [www.who.int/nha/country/MWI.xls](http://www.who.int/nha/country/MWI.xls).
- WHO. 2005c. WHO NHA estimates, 1997-2001, Ethiopia. [www.who.int/nha/country/ETH.xls](http://www.who.int/nha/country/ETH.xls)
- WHO. 2005d. WHO vaccine-preventable disease monitoring system, 2005 global summary. [http://www.who.int/immunization\\_monitoring/en/globalsummary/countryprofileselect.cfm](http://www.who.int/immunization_monitoring/en/globalsummary/countryprofileselect.cfm)