Partners for Health Reform*plus*

The System-Wide Effects of the Global Fund in Ethiopia: Baseline Study Report

October 2005

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- *Availability and appropriate use of health commodities.*

October 2005

Recommended Citation

Banteyerga, Hailom, Aklilu Kidanu, Sara Bennett, and Kate Stillman. October 2005. *The System-Wide Effects of the Global Fund in Ethiopia: Baseline Study Report Final Draft.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

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

Submitted to: USAID/Addis Ababa

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United States Agency for International Development

Abstract

Ethiopia has been granted significant resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). The success of GF activities in-country depends upon the health system being able to absorb and effectively utilize these new resources. This is the baseline report of the System-wide Effects of the Fund (SWEF) study in Ethiopia. The study seeks to understand how monies being disbursed by major new disease-specific initiatives, such as the GF, affect health systems. Four principle areas are focused on: the policy process, the role of the private sector, human resources for health and the procurement and distribution of pharmaceuticals and commodities.

While it is still early in the implementation of GF grants in Ethiopia, several lessons are identified; for example, there is a need for more effective communication between multiple layers of the health system, and stronger management and leadership capacity is also needed throughout the system. Ethiopia has an extremely weak human resource base, and a broad human resource strategy needs to be developed to address the challenges related to scale-up of GF activities. These and other lessons are presented. A follow-up study will be conducted early in 2006.

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Acronyms

AIDS	Acquired immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavioral Change Communication
CCM	Country Coordinating Mechanism
CCM/E	Country Coordinating Mechanism for Ethiopia
CRDA	Christian Relief and Development Association
EHNRI	Ethiopian Health and Nutrition Research Institute
EMSAP	Ethiopia Multisectoral AIDS program
FDRE	Federal Democratic Republic of Ethiopia
GC	Gregorian Calendar
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Good Manufacturing Practice
HAPCO	HIV/AIDS Prevention and Control Office
HSDP	Health Sector Development Program
IEC	Information Education Communication
ITN	Insecticide-Treated Nets
LFA	Local Fund Agency
MDG	Millennium Development Goals
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NGO	Non-governmental Organization
NHAPCO	National HIV/AIDS Prevention and Control Office
PASS	Pharmaceuticals Administration and Supply Services
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHR*plus*	Partners for Health Reform*plus* Project
PLWHA	Person Living with HIV/AIDS

PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Papers
SDPRP	Sustainable Development and Poverty Reduction Program
SPA	Service Provision Assessment
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
SWEF	System-Wide Effect of the Fund
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Glossary

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

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

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

Acknowledgments

The research team acknowledges the full-hearted cooperation it received from the Country Coordinating Mechanism of Ethiopia (CCM/E), the CCM/E Secretariat, and the officials of the Ministry of Health (MOH) and HIV/AIDS Prevention and Control Office (HAPCO) both at the federal and regional levels, the representatives of donors and bilateral organizations, the private sector and non-governmental organizations, as well as all the health facility staff who participated in the research as key informants.

The research team would like to pay its gratitude to Mrs. Holly Fluty Dempsey of the U.S. Agency for International Development (USAID), who stood firmly on the side of the research team, and encouraged and supported it in its endeavors.

The team is also grateful to members of the CCM steering committee, namely, Dr. Teferra Wonde, World Health Organization; Dr. Omer Ahmed, USAID; Dr. Klaas Wit, Royal Netherlands Embassy; Ato Tilahun W/Michel, Ethiopia Health and Nutrition Institute; Dr. Teklu Belai, Dr. Tsegay Legesse, Ato Ali Beyene, Ato Workneh Kasie, and Dr. Bona Hora of the Global Fund Secretariat, Addis Ababa. Special thanks goes to Dr. Omer Ahmed of USAID, for his constructive and useful comments on the draft report.

The team acknowledges the support and cooperation it received from Dr. Girma Azene, Planning and Programming Department, MOH; Drs. Alemayehu Seifu, Zerihun Tadesse, Dereje Muluneh, and Ato Gezahegn Tesfaye of the Department of Disease Prevention and Control, MOH; Ato Alemayehu Lema, Pharmaceuticals Administration and Supply Services, MOH; Ato Negatu Mereke and Ato Shimeles Worku of the National HAPCO. Their heart-felt support to the study enabled the researchers to execute the data collection as planned.

The research team duly recognizes and acknowledges the cooperation and timely response it received during ethical clearance of the study from the Science and Technology Commission of Ethiopia.

Dr. Ahmed Ali of the Medical School at Addis Ababa University and the staff of Miz-Hasab, namely Wts. Frehiwet Abebe, Martha Alemeyehu, Beiza Fisseha, and Meron Bekele directly contributed to the research work through data collection and processing. The authors are very appreciative of their efforts.

Dr. Ruairi Brugha provided helpful technical review of the final report.

Of course, the standard caveats apply. None of those named above are in any way responsible for the final content of this report.

Executive Summary

Background and Objectives

Significant resources have been committed to Ethiopia to support the fight against HIV/AIDS, tuberculosis (TB) and malaria. While it is clear that, given the country's problems and size, the financial support is needed, there are critical questions concerning how effectively the health system can absorb and apply this very significant increase in funding.

The overall research objective of the study reported here, is to document the effects of the processes involved in applying for and receiving a grant from the Global Fund to Fight AIDS, TB and Malaria (GF) and implementing GF-supported activities on the health care system of the recipient country, Ethiopia. The study focuses in particular on four thematic areas: policy processes, human resources, the public/private mix, and procurement and distribution systems for pharmaceuticals and other commodities. This report presents the baseline findings from the study; a further report integrating findings from follow-up data collection activities will be produced in 2006.

Study Design

The study design is that of an impact evaluation, with baseline and follow-up surveys. In addition to document review, two primary forms of data collection were used: (i) a facility survey and (ii) in-depth interviews with key informants. This report is based mainly upon the qualitative element of the study. A total of 57 in-depth interviews were conducted with key informants at the national and regional levels.

Findings and Recommendations

1. GF Systems and Structures

The Country Coordinating Mechanism of Ethiopia (CCM/E) is currently perceived to be an entity with limited power and no clear position in the national architecture. While the numerical distribution of CCM/E seats favors non-government actors, some respondents still viewed the CCM to be government dominated and they stated that members from non-government and private sectors were less active participants in CCM/E deliberations. To be effective, the CCM/E cannot derive its power solely from the powerful government actors who sit on the committee. It needs to derive its authority from the composition and legitimacy of its membership, as well as its effectiveness in overseeing GF-supported activities.

- The CCM/E should broaden its membership to include additional members from the regions and non-state actors.

- The roles of the CCM/E, principal recipients (PRs), regions, and implementing agencies should be revisited to ensure that they are clear to all.

- The CCM/E should promote greater communication and exchange with a broad array of stakeholders, proactively linking to other ministries, regional-level actors, and civil society actors in order to promote greater awareness and transparency concerning GF operations in Ethiopia.

Respondents directly involved in managing GF-supported activities expressed frustration with respect to communications with the GF Secretariat in Geneva, stating that more face-to-face communication would enhance understanding between local stakeholders and the Secretariat.

- The GF Secretariat should be requested to enhance its ability to conduct face-to-face communication with GF actors within Ethiopia.

2. GF Planning Processes

The GF has exposed the existing tension between centralization and decentralization in the health system. Due to time constraints in the early rounds of GF grant applications, there was little consultation between the core team working on developing the proposals and implementers at regional level and below. This has led to difficulties in implementation. While some measures have been taken to improve communication with regional stakeholders, many at the regional level felt that more needed to be done in this area.

- **Promoting participation and ownership by stakeholders at the regional and sub-regional level.** Since implementation of GF-supported activities is done at the regions and sub-regions, or zones and *weredas*, attempts should be made to continuously inform staff at these levels about the GF as well as to consult with them about what they can do with the GF. Planning needs to be done interactively, considering the priorities and needs of regions.

One specific aspect of current GF planning arrangements about which regional-level respondents commonly voiced concerns was the lack of transparency as to how GF resources are allocated among regions.

- **Allocation of GF resources among regions**. The CCM and PRs need to make it clear how decisions are being made regarding allocation of GF resources among regions. The nature of the allocation and planning mechanism needs to be clearly communicated to regional staff.

Monitoring and evaluation (M&E) systems in Ethiopia were viewed as very weak by many of the respondents interviewed, and it was thought that this would impact the country's ability to monitor GF-supported activities. There is a tendency to depend on financial reports submitted by implementing bodies; however, physical monitoring of activities accomplished, funds used, and impacts is necessary.

- **Strengthening M&E.** More comprehensive and reliable M&E systems urgently need to be developed, including strengthening monitoring skills and building the necessary information systems and procedures.

3. Alignment and Integration

Many respondents viewed the GF as a "gap filling" opportunity,[1] and stated that GF monies were being used to support activities planned under Health Sector Development Plan (HSDP) II. However, while in broad terms the GF support was perceived to be aligned with national plans, a number of specific concerns were voiced about how in practice GF-supported activities were harmonized with those of other funders, and integrated into existing systems. Donor representatives in particular expressed concerns about harmonization with the Ethiopia Multisectoral AIDS Program and the U.S. President's Emergency Plan for AIDS Relief.

Multiple respondents expressed concern that the mode of planning and implementation of the GF grants was contributing to more vertical approaches than those typically supported by government. The root cause of this concern appears to be the substantial amount of GF resources (compared to national budgets) which are now managed by rather vertically oriented disease control programs in the Ministry of Health, rather than being controlled by regions through the usual budgetary channels.

In addition, some respondents felt that GF-supported programs in Ethiopia were not strongly multisectoral and there was a danger of the "medicalization" of HIV/AIDS – which conflicts with government's own policy statements. Respondents suggested that this tendency toward the medicalization of HIV/AIDS might be exacerbated by the planned antiretroviral therapy (ART) roll-out supported under the Fourth Round grant from the GF. Given the very weak health systems in the country, the challenges of effectively implementing a broad-scale ART program might detract from other (non-clinical) interventions.

Relatedly, respondents observed weak links between GF-supported activities and the Ethiopian Sustainable Development and Poverty Reduction Program – although this concern also applies to how well the HSDP is linked to broader poverty-reduction strategies. In general, there appear to be weak links between the GF structures and non-health sectors.

- **Building links to non-health sector actors**. People's understanding of the GF within the broader bureaucracy is minimal and sometimes non-existent. It is essential that stakeholders in other related sectors have a stronger understanding of what the GF is and its contribution to national development goals.

4. Human Resources for Health

Ethiopia has extremely limited human resources for health, as has been documented elsewhere. Given the early stages of implementation of the GF grants in Ethiopia, to date the primary bottlenecks have been in terms of lack of high-level staff to undertake planning and management of GF-supported activities. An active debate is raging about how to best secure and motivate such high-level staff. Different responses have been taken by different regions, and there appears to be no overarching strategy. In terms of health workers at lower levels of the system, regional respondents had differing opinions as to how critical a constraint the shortage of health workers would be. Remote rural regions, such as Somali, clearly face a more acute problem than more urban and better connected regions.

[1] I.e., an opportunity to plug funding gaps in existing health sector plans.

- **Building a strategy for human resources**. Implementing bodies at the regional level and below are developing ad hoc responses to the human resource crisis. It is essential that this issue be dealt with, in consultation with implementing bodies and both public and private stakeholders, and that a broad human resource strategy is developed.

5. The Private Sector

While the GF promotes approaches that encourage participation on the part of private sector actors, a lack of previous experience in collaborative work between government and non-government organizations, as well as a lack of trust between sectors, has undermined the effectiveness of this strategy in Ethiopia. Government actors and non-state actors have differing opinions about the nature and magnitude of the problem. Unfortunately, some of the problems have been exacerbated by lack of clarity about how GF resources may be used, and how much of the support channeled to the country by the GF could be used by the private sector. There are, nonetheless, multiple examples of GF resources being used to support private sector initiatives, particularly at the regional level.

- **Creating greater clarity and consensus on public and private roles**. An organizational development process should be undertaken to create greater understanding, on the part of all stakeholders, as to appropriate roles for public and private sectors.

6. Procurement of Drugs and Commodities

Delayed procurement of drugs and commodities has been a major barrier to the timely implementation of GF-supported activities and was voiced as a concern by many regional staff. However, there appear to have been positive changes within the unit responsible for procurement, and a shift away from direct procurement to overseeing and supervising procurement and distribution by a range of other agencies. Finally, it appears that drugs and commodities are arriving in country and being distributed to where they are needed.

7. Building Stronger Institutions and Systems

Decision-making capacity on GF issues needs to be strengthened at multiple levels. To date, decision making at the regions and the center has been slow, reflecting inabilities to manage risk and limited leadership capacity. This will hamper quick implementation of scale-up.

- **Strengthening leadership and management skills**. If implementation is to proceed as planned and strengthen the health system, there is a need for serious investment in the development of a management cadre within the public health sector. This would include (i) the employment of capable leaders/managers and (ii) training those already appointed. This is needed at all levels of the Ethiopian health system.

- **Using GF funds to provide support for system strengthening and training**. GF support for training should be addressed not only at the development of important clinical and counseling skills but also at skills which will help build stronger health systems, including management strengthening and the development of M&E systems.

Conclusions

While it is still early in the implementation of GF-supported activities in Ethiopia, it is apparent that many challenges have already been confronted by the key stakeholders and that, just as the GF is an ever-evolving organization, actors in Ethiopia are steadily learning how best to manage GF resources. Many of the constraints encountered to date were not generated by the GF, but rather reflect underlying weaknesses in the health system. That said, the tendency to more vertical approaches, which has emerged primarily due to the way in which GF monies are being managed and disbursed in-country, could serve to undermine system strengthening.

While there is intense pressure on those involved in implementing GF-supported programs, it is important that time is made to absorb and exchange lessons learned and to communicate effectively with all stakeholders – including those at the regional and sub-regional levels, and non-state actors. Effective implementation depends upon stronger communication between different levels of the health system, and between health sector actors and those outside of the health sector. Without such communication and exchange, there is a danger that successes are not recognized and effective implementation is undermined by lack of partnerships.

The Ethiopian experience so far observed has many successful aspects. The research team observed that the leadership has become more sensitive and responsive to GF requests. The change observed in the Pharmaceuticals Administration and Supply Section regarding procurement is a case in point. An in-country forum for sharing lessons learned should be set up.

Next Steps

A workshop to disseminate baseline findings to a broad set of national and sub-national level stakeholders was organized in Addis Ababa, Ethiopia, in October 2005 (see Annex A).

Follow-up SWEF research is planned in Ethiopia for 2005-2006. Final findings from the studies will be available in mid-2006. Interim updates will be provided on the PHR*plus* website.

1. Introduction

In recent years, Ethiopia has been the recipient of a large amount of money targeted to support its health sector in the fight against HIV/AIDS, tuberculosis (TB), and malaria: The Global Fund to Fight AIDS, TB and Malaria (GF) has approved grants of a significant amount; in fact, the two-year approved total of $162 million[2] – on an annual basis, this represents about 80 percent of the government's budget for health – makes Ethiopia one of the major recipients of GF funds. In addition, Ethiopia has received from the World Bank a nearly $60 million loan for activities of the Ethiopia Multisectoral AIDS Program (EMSAP I), and the Bank is considering a EMSAP II grant. The U.S. Presidential Emergency Plan for AIDS Relief (Emergency Plan, or PEPFAR) approved $40 million for 2004, and ACTION AID is implementing a $10 million HIV/AIDS program, funded mainly by the British Department for International Development. A number of other donors also provide support to the health sector, including for HIV/AIDS, TB, and malaria.

It is clear that, given the country's size and problems, the financial support is needed. Nevertheless, critical questions arise concerning how effectively the health system can respond to this significant increase in health care funding. For example:

i. Can the health system absorb and effectively utilize the additional funding?

ii. Will the new services, and the way in which they are delivered, strengthen the health system?

iii. Will the focus on HIV/AIDS, TB, and malaria affect the delivery of services for other diseases and conditions?

iv. To what extent are the planned new activities harmonized with existing national policies and programs such as Poverty Reduction Strategy Paper (PRSP), Health Sector Development Program (HSDP), HIV/AIDS program, civil service reform program, decentralization and democratization, and the like?

v. How well are these funds integrated into the HSDP so that continuity and sustainability can be ensured?

vi. How do these funds impact capacity building, particularly human resource and organizational systems such as monitoring and evaluation (M&E), procurement of drugs and commodities, and the public/private mix?

Answers to these questions will contribute to promoting the effective and timely utilization of the funds, strengthening of the country's health system, and development of the country's leadership.

This report is the **baseline report** of the System-wide Effects of the Fund (SWEF) study in Ethiopia. SWEF is a collaborative research network that seeks to understand how monies being

[2] Table 4.1 in Chapter 4 provides more details on the grant awards and disbursements.

disbursed by major new disease-specific initiatives like the GF depend both upon well-functioning health systems and upon how those systems are affected by the new funding.

The study in Ethiopia is one of a series of SWEF country studies[3] intended to inform country-level stakeholders, as well as the GF Board and Secretariat, and the broader development community.

1.1 Study Objectives

The overall objective of the current research is to document the effects that the processes involved in applying for and receiving a GF grant and implementing GF-supported activities have on the health care system of Ethiopia.

The concept paper which supported the study design (Bennett and Fairbank 2003) identified four thematic areas where health system effects of the GF were particularly likely to be felt:

- **The policy environment:** The GF proposal and planning processes are designed to enhance the range of actors involved in informing policy and implementing disease control activities. The research examines the effects of the GF on the relative power of different policy actors, the degree of alignment between the GF processes and other national planning processes, and the extent to which GF money is truly additional to other sources.

- **Public/private mix:** The term private is used to represent non-governmental organizations (NGOs) that are non-profit or private for-profit entities and other civil society organizations that are non-governmental. The GF explicitly welcomes innovative approaches to expanding service coverage, and approaches that draw private sector actors into the health system. This component of the study examines whether the GF has contributed to a changed role for private sector actors, and how it has affected the quality, quantity and distribution of private sector providers.

- **Human resources:** The study examines how the GF affects capacity building and the distribution of human resources, and whether there is any shift of personnel from non-focal diseases. The impact of GF-supported activities on the distribution, quality, and numbers of health staff is also assessed.

- **Pharmaceuticals and commodities:** Approximately 50 percent of GF money committed globally is dedicated to the procurement of pharmaceuticals and commodities. This injection of funding may affect national procurement, supply and distribution systems, and the quality and prices of drugs and other commodities. The research evaluates the impact of GF support for HIV/AIDS, TB, and malaria drugs on pharmaceutical procurement and distribution systems and the accessibility of drugs for non-focal diseases.

Across each of these four thematic areas, the study assesses how the changes observed have affected overall health system performance, particularly the equity, sustainability, quality, and efficiency of health services.

[3] The U.S. Agency for Development-funded Partners for Health Reform*plus* Project is concurrently publishing baseline studies on Benin (Smith et al. 2005) and Malawi (Mtonya et al. 2005).

1.2 Organization of the Report

The report is organized as follows: after this brief introduction, Chapter 2 describes relevant aspects of the Ethiopian context. Chapter 3 presents research design and methods. Chapter 4 summarizes the findings regarding the process of applying for and receiving GF monies, Chapter 5 the findings regarding impacts on the Ethiopian health system. Chapter 6 presents highlights from the facility survey conducted as part of baseline data collection. Chapter 7 discusses the findings and presents preliminary conclusions.

2. Context for the Global Fund Grants

2.1 The Socioeconomic and Administrative Context

Ethiopia is a huge country, both physically and in terms of population, but with poorly developed resources and infrastructure. It has suffered from civil wars and repeated droughts and famines. With a per capita income of about $100 per annum (World Bank 2004), Ethiopia is among the least developed countries in the world.

Ethiopia has the second largest population in sub-Saharan Africa, after Nigeria. Annual population growth is estimated at 2.7 percent (Population Reference Bureau 2000), and the current population of 71.1 million (Federal Ministry of Health [FMOH] 2004a) is expected to reach 106 million by 2020. Eighty-five percent of the population lives in rural areas.

The administrative structure is a federal one: there are nine regional states and two city administrations. The highest governing body at the federal level is the Parliament. The regional states have regional councils. Zones, *weredas* (districts), and *kebleles* (the smallest administrative unit) constitute lower levels of the administrative hierarchy.

2.2 Health Indicators

Health and health-related indicators published by the FMOH in 2004 show a fast-growing population and limited health services (see Boxes 2.1 and 2.2). The average per capita expenditure on health is approximately $1.30 per person (World Bank 2004), much lower than the minimum amount ($12 per person) that the World Bank recommends to maintain a basic package of health services. The total share of government budget allocated to health is approximately 7 percent (2000). Public health expenditure is estimated at 1.8 percent of gross domestic product (2000). Not surprisingly, given this low expenditure, the coverage of basic services is very poor (for example, skilled health staff attend only 10 percent of births in the country) and accordingly health outcomes are also very poor.

Box 2.1. Population Indicators (2004)

Total population (millions)	71.1
Infant mortality rate (per 1,000)	96.8
Total fertility rate	5.9
Maternal mortality rate (per 100,000 live births)	871

Source: Federal Ministry of Health (2004a)

Box 2.2. Health Service Indicators (2004)

Primary health care coverage %	73.2
EPI coverage (DPT3) %	60.8
Health service utilization (visits per capita per annum	0.36
Contraceptive prevalence rate %	23.0
Antenatal coverage %	40.8

Source: FMOH (2004a)

2.3 Health Policy and the Health Sector Development Program

The Health Sector Development Program (HSDP II) is the main statement of health policy in the country. It underlines the importance of access, equity, and quality, and focuses on health promotion and prevention, and curative services. The health system theoretically consists of a four-tier health service delivery system:

i. A health center with five satellite primary health care units is expected to serve 25,000 people

ii. A district hospital is expected to serve 250,000 people

iii. A zonal hospital is expected to serve up to 1 million people

iv. Specialized referral hospitals are part of a two-way referral system, i.e., referrals from the periphery and feedback from the center.

However, due to limited health facilities and human resources (Box 2.3), this system has not yet been fully implemented.

Box 2.3. Number of Facilities and Human Resources in Service, 2004

Hospitals	126
Health centers	519
Health stations	1,797
Health posts	2,899
Private clinics	1,299
Pharmacies	275
Drug shops	375
Rural drug vendors	1,783
Physicians	1,996
Health officers	683
Nurses	15,544
Health assistants	6,628
Paramedics	5,215

Source: FMOH (2004a)

The health system is decentralized. The FMOH is mandated to issue policies, guidelines, and standards, to do procurement, to provide major training, etc. Implementation is the responsibility of the regions. According to the HSDP II, health sector development is in harmony with the policy of decentralization:

> *Primary responsibility for service delivery and management has been devolved to regional health bureaus since the outset of HSDP I. From 2002 G.C., and thus for the periods of HSDP II onwards, these functions are to be further devolved to the wereda level.* HSDP II (p.23)

Other relevant elements of the HSDP II include:

- NGOs and private for-profit organizations are recognized as partners in the delivery of health services.
- Capacity building is emphasized as a major objective of the health sector, and it is stated that human resource and organizational systems must be developed at government and non-government institutions of all levels of the system.
- The health development program should be integrated with other national policies and programs, such as the Sustainable Development and Poverty Reduction Program (SDPRP), Rural Development Policies and Strategies, the policy on Agriculture Led Development Industry, and The National Policy on Ethiopian Women.
- Integration with the principles outlined in the Civil Service Reform Program regarding planning and administrative processes in the health sector.

There is an increasing number of activities to which Ethiopia is being introduced by global public/private partnerships, particularly in the area of drugs and vaccines. Ethiopia has adopted several of the global strategies (notably Roll Back Malaria), and the country also receives support through the Global Alliance for Vaccines and Immunization.

2.4 Health Challenges: The Focal Diseases

Infectious diseases account for 60–80 percent of health problems (HSDP II). Malaria, TB, and sexually transmitted infections (STIs), including HIV/AIDS, rank among the top causes of morbidity and mortality in the country.

2.4.1 Malaria

Malaria is reported to be one of the three leading causes of morbidity and mortality in Ethiopia in past years. According to an FMOH report on malaria (FMOH 2004b), "*The magnitude of the problem in 2002/03 has even worsened and the disease has been reported as the first cause of morbidity and mortality accounting for 15 percent of outpatient consultations, 20.4 percent of admissions and 27.0 percent of inpatient deaths*." The report adds:

> *In a non-epidemic year, 5-6 million clinical malaria cases and over 600,000 confirmed cases are reported from health facilities. However, as the potential health service coverage is accessible to about 61 percent of the population and due to the low service utilization rate (MOH 2004), the number of malaria cases reported by health facilities is only a portion of the actual magnitude.*

A high treatment failure rate for chloroquine-based treatment of falciparum malaria has driven the FMOH to change the treatment of uncomplicated falciparum malaria to artemisinin-based comnbination therapy (ACT) and, for the treatment of vivax malaria, to chloroquine. Early diagnosis, and prompt and adequate treatment of malaria is compromised by low health service coverage and utilization rates. The DHS found that less than 5 percent of patients seek treatment for fever within 24 hours of onset (Central Statistical Office and ORC Macro 2001). Poor quality diagnosis and treatment, plus intermittent availability of malaria drugs is reflected in the relatively high case fatality rate (16-35 percent) (Negash et al. 2004). The DHS 2000 also found very low coverage of nets (1.5 percent) and insecticide-treated nets (ITNs) (0.5 percent), although since 2000 sales of subsidized nets through health facilities have increased.

2.4.2 Tuberculosis

TB is among the major causes of morbidity and mortality, and manifests as the leading opportunistic illness for AIDS patients. "Ethiopia ranks seventh in the list of the world's 22 high burden countries for TB, with incidence of TB of all forms 356/100,000, smear positive 155/100,000, prevalence of all forms of TB 533/100,000 and prevalence of HIV among TB patients 21 percent" (FMOH 2005a). A TB control program, incorporating directly observed short course treatment (DOTS), has been in place since 1992. Coverage, however, is still limited due to the overall low health service coverage and lack of resources in the country. The FMOH report indicates, "TB case detection is 36 percent. The main strategies of the control program are early case detection, adequate chemotherapy and comprehensive patient care. The Health Extension Programme is the flagship of

the health delivery system" (FMOH 2005). The treatment success rate is estimated to be 76 percent (Stop TB 2005).

The FMOH report adds that the TB control and prevention strategy includes:

- Strengthening TB control through expansion and improving quality of DOTS.
- Addressing human resource development issues of pre-service and on-the-job training.
- Conducting advocacy activities through communication and social mobilization. This is believed to bring about better health seeking behavior and subsequently increase case findings and treatment adherence, which in turn improves treatment outcome.

2.4.3 HIV/AIDS

HIV/AIDS is a major epidemic and health threat in the country. Ethiopia currently has an estimated 1.5 million people living with HIV/AIDS (UNAIDS 2004). The national adult HIV prevalence in 2003 was estimated to be 4.4 percent (FMOH 2004c). The HIV prevalence rate in urban areas is estimated at 12.6 percent and 2.6 percent in rural areas.

> *The trend of the HIV epidemic from 1982 till 2003 suggests three key points: a continuing gradual rise in national prevalence (3.2 percent for 1995, 4.1 percent for 2001, 4.2 percent for 2002, and 4.4 percent for 2003); an urban epidemic that has peaked and plateaued at high prevalence levels; and a very gradual but steady rise in HIV prevalence in rural Ethiopia.* (FMOH 2004c: 7).

Table 2.1 shows the estimated and projected adult HIV prevalence by sex and urban/rural setting for selected years during the period 1982–2008.

Table 2.1. Estimated and Projected Adult HIV Prevalence (%) by Sex and Setting, Selected Years, 1982–2008

	1982	1985	1990	1995	2000	2001	2002	2003	2008
National	0.0	0.2	1.6	3.2	3.9	4.1	4.2	4.4	5.0
Male	0.0	0.2	1.5	2.8	3.4	3.5	3.7	3.8	4.4
Female	0.0	0.2	1.7	3.6	4.4	4.8	4.8	5.0	5.7
Urban	0.0	0.7	7.0	13.4	13.0	12.8	12.8	12.6	12.6
Rural	0.0	0.1	0.3	0.8	1.9	2.1	2.1	2.6	3.4

Source: FMOH 2004c

The epidemic is deeply rooted in all sectors of the population and the consequent economic impact is considered to threaten overall development. The consequences for the health sector include both loss of health workers and congestion in health facilities as people seek care.

The challenges in the fight against HIV/AIDS in Ethiopia are immense. There are only 67 antenatal-based sentinel surveillance sites in the country, about half of them in rural areas. Screening of donated blood is done in only a few centers. It is reported that about 450 voluntary counseling and

testing (VCT) centers exist in the country. There is limited provision for prevention of mother-to-child transmission (PMTCT), mostly in Addis Ababa and a few regional capitals. Diagnostic screening exists only in major urban centers. Premarital screening of couples is carried out in major health facilities.

In addition, data on the prevalence of HIV/AIDS are inadequate and unreliable. Shortage of HIV testing laboratory facilities and HIV tests hinder efforts to encourage voluntary testing. The management of antiretroviral therapy (ART) is poor. Counseling services before and after testing are limited. Care and support for people living with HIV/AIDS (PLWHA) and their families is insufficient. Organizations that provide HIV/AIDS orphans with assistance are limited and those that exist have only limited resources and capacity compared to the extent of the problem. Programs that target vulnerable populations, including commercial sex workers, internally displaced populations, and street children are insufficient. Massive rural–urban migration, coupled with high rates of unemployment, contribute to the high number of children living on the streets.

The government's response to HIV/AIDS was immediate, but inadequate. A National Task Force was established in 1985 following the report of HIV prevalence in the country. Efforts were made, although on a limited scale, to expand information, education and communication (IEC), condom promotion, surveillance, patient care, and HIV screening laboratories at different health institutions.

The government issued its HIV/AIDS Policy in 1998 in order to create a favorable environment to fight the disease. The National AIDS Prevention and Control Council was established in April 2000 and is headed by the President of the Federal Democratic Republic of Ethiopia (FDRE) with membership from sector ministries, regional states, NGOs, religious bodies, civil society representatives, and PLWHA. The Council has the responsibility to oversee implementation of the federal and regional HIV/AIDS plans, examine and approve annual plans and budgets, and monitor plan performance and impact. It has a National HIV/AIDS Board of Advisors that meets on a monthly basis to oversee plans and activities. The National HIV/AIDS Prevention and Control Office (NHAPCO) was established under the Prime Minister's Office to coordinate and facilitate the multisectoral response to HIV/AIDS in Ethiopia. It was recently placed under the Ministry of Health.

2.5 Other Support to HIV/AIDS Activities in Ethiopia

As noted above, there are numerous sources of support for HIV/AIDS in Ethiopia. Two of the largest sources, other than the Global Fund, are EMSAP and PEPFAR. EMSAP has been operational for more than five years; however, it has been very slow in implementation. An informant reports that only 72 percent of EMSAP funding has been utilized, and, in order to implement remaining activities, the program was extended by 18 months. During this time it was planned that 70 health posts and 11 youth centers would be built. Capacity constraints have been the major obstacle to implementation. The World Bank, having been made aware of this, made it a requirement that civil society should have its own share of EMSAP activities. Several NGOs have worked using EMSAP funds, and EMSAP has reached 271 weredas, almost half of the country.

Ethiopia is one of the 15 beneficiary countries of PEPFAR. More than US$ 100 million is allocated to the PEPFAR program in Ethiopia in 2004 and 2005 for HIV/AIDS prevention, for medical treatment including antiretroviral (ARV) drugs, and for care and support. The Ethiopian targets aim to avert new infections in 61,500 people in 2004, increasing to 810,000 infections averted in 2010. US$ 3 million was allocated in 2004 to the treatment of 7,200 AIDS patients with ARV. The

target for 2005 is to treat 40,000 eligible patients, increasing to 210,000 by the end of 2008. By 2008, about 1,050,000 people should have benefited from the care and support program.

The funds allocated to PEPFAR are not directly channeled to government ministries and agencies. Two large stakeholders meetings were held in Addis Ababa to inform representatives from the MOH, HAPCO, the regions, development partners, and other public organizations about the 2004 and 2005 plans and activities. PEPFAR is implemented in Ethiopia by a group of U.S. government agencies including the Department of State, Department of Defense, Centers for Disease Control and Prevention, and Agency for International Development.

3. Research Design and Methods

3.1 Preparation for Research and Consultative Processes

Given the sensitivity of the research in-country, the researchers endeavored to ensure key stakeholder knowledge of and support for the work. Steps in this process included the following:

i. Research teams at both Miz-Hasab Research Center (the local research institution) and Partners for Health Reform*plus* conducted a series of consultative meetings with the Ethiopia's Country Coordinating Mechanism (CCM/E) and other stakeholders.[4] On the basis of those discussions, the CCM/E agreed to respect the independence of the research and to cooperate with the research team. The research team agreed to update the CCM/E on the research regularly and allow the CCM/E to review research reports prior to general release.

ii. The research proposal and research instruments were submitted to the CCM/E/E for review and comments. The CCM approved the proposal and the research instruments.

iii. Miz-Hasab obtained ethical clearance for the study from the Ethiopian Science and Technology Commission before conducting the fieldwork.

iv. The CCM/E Steering Committee asked Miz-Hasab to share the research instruments with regional health and HAPCO bureaus. Miz-Hasab consulted the regional bureaus to comment on the topics included for investigation.

3.2 Study Design

The study design is that of an impact evaluation, with baseline and follow-up surveys. In addition to document review, two primary forms of data collection were used: (i) a facility survey and (ii) in-depth interviews with key informants. The in-depth interviews were conducted between November 2004 and February 2005. The facility survey was conducted between December 2004 and January 2005.

While the findings from the interviews are relevant and valid on their own, the baseline facility survey will be of significantly greater value once the follow-up survey, to be done after GF activities have properly started implementation, so that a comparison can be made between the two sets of findings.

[4] Meetings between the researchers and the CCM took place in (i) December 2003 with the broad CCM where initial approval for the study was given and (ii) April 2004, June 2004, October 2004, May 2005 with the CCM Steering Committee to report progress and discuss any issues arising.

3.3 Selection of Study Regions and Facilities

3.3.1 Selection of Regions

As noted above, Ethiopia is a large country, so, given the limited resources and budget of the study, it was necessary to select representative regions for the study. Selected were: Addis Ababa City Administration, Oromiya National Regional State, Amhara National Regional State, and Somali National Regional State. The CCM Technical Committee approved the selection.

Addis Ababa, Oromiya, and Amhara were selected because (i) they are large and densely populated, (ii) they have large urban settlements with access to road transportation, (iii) they have high prevalence of HIV/AIDS/STI, TB, and malaria, and (iv) there are VCT/PMTCT and ART activities in these regions. Moreover, the three also are regions where PEPFAR is likely to have intensive activities during the coming years. Somali region was selected because (i) it is remote, (ii) it has pastoral communities, and (iii) there is high malaria prevalence. It was meant to represent the remote regions and pastoralist communities.

3.3.2 Selection of Health Facilities for the Facility Survey

In the first three GF grants, nearly all activities are focused at the primary health care level. Therefore, it was agreed that hospitals would not be included in the survey sample, but that all types of primary health care units (health posts, health stations/clinics, and health centers; public, private for-profit, and NGO) would be included.

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. Selection of sample facilities within regions was purposeful (convenience sampling). The research team traveled first to the regional health offices to conduct interviews with regional health staff. At this point, the research team consulted with local informants to ascertain which facilities in the regions were considered urban or rural. The research team purposively selected the required number of urban and rural facilities so as to minimize travel time, whilst also ensuring adequate representation of rural and urban areas. As shown in Table 3.1, a total of 60 (public and private) health facilities were selected for the study.

Table 3.1. Rural and Urban Breakdown of Sample Facilities for GF Assessment in Ethiopia, 2005

		Addis Ababa	Oromiya	Amhara	Somali	Total
Health center	Rural	0	5	4	1	10
	Urban	3	2	1	1	7
Health post/ health station/ 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

In each facility surveyed, it was agreed that all health providers present at a selected facility at time of the interview would participate in the provider survey. The research team did not attempt to interview those who were not present at the time of the survey.

3.4 Data Collection, Processing, and Analysis

3.4.1 In-depth Interviews

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 areas namely, policy and program, human resource, public/private mix, and procurement of drugs and commodities.

A list of key informants was prepared and interview guides were adapted to reflect the knowledge and experience of different sub-groups of key informants. Qualitative data collection included 34 interviews with government officials (including 22 at the regional level), 12 with experts/heads of health programs, seven with NGOs, two with bilateral organizations, and two with multilateral organizations. Certain key informants were interviewed twice in order to get the latest information on GF activities.

Respondents were told that any information they provided would be confidential and used only for the purposes of the study, but that participation in the study was entirely voluntary.

Interviews were conducted by an experienced interviewer, and were largely in Amharic.[5] A note taker took notes throughout the interviews and later transcribed and translated these into English for analysis.

Key themes were identified and marked in the interview transcripts. Quotations from the interviews are used liberally in the text below. All findings reported here have been triangulated, i.e., similar observations were reported by more than one respondent. In cases where multiple quotations are used to illustrate a point, these quotations come from multiple respondents. It should be borne in mind that these quotations reflect the perspectives and opinions of the respondents, and may not necessarily coincide with facts.

3.4.2 Facility Survey

The quantitative data included both facility (N=60) and provider surveys (N=335). The instruments were adapted from the Service Provision Assessment, tested, piloted, and finalized on the basis of the pre-test results.

The facility survey included issues related to resources, staff, management, patient referrals, laboratory services, distribution of staff time, curative and care services such as inpatient care, availability, and use, outpatient consultations and case mix, STI and HIV/AIDS services such as VCT services and other HIV/AIDS services, and priority services such as immunizations and family planning.

[5] With the exception of foreign staff of bilateral and multilateral institutions.

The provider survey included questions on provider training, position and experience, supervision, motivation and job satisfaction, provider incomes as well as provider suggestions.

Data were entered into SPSS (Statistical Package for Social Science) for analysis.

4. Findings 1: Processes in Applying for and Executing Global Fund Grants

4.1 Global Fund Structures

This section describes the structures involved in applying for, receiving, and implementing a GF grant.

As noted previously, Ethiopia is a major recipients of GF monies. Table 4.1 shows the GF grants and disbursement status as of March 15, 2005.

Table 4.1. Global Fund Grants and Disbursement Status as of March 15, 2005 (Ethiopia) (US$)

Component	Round	Grant amount	Disbursed	2 years approved maximum $	5 years approved maximum $
HIV/AIDS	2	55,383,811	40,444,917 (73.03%)	55,383,811	139,403,241
HIV/AIDS	4	41,895,884	19,390,093 (46.28%)	41,895,884	401,905,883
TB	1	10,962,600	8,732,765 (79.66%)	26,980,649	26,980,649*
Malaria	2	37,915,011	32,600,733 (85.98%)	37,915,011	76,875,211
All three	1,2,4	146,157,306	101,168,508 (69.22%)	162,175,355	645,164,984

Source: CCM Secretariat office based upon PR's reports

* Figures for TB grant two-year and five- year amount need to be checked and re-confirmed.

The GF Secretariat in Geneva prescribes a set of structures and processes for the design, oversight, and implementation of GF grants (see glossary). In Ethiopia, all of these structures and processes are in place. The National HIV/AIDS Prevention and Control Office, and the Ministry of Health through the Department of Disease Control and Prevention, are the principal recipients (PRs) of GF grants.

One unusual feature is that in Ethiopia, for the Malaria and TB grants, local technical review panels were established[6]. These panels are in charge of reviewing local proposals submitted for funding under grants already approved by the GF in Geneva. NHAPCO has its National Review Board for HIV/AIDS that also scrutinizes proposals submitted for funding.

[6] Typically, in connection with the Global Fund, the term Technical Review Panel refers to the expert panel established at by the GF Secretariat in Geneva to review proposals submitted for funding.

4.1.1 Country Coordinating Mechanism, Ethiopia

The CCM/Ethiopia was established in February 2002 to facilitate and coordinate the management of GF-supported activities. A document, approved by the CCM/E, states that

> *As the Fund deals with the Federal government, the CCM/E derives its legal status from the Government, represented by the Federal Ministry of Health, Ministry of Finance and Economic Development and HIV/AIDS Prevention and Control Office.* (CCM/E 2003)

However, no further details are given as to how the CCM/E relates to existing Ethiopian institutions.

The same document states that the CCM/E is mandated to:

i. Strengthen and reflect high-level sustained national involvement and commitment in determining the content of proposals and making allocations of the awarded funds to support the substantial scaling up and increased coverage of proven and effective interventions;

ii. Ensure that GF resources augment existing spending on HIV/AIDS, TB, and malaria;

iii. Strengthen the system for working within the health sector, across government ministries, and with communities to build on, complement, and coordinate with existing programs in Ethiopia including the government, public/private partnerships, and civil society initiatives;

iv. Ensure that resources from the GF are designated to support national policies, priorities, and partnerships, including Sustainable Development and Poverty Reduction Program.

The GF Secretariat provides guidelines for the composition of a CCM. Ethiopia's was established with 12 seats representing the government (five seats, including the chairmanship and Ethiopia Health and Nutrition Research Institute [EHNRI]), U.N. and bilateral agencies, civil society, and the private sector (GF and FDRE 2002). The number later was raised to 15. The Ministry of Finance and Economic Development (MOFED), which was an original member, was dropped. The World Health Organization (WHO) presence has been increased to two seats (see Box 4.1). Representatives from each of the three targeted diseases attend CCM meetings to provide technical advice, review, present and explain work plans to the CCM, as well as facilitate CCM–technical group communications.

Despite the relatively varied composition of the CCM/E, several interviewees thought that the CCM/E was government dominated. Informants believed that the CCM/E does not represent the interests of a sufficiently broad group of stakeholders, particularly non-governmental stakeholders. Respondents noted in particular that the CCM/E was not very interactive in its deliberations and some members, particularly those from the private sector, did not participate actively. The reasons behind this lack of participation remain unclear in terms of to what extent it is attributable to an indifference on the part of certain CCM/E members, and/or a sense that their voice was not heard or valued. While government officials presented rational arguments as to why it was necessary to keep the CCM/E relatively small so that it could be an effective decision-making organ, there was fairly strongly held views about the inadequate current composition of the CCM/E.

Box. 4.1. CCM/E Composition in Ethiopia

- Minister of Health – Chair of Committee (govt.)
- Head of Planning, FMOH (govt.)
- Head of Disease Control Division, FMOH (govt.)
- Head of NHAPCO (govt.)
- Christian Relief and Development Agency (NGO)
- Representative of People Living with HIV/AIDS organization (civil society)
- Chamber of Commerce (private for-profit sector)
- The Ethiopian Health and Nutrition Research Institute (govt.)
- UNAIDS (U.N.)
- WHO (country representative, U.N.)
- WHO (policy advisor, U.N.)
- UNICEF
- USAID
- The Netherlands Embassy
- Ethiopian Public Health Association (civil association)
- Ethiopian Interfaith Forum for Development

The dominance of government in the CCM/E was perhaps one of the reasons why, for all of the approved GF grants, the PR is a government actor. On the one hand, this enables the government (namely, the FMOH) to have a broad decision-making power on the GF grant, but it also increases the risk and responsibilities faced by government officials.

The CCM/E meets every month to review NHAPCO and FMOH reports on the progress of implementation. It performs routine tasks such as signing agreements and protocols. The general perspective of informants knowledgeable about the CCM/E was that the PRs have more say about the use of GF grants than does the CCM/E. Several respondents suggested that the CCM/E is not an active leader and coordinator of GF-supported activities, but is rather inclined to leave such a leadership role to the FMOH.

As reflected in the CCM/E terms of reference described above, CCM/E responsibilities are relatively fewer than those of the PRs. Key informants, including CCM/E members, suggested that this was due a number of inter-related factors. First, the GF Secretariat in Geneva and its local fund agent (LFA) deal more with the PRs than with the CCM/E. While the CCM/E is informed of decisions made by PRs, the LFA, and the GF Secretariat, it is not involved in much decision making. The GF Secretariat appears to have unwittingly reinforced this distribution of power by limiting the role of the CCM/E to signing grants, agreements, and protocols; receiving reports; and approving decisions made by PRs. These limits on the CCM/E role are illustrated in the following example: While the CCM/E initially received quarterly reports from the PRs for onward submission to the GF Secretariat, this procedure was changed so that the PRs now send reports directly to the Secretariat and simply copy the CCM/E for information purposes. One informant stated that, despite concerns about the reports submitted, the CCM/E was unable to get further information from the PR.

A further example concerns the in-country technical review panels: For each grant, a technical review panel was to be established to review proposals from local entities that wished to be grant sub-recipients. While initially the CCM/E was to establish these review boards, in the end the PRs finally set them up. While PRs claim that they took this action because the CCM/E was slow to do so and point out that decisions are still approved by the CCM/E, this clearly also reflects a shift in the balance of power.

The FMOH maintains a high-level presence on the CCM/E. Much of the responsibility for planning, implementation, and monitoring rests with the MOH (at national and regional levels), leaving the CCM/E with a relatively weak role. This situation is very similar to that which has been reported elsewhere, particularly in other sub-Saharan African countries (Brugha et al. 2004). The sense that emerges from the interviews is that, while the FMOH and the PRs abide by the formal

procedures and functions specified for the CCM/E, they do not in any way actively seek the broader legitimacy that the CCM/E could confer on GF-supported activities, preferring instead to keep key decisions in-house.

To the extent that regional staff were aware of the CCM/E, they perceived it be a centralized body and somewhat unconnected to them: Few regional-level respondents had any idea of the CCM/E's role.

> *Unfortunately the CCM has no connection with us. In fact, we need to have a regional coordinating mechanism which should be represented in the CCM to reflect regional interests.* Regional respondent

> *I have heard of the CCM like any citizen. The CCM has no connection with us and we do not know what it is.* Regional respondent

Although the GF requires the participation on CCMs of both government and non-government stakeholders, the CCM/E appears somewhat centralized. There is no regional level representative on the CCM/E, and interactions between the CCM/E and regional- or wereda-level staff have been limited. This is particularly problematic in a federal structure such as that in Ethiopia.

4.1.2 Principal Recipients

NHAPCO and the FMOH Department of Disease Prevention and Control are the principal recipients of the GF grants: NHAPCO for HIV/AIDS and the FMOH for TB and malaria.

The PRs complain that they lack the capacity to implement the GF activities. There is a shortage of highly skilled human resource to plan, monitor activities, and process information. With very few exceptions, the PRs have not hired new staff to assist with the management and implementation of GF-supported activities but rather have hired on the basis of short-term contracts (consulting agreements) that have taken some time to set up. Moreover, the government did not accept the top-up of salaries of focal personnel needed for managing GF activities. The government feared that paying better salaries to those involved in GF activities would further exacerbate staff turnover from the public health sector.

The other problem is the structural link between the PRs and their regional subordinates. Tension in the center–region relationship was apparent for both NHAPCO and the Department of Disease Prevention and Control. Some regional HAPCOs have taken independent steps including hiring new staff to implement GF-supported activities. Oromia and Addis Ababa Regional HAPCOs have each employed one expert, but say they would like to employ more or top-up salaries of focal staff. However, they complain that they have not been given approval to do so. HAPCO contractual salaries are two or more times regular salaries. This has enabled HAPCO to employ better staff than the MOH at the center and in regions.

Also hindering implementation is a communication gap between the center and the regions, which exists even though the roles of the center and regions are defined.

> *Our problem is structural and the way we are connected to the regions. The existing structure is not conducive for quick implementation of activities. In some regions malaria and TB are departments, in others they are at the team level. We have no*

say on the structural relations between the regions and us. The regions say they are governments/states and have a say on what needs to be done in their regions. But you see disease is not regional, it is not even national. It is international. MOH respondent

4.1.3 Review Panel/Board

TB and malaria have their own technical review panels and HIV/AIDS has the National Review Board. Each panel/board has five members selected by the PR and endorsed by the CCM/E. Members work on a part-time basis and are financially remunerated for their services. Each panel/board assesses proposals for funding that are submitted by different bodies (government, NGOs, and others) and either approves or rejects the proposals. The review bodies do not meet on a regular basis.

Key informants complained about the fact that the panels/board do not meet regularly to decide on funding proposals, and that it takes a long time for a proposal to get a final response from the PR. Some key informants stated that proposals submitted by NGOs and the private sector to the country-level technical review panels could take up to a year before they received a final response. Some respondents suggested that there was preferential treatment for requests coming from government and NGOs, even if, sometimes, the money received may not be fully utilized.

4.1.4 Local Fund Agent

The LFA, which is based in Nairobi, was not perceived to be supportive of Ethiopian actors in their endeavors to implement GF grants.

4.2 GF Proposal Development and Planning Processes

This section discusses the GF planning processes. In principle, the GF requires that concerned government and non-government bodies actively participate in the proposal development and planning process.

The planning for early GF rounds was hampered by the short time frame between the call for proposals and the submission date, lack of previous experience in writing such proposals, lack of experience on the part of the GF Secretariat in structuring requests for proposals, and general confusion around what was needed.

The regions did not participate in the development of early proposals, the major reason given being shortage of time. The experts who prepared the proposals for HIV/AIDS, TB, and malaria used HSDP II as a point of reference in the selection of objectives and activities for those focal diseases. A key informant said:

The staff had a lot of pressure to meet the deadline and had to work round the clock. It was done on short notice. Information on GF came late. However, we learned a lot in the process. Our decision was to write the proposal and submit it although there were many things that we should have considered to make sure that the proposal reflects the needs of the regions. There was no time to consult them. Of course we made use of available experts at the center. We thought that meeting the

deadline was more important. We did not consult regions. This was a shortcoming…. However, the proposal we submitted was approved by GF. Then, we informed the regions. Some did complain that some of their needs were not addressed in the proposal. We based our work on the national health program and policy. We tried to address the national needs; of course, there are regional variations which could have been included, if we had consulted them. However, time was against us. For the subsequent planning we will include all stakeholders in the planning process. Moreover, now we know it very well and we know what we need to do in the next proposal. MOH official

Other key informants involved in the study thought that initial planning was done in too hasty a fashion. Some suggested that the allocation of most of the funds to the purchase of drugs and commodities was done in order to make planning quick and easy without considering the real pattern of needs or problems that might be encountered in procuring such drugs and commodities.

While some regional respondents believed that over time the degree of consultation between the center and the regions on GF activities (particularly proposals) had improved, this view was not universally held.

We were not invited to the initial planning of the GF. We only participated on the action plan. But we still feel that there should have been adequate time for planning so that the regions could have participated and included their needs and priorities in the plan... But there is lack of communication. We still are not communicating as to what needs to be done for the second plan year. We do not get clear guidelines as to what to do with GF; it is only suggestions. Many things are done at the center without the knowledge of the regions. We should have been asked what we think is needed, regionally and locally. Regional respondent

GF is centralized and we have no say on it apart from implementing the activities set in the action plan…We have no ownership or say on the fund. We do what we are asked to do. This has affected the effectiveness and quick implementation of the GF programs. Regional respondent

The additional GF demand for implementation of activities in a given time frame also has forced the center to sometimes take decisions on behalf of the regions.

It is clear that weak communication between the center and the regions has led to problems. (All regional respondents said that they were asked to implement what has been planned for them by the center, irrespective of their regional strategic plans.) In particular, the initial planning process entailed problems related to lack of proper budgeting of activities and costing of items. Budgets for regional strategic plans and the GF plan of action differed significantly, and, given GF rules, it was not easy to reallocate funds once regions got involved in planning and the differences became evident. The GF-supported plan for VCT, training of human resources, and development of IEC and behavior change communication (BCC) resources remains controversial:

In the action plan, we made comments. But the comments we made were not considered because the budget was earmarked for each activity selected at the center. This has affected the implementation of the plan, for we did not participate and we were only told to implement activities selected at the center. Regional official

We were not involved in the planning process of the GF. All things including writing the proposals were done at the Ministry of Health without adequate consultation with the regions. We were asked to prepare implementation plans when the GF was released. There are activities that we give priority, which are not included in the plan. There are activities budgeted that we do not need. For example, we do not need any budget for TOT (training of trainers) because we have trained enough trainers. We could have used the fund for training counselors... In addition, the GF is not flexible and it is earmarked. Regional official

GF is centralized. Planning is done at the center. We have not participated in the planning process. We are asked to implement activities, though the activities selected fit to our needs. Communication between the center and the region is inadequate and and really we do not know how the GF operates. We do what we are told to do… the activities did not include management expense and this is really a problem. The regional government budget is for salary of employees and not for the management of activities. Under GF, we have selected 30 weredas for implementing activities of HIV/AIDS. However, we are only able to reach three weredas. We are still using EMSAP funds in the other weredas. Regional official

4.3 Links to Broader Planning Processes and Other Ministries

The lack of knowledge on the part of MOFED respondents about the GF was quite striking. MOFED was initially represented on the CCM/E with the aim of ensuring that GF activities be part of the SDPRP. However, MOFED did not actively participate in CCM/E meetings and was later replaced. At the regional level, representatives of MOFED seemed indifferent to the GF and poorly informed.

There are potentially significant implications of this for the grant. The GF requires its grants to have an effect on the country's SDPRP, the three phases of which are based on the Millennium Development Goals (MDGs). HSDP II is envisaged as a part of the broader SDPRP. There are formal linkages between the GF plans, the HSDP II, and the SDPRP; however, there is little interaction and notably limited engagement in the GF-supported activities by stakeholders with broader interests in the SDPRP. Given that capacity is a major concern in the implementation of GF activities, one would have anticipated that the Ministry of Capacity Building would be viewed as a key partner; however, it is not involved in GF activities and is not a member of the CCM/E. While the SDPRP requires the linking and harmonization of activities across sectors in order to achieve MDGs, it is difficult to see any horizontal relation among sectors. In-depth interviews suggested that stakeholders outside of the health sector were uniformly poorly informed about GF activities.

4.4 Funding Channels and Financial Flows

In Ethiopia, external grants may be channeled in three different ways.

- Under Channel 1, the grant goes to the MOFED, which administers the grant as part of the government budget. MOFED also is involved in monitoring and evaluation, in collaboration with the source of funds and the implementing bodies.

- Under Channel 2, the grant goes directly to the receiving sector ministry (such as the MOH). It is an additional grant on top of government budget.

- Under Channel 3 the grant goes directly to implementers such as regions, NGOs, civil and private organizations. This channel makes the work of regions, NGOs and other civil societies easier and such organizations would prefer the Channel 3 funding route.

The GF grant uses Channel 2, with monies going directly to the concerned government actors, MOH, and NHAPCO. Apparently the GF Secretariat required this channel in order to speed up implementation. MOFED's only engagement in supporting the GF grant is in the use of banking services.

Respondents in several regions complained that financial disbursement was not done from the center as planned and agreed upon. Key informants explained:

> *The implementation level is slow….We are asking the MOH to send us the funds for the different activities we planned to be implemented with GF. We are not getting them and we are always informed that the funds and the commodities would be sent soon. But we have programs awaiting funds.* Regional health bureau official

> *The money promised to us is not coming as agreed upon. For VCT construction we have been promised Birr 340,000.00 but we received less than 100,000; for health post construction only Birr 40,000. I am not sure whether the source is GF or EMSAP; for TB we have received Birr 115,000.00. Overall the health implementation is weak. The funds for TB and HIV/AIDS do not arrive on time. Malaria seems to be given less attention. The GF is earmarked and is not flexible.* Regional respondent

Furthermore, during interviews, regional-level respondents expressed concerns about how GF grants are allocated among regions and the lack of transparency in this process.

> *There is no index for allocating GF resources. This has created tension and a sense of distrust.* Regional official

> *Now we do not know on what basis they are allocating the GF funds.* Regional official

For government funding, budgets for different regions are clearly identified and regional staff have authority over these budgets. However for GF-support there is no such transparency.

4.5 Harmonization

MOH officials universally were of the opinion that there were no problems in terms of harmonizing GF support, as opposed to certain other forms of support, with the government's own policies and priorities. However, donor representatives raised concerns about harmonization, particularly across different funding sources.

GF, PEPFAR and EMSAP are not integrated. From my perspective the benefits are less than the side effects when seen in relation to the way the funds are being administered. Disjointed operation of the funds results in a waste of money, time and energy. I believe that the MOH has to improve and be able to coordinate all the opportunities available to make the health delivery service satisfactory…. We are not represented in the CCM, we do not get information as to what is happening with the GF. I know that GF activities are planned in EMSAP weredas. There could be duplication of work. There is a problem of harmonization of grants and activities. Donor key informant

4.6 Additionality

The GF requires that the resources that it provides be additional, and not replace existing resources devoted to the three focal diseases and the health sector. According to officials interviewed at both the federal and regional level, in Ethiopia, GF resources are truly additional, as, to date, the government has dedicated a very minimal amount of its own resources to fight the three focal diseases:

Ethiopia is a poor country. To tell you the truth the three focal diseases have been run by funds raised from donors. There was no budget to reallocate to other health matters. MOH official

There is no shift of government budget because these diseases, although indicated as priorities in the health plan, were not adequately budgeted. They depend on donors for most activities. MOH official

With respect to replacement of donor funding, most respondents felt that donor support for the three focal diseases, but particularly HIV/AIDS, had increased during the recent past. The one partial exception to this was support that was previously received from a bilateral donor for the procurement of TB drugs. This support ceased with the advent of the GF grant, although the donor concerned continues to be active in the sector and has stated that it would in the future provide support for TB drugs if GF support became insecure.

4.7 Status of Implementation

4.7.1 HIV/AIDS

The Round 1 GF HIV/AIDS grant was signed in November 2003. The money began to arrive in April 2004, three months after the budget year began. The activities include "software" such as training and social mobilization and "hardware" such as procurement of drugs and commodities and building of VCT facilities.

The NHAPCO report on GF activities (NHAPCO 2005) sent to the GF for January 1, 2004 to December 31, 2004 shows that, while credible progress was made, implementation did not proceed exactly according to the action plan (see Box 4.2). Most of the activities conducted during 2004 related to procurement and training. The total funds disbursed during the 2004 budget year was US$

20,763,6054.30 out of the fund released from the GF US$ 21,344,497.00. The report details financial disbursement to regions, government bodies, NGOs, and civil societies.

Box 4.2. Summary of NHAPCO Achievements Reported to the GF for 2004

- VCT services – the plan was to construct 55 VCT centers in all parts of the country. However, most regions have not yet started construction. The referral network has not started. However, training has been successful, with over 90 percent achievement.
- Clinical management of HIV infection – 69 percent of the training target group was achieved, with regional variations.
- Community home-based care and support to PLWHA – achievement was over 60 percent.
- Expanding STI syndrome management – achievement was 73 percent.
- Expanding PMTCT services – over 86 percent professionals in target group were trained.
- Ensuring availability and accessibility of safe blood – 34 percent of the target group were trained.
- IEC/BCC – 80 percent of the target group received training.
- Strengthening national capacity to implement HIV/AIDS program five out of 12 professionals needed were recruited.
- Monitoring and evaluation – 21 percent of the target group received training.
- On procurement
- Drugs for opportunistic infections (US$ 469,343.18) – supplier has started to deliver.
- ARV drugs (US$ 2,072,440) – contract agreement signed and delivery is awaited
- Computers and photocopiers (US$ 676,389) – being distributed to regions.
- Vehicles and motorcycles (US$ 3,486,586.53) – being distributed to regions.
- Equipment and furniture (US$ 37,808) – being distributed to regions.

The regions also reported that the status of implementation in the soft programs is moving reasonably well and was mostly for HIV/AIDS. A key informant reports:

> *During the first round we received Birr 1,937,488.55 and we have 100 percent liquidation, more than 75 percent is required by the Global Fund to get the subsequent disbursement. For the second one, we have received Birr 1,590.000.00. The beneficiaries are government institutions, NGOs, nursing association and civil societies. The private for profit is involved in the training of counselors and promotion and HIV/AIDS advertisements. We have given more focus to grassroots structures such as Kebele, idirs (local associations), and civil societies working at that level. Hospitals namely Meneilik II, Ras Desta and Ghandi and Arada Health Center are implementing HIV/AIDS programs with Global Fund. We faced a problem in disbursing fund to hospitals because they did not have their bank account. Now, hospitals are administered by boards and are made to have bank accounts of their own; in the second round, we will send funds directly to their bank accounts, not to the health bureau.* Regional respondent

> *HIV/AIDS is moving reasonably well. We have received in cash Birr 1,797,968. 00 and we have effectively utilized the fund as per the activities indicated in the plan of action…. The budget for malaria and TB is mostly procurement and this is taking a*

lot of time…. On the training aspect, we are doing well. We have trained 163 professionals to work as VCT, ART and PMTCT providers. We have also trained in IEC/BCC, home-based care. We have trained 210 professionals in IEC/BCC, conducted two public meetings on HIV/AIDS/STI, published different IEC/BCC materials, about 22 types, bought IEC/BCC equipment such as TV, video deck and amplifiers, LCDs. We are now working on a documentary film. Regional respondent

However, in the approved grant for Round 4, almost all the funds are allocated to the purchase of ARV drugs, with some money assigned to strengthening institutional capacity and human resource development. Respondents thought that this presented particular challenges, especially given the existing ART services. As the quote below illustrates, success of the Round 4 grant will depend upon the ability of the PR to procure and distribute combinations of drugs in a timely manner. Availability of only some of the drugs in the regimen would completely undermine ART services.

There are obstacles to providing ARV services. The government distributed ARV drugs to some facilities like the Police Hospital and the Black Lion Hospital, but these are not complete. A PLWHA is expected to take three tablets for a complete medication, but what is being distributed is short of that. Health specialist

4.7.2 Tuberculosis

The situation with TB is different to that for HIV/AIDS; for TB there is an established structure with adequate human resources. Although there was delay in the first phase of implementation, implementation of TB activities has accelerated. The FMOH report (2005b) shows that the main activities carried under GF Round 1 include:

- Strengthening program management, supervision, and M&E and raise the capacity to conduct operational research in TB and TB/HIV.
- Effecting procurement of drugs, vehicles, computers; training general health workers and community DOTS providers
- Establishing an operational structure for TB/HIV collaborative activities.
- Increasing health facility DOTS coverage from 30 percent (2002) to 75 percent (2005). The report adds that inadequate access to services is still a major barrier to TB control. Thus TB case detection is 36 percent and treatment outcome is 75 percent, which are still below the acceptable levels.

Box 4.3 summarizes the latest progress report sent to the GF in March 2005.

Box 4.3. Achievement of TB Grant against Targets, as of March 2005

- Numbers of people receiving DOTS – 165,000 people were receiving DOTs against a target of 208,000 (although this is apparently partially due to late reporting by one region).
- Number of new smear positive pulmonary TB cases successfully treated – 41,000 cases achieved against a target of an additional 54,000 (again partly due to late reporting).
- Number of service providers trained in TB/HIV collaborative activities – 109 trained against 158 targeted.
- Number of newly diagnosed TB patients who are HIV positive – 163 identified against a target to identify 700.
- Number of newly diagnosed TB patients being treated with DOTS at the community level – the target of 500 new patients has been surpassed with 700 being treated.
- Number of community DOTS providers trained – the activity was delayed and none of the target 600 were trained.
- Number of additional people who received IEC on TB/HIV – 600,000 were targeted but the activity was not yet started due to delays in finalizing IEC materials.
- As planned, four operational research studies were supported, but due to delays, expenditure against this budget line has been low.

With more funding from the GF, the TB program in Ethiopia is intending to (FMOH 2005b):

- Strengthen TB prevention and control through expansion and improving quality of DOTS
- Promote HIV counseling and testing among TB patients and improve the treatment outcome of HIV-infected TB patients
- Strengthen political and community support through advocacy, communication, and social mobilization
- Incorporate programmatic aspects of TB control into pre-service curricula of health training institutions
- Increase capacity in operational research in TB and TB/HIV.

4.7.3 Malaria

Informants say that the malaria program is well established and that the needs of the program are clear. *The National Five Year Strategic Plan for Malaria Control in Ethiopia: 2001-2005* (FMOH 2000b) identified four main strategic approaches to malaria control and prevention (mainly disease management), selective vector control, epidemic prevention and control, and prevention and control of malaria in pregnancy. In addition the strategic plan identified human resource development, information system development, education and communication, operational research, and development of M&E capacity as supporting components to be achieved during the strategic plan.

With GF moneys, a considerable amount of training activity with respect to malaria has already taken place in the regions. But drugs to support clinical training were still missing at the time of early data collection. However, malaria, like TB, which has been lagging in implementation due to delay in

the procurement of drugs and commodities, was at the time of report writing (June 2005) beginning to increase the speed of implementation. The total amount of drugs, commodities, and other supplies distributed to all the regions of GFTAM malaria components is summarized in Annex A.

4.7.4 Procurement

Procurement has been a major problem and has slowed down implementation particularly during the earlier grant phases. The MOH's Pharmaceuticals Administration and Supply Services (PASS) has to do all the procurement for the three focal diseases. Ninety-two percent of TB and 85 percent of malaria GF moneys go to procurement of drugs and commodities. A key informant explains:

> *The implementation of malaria and TB activities has been delayed because of problems related to procurement. Almost all the fund goes to procurement: TB (92 percent) and malaria (85 percent). Only IV fluids have arrived so far. We are told that the other commodities are on their way. We do not know where they are.* MOH official

A regional official reflects on similar problems with procurement:

> *Overall, procurement is a problem. We have not received the ITNs [insecticide-treated nets]. We are settling people in malarious areas. Everything is left to PASS, and it does not have the capacity to meet the procurement demands of GF. The international situation also makes procurement sluggish. There is problem with the production of drugs. Some drugs have high demand and the companies producing such drugs cannot meet the demand on time. This has made procurement of drugs from abroad time consuming.* Regional respondent

The research team learned that some of the factors that delay procurement of drugs and commodities are outside of the control of the FMOH (and outside of the control of the country). Nevertheless, capacity constraints have also been an issue.

While GF procurement may be slow compared to work plans, one respondent compared it favorably with EMSAP procurement, suggesting that the process was accelerating:

> *When we see the implementation of GF in relation to EMSAP, it is really fast. We are now expecting the procured commodities to arrive here soon. It is only a year. If this happens, it is really fine. In EMSAP, even procurement used to take place more than two budget years. GF has clear reporting formats, indicators, and timetable as compared to EMSAP. It is essential that the Action Plan strictly follows what is approved by GF and this makes it more precise and quick, although the lack of flexibility could be a problem. Anyway, we have successfully liquidated the first two quarters and we are working on the third quarter.* Regional respondent

Procurement for GF-supported drugs and commodities, although problematic during the first phases of GF implementation, has picked up considerably and PASS has made significant changes and improvements (see Chapter 5) to cope with the challenge including improving its management systems and outsourcing procurement to local and international agencies and organizations.

4.8 Monitoring and Evaluation

All regions report that M&E as a whole is weak. At present M&E depends on reports, visits, and meetings. NHAPCO in consultation with the FMOH and bilateral and multilateral organizations have developed guidelines on M&E. A senior health specialist explains:

> *Monitoring and evaluating methods have been set up. There are input and output indicators. We ask the implementing bodies and wereda to submit reports on status of implementation. We evaluate them on the basis of time of implementation and on the content of the report. The problem is standardizing M&E. We helped HAPCO to prepare an M&E manual with technical assistance. HAPCO now is using the manual to evaluate implementation of the activities. We also use spot supervision at the place of implementation. We have monthly meeting with HAPCO. We discuss every issue on the meeting and unresolved questions are discussed in subsequent meetings.* Donor informant

Regions also stated that they typically used reports and visits to determine status on implementation of funds and GF activities. Regions report that they would use the M&E guide when it is ready:

> *HAPCO has proposed the framework for HIV/AIDS M&E. It is a national framework and we are going to follow that. Our M&E is based on site visits and reporting, as well as calling a meeting. We are now conducting a meeting of all wereda health officers to evaluate the implementation of activities. All in all M&E is based on selective supervision; review meeting conducted biannually and sometimes specific supervision. However, M&E is very weak. The surveillance system is also part of the evaluation of programs such as HIV/AIDS prevalence.* Regional official

> *The M&E is weak and we are working on it. It is based on the plan of action. We rely on reports. We make selective visits in the weredas and supervise the activities onsite. Evaluation would be done at the end of the plan year- that is when the fourth quarter is implemented. It follows the framework of the national M&E. Of course, there are indicators that are not relevant to our context and there are those that are missing and we would try to make specific considerations for our case in consultation with NHAPCO.* Regional official

Some respondents were concerned that, as the GF is often working in concert with, or at least in parallel with other sources of funding for HIV/AIDS, TB, and malaria, this would make it difficult to assess the impact of the GF alone. A more pressing concern perhaps, is how Ethiopia will demonstrate effective implementation of the GF grants when M&E appears so weak.

5. Findings 2: System-Wide Effects of the Global Fund

As described above, implementation of Global Fund-supported activities is still at a relatively early stage in Ethiopia. This section considers the evidence available, and opinions of respondents, regarding how the GF will impact upon the health system. Findings are presented according to the four main thematic areas of the study: (i) policies and programs, (ii) human resources for health, (iii) public/private mix, and (iv) pharmaceutical and commodity supply system.

5.1 Policies and Programs

As noted above, in principle, the GF-supported programs provide direct support to activities and plans already set out by the government in HSDP II and in the PRSP, and therefore GF-supported activities should closely match the government's own priorities. This was frequently stated by respondents, particularly federal-level officials, and the GF was commonly referred to as a "gap filling" opportunity.

> *In the PRSP, HIV/AIDS, TB, and malaria are pinpointed as diseases that have to be controlled in order to deal effectively with poverty. GF is a perfect fit. The HSDP II does focus on these three diseases. Thus, the GF activities do reflect the strategies in HSDP and SDPRP.* MOH official

> *Global Fund is a gap-filling opportunity. It is filling the gaps we have in implementing health programs in HIV/AIDS, malaria, and TB. These three diseases are priorities in our health program.* MOH official

However, there was not a full consensus among respondents that GF support fitted seamlessly into existing plans and priorities. In addition to the comments explored above about the centralized nature of GF support and lack of fit with regional or local plans, some respondents expressed concern about (i) the verticalization associated with GF support and (ii) weaknesses in government plans which meant that they were not a solid basis for guiding GF-supported activities. These two criticisms are explored here.

Several respondents expressed concern about the vertical nature of GF support:

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

The other thing is that the whole HIV/AIDS program is not integrated with other sectors. People speak of mainstreaming. This is not understood and has not started yet.…GF can be used to support integrated HIV/AIDS activities. Future planning of GF support needs to consider this. Regional official

At present the MOH focuses on vertical relations of the health service, not on an integrated delivery system at the level of the facility. If you use an integrated system to prevent malaria or HIV/AIDS you will succeed. But if you see from a vertical point of view you can't prevent those diseases. Mostly people see malaria or HIV/AIDS or TB programs separately, but they should be handled in the context of integrated health care. Donor representative

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

At present GF is giving support for HIV, malaria and TB separately but in my view it would have been better if it supports integrated health delivery. NGO/private sector respondent

While respondents were not always clear as to the underlying cause of the verticality which they perceived, it is probably at least partially attributable to the fact that the PRs are all national-level, disease-focused entities. In contrast to typical channels for financial disbursement, regional officers have relatively little say over the use of these funds, and the funds are tied to the three diseases.

Concerns about a rather vertical approach extended not just to the relationship between GF-supported activities and other health sector activities, but also to other sectors. While it is assumed that GF support will have positive impacts on poverty reduction and contribute to sustainable development, there were concerns that GF support had made HIV/AIDS activities more focused within the MOH. The country's multisectoral approach to HIV/AIDS involves mainstreaming as a basic strategy in HIV/AIDS prevention. GF-supported activities on HIV/AIDS do not appear in alignment with this strategy. Furthermore, since the initiation of the GF grants to Ethiopia, NHAPCO, which formerly reported directly to the prime minister's office and had a special status and mandate to encourage multisectoral approaches, has been brought back under the FMOH, although this change has not yet been made official. Concerns were also expressed that the roll-out of the ART program may reinforce this trend towards the "medicalization" of HIV/AIDS.

Secondly, while many respondents stated that the GF has been planned within the context of the national health policy, national health sector development program, and policy on HIV/AIDS, key informants questioned whether in practice these policies meant very much. For example, according to HSDP II, the health system takes NGOs and the private sector as part of the health development system. But there is a feeling that the MOH does not seriously consider private actors and NGOs as real partners in the health system. On the other hand, it should also be acknowledged that the private for-profit sector in particular is not well organized and this makes it difficult for it to be a strong partner. The GF grants have brought to the forefront the tension that exists between government and non-state actors – as has been reported elsewhere (Brugha et al. 2004).

The HSDP II also sees regional health bureaus as primary implementers of health activities who should identify their own needs and prepare strategic plans. However, as described in Chapter 4, the

strategic plans of regions were not considered in the planning process. The GF was perceived to have promoted a centralized system instead of reinforcing the government's policy of decentralization as expressed in the civil service reform program and HSDP.

Some respondents expressed strong views about the overall practicality of the plans and policies, which the GF is supposed to feed into. Informants stated that the health policy is ambitiously designed and difficult to implement, given the present capacity of MOH and other stakeholders. An informant reflects:

> *The reality and the policy plans do not match. When we think about the reality, only few Ethiopians can find a health facility within walking distance. I wonder if building health centers and hospitals without proper staff would improve the health delivery system. I think there is a big disconnection between the technical staff in MOH and the political leaders.* Donor, key informant

There are obvious weaknesses in the health system that need to be addressed so that GF support will be able to bring about the desired benefits. Informants expressed a range of views about how the GF may affect the health system.

> *No question GF will have strengthened our health system by the end of the grant period. We will have good laboratory facilities, the program in the three diseases will be implemented and the impact will be tremendous, the human resource requirement will be developed. The capacity of the country to control and prevent diseases will be significantly developed.* MOH official

A health specialist argued that the GF constitutes a big opportunity for the county. Government leaders have to act quickly and avoid a bureaucratic way of managing. Working within the existing system, which is time consuming, would make the GF more of a problem to such officials.

> *As far as I am concerned a system is something that is used to solve problems. But, the government, rather than using the system to solve problems, is very much concerned on sustaining existing bureaucratic procedures. Skipping such procedures would put an official in trouble. Thus the system does not encourage leaders to take initiative and make decisions.* Health specialist

This problem is exacerbated by the fact that some government officials fear that the GF may not be a reliable source of funding. They do not want to upset existing systems (such as hiring procedures) to scale up activities if there is a danger that the external support will not be maintained. However, a good system must be able to accommodate change in order to make use of new opportunities like the GF. The same respondent argued:

> *The major fear of government is getting funds for programs that may not be sustainable after the support comes to a finish. Definitely, there is a question of fund sustainability, but we should save the number of people that are dying today. Using any fund available to treat PLWHA would lower the infection rate...There should be a way that helps the system to develop and not to stand as it is. Otherwise, being concerned about the status quo, would bring no change.* Health specialist

5.2 Human Resources and Capacity Building

It is clear from all sources that Ethiopia has an extraordinarily weak base of human resources for health. In 2003, the physician population ratio was 1:34,000, which was five times lower than the average for sub-Saharan Africa (Kombe et al. 2005). Ethiopia has lost a significant number of its highly qualified staff to the private sector, NGOs, and bilateral and multilateral organizations, on top of those who left the country to work abroad. The scale-up of activities in HIV/AIDS, TB, and malaria will require large increases in the number of health providers if the GF is to be implemented as planned. This section explores early evidence regarding the human resource demands that GF-supported activities have placed on the health sector, and the kind of responses occurring. It should be stressed that, in many cases, implementation of activities in the field has not progressed very far, and that this is a preliminary assessment. The discussion is divided as follows: the first sub-section considers demands upon highly qualified managerial and technical staff needed to manage the planning and implementation of GF-supported activities, the following sub-section considers availability and demands upon regular health staff, and the third and fourth sub-sections consider responses to date.

5.2.1 Highly Skilled Technical and Managerial Staff

It is clear that GF support has placed a significant additional burden upon senior health staff.

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

> *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. The procurement head is responsible to manage about 28 subcontracts. The Purchasing and Logistic committee makes meetings every two weeks and they are expected to prepare a report. There is a tender committee organized from the staff in planning, law and audit department. Actually this is all the pressure of GF*. MOH official

Availing qualified human resource to execute GF plans has become a crucial problem. This problem arises from both the shortage of qualified personnel in the country and fears within government about the consequences of employing new people with better salaries paid for by GF grants.

> *GF is very slow. We have not implemented even the first two quarters of the first plan year. The main reason is the financial disbursement started late sometime last August. The second reason is lack of capacity. There is shortage of human resource and we could not employ new staff as per GF provision.* Regional official

Informants agreed that there were particular shortages of high-level human resources in the areas of planning, M&E, data and information processing systems, procurement and financial management as well as auditing. The huge amount of money from the GF creates work pressure in all these areas.

There are clearly defined processes for employing new staff on a short-term basis: vacancies are advertised, applicants submit their credentials, and a selection committee (where the PR is represented) does the screening and selection. So far, a limited number of professionals at the center

and in the regions have been employed with significantly higher salaries than what the government offers to its regular staff with the same qualification and skills. The center has hired five consultants to work at the center and the regions with a salary scale of up to Birr 7,000.[7] It has also hired two procurement officers and one accountant with a salary range of Birr 4,000-5,000. These salaries are approximately triple those of civil service employees with similar responsibilities and qualifications. HAPCO has hired staff mostly using EMSAP funds and some using the GF. Somali and Amhara regional HAPCOs have hired new staff in M&E, project coordinators, and financial managers with salaries ranging from Birr 3,500 to 6,000.

However, the government seems to be reluctant to employ new staff using higher salaries that can be paid from GF money. It fears, firstly, high turnover in the public sector as people migrate to better-paying consulting contracts, but also the sustainability of funds.

5.2.2 Regional-level Staffing Issues

At the regional level, human resource issues are perceived differently. Amahara region does not think human resources is a problem even with scale-up. Staff in the region state that both malaria and TB have enough staff and they are currently under-employed. The two programs are currently awaiting drug and commodity supplies. Addis Ababa, Oromia, and Somali regions stated that they faced shortages of human resources in the three focal diseases.

> *Due to lack of money some staff were not utilized, especially at regional levels. Now GF is making them busy.* MOH official

Particularly great concerns were expressed about the human resource implications for the effective scale-up of HIV/AIDS services. For scale-up of TB and malaria activities, there is an assumption that the prevailing structure and human resources can cope. However, it is possible that, as people learn of the new services and drugs available, the pressure on clinical services may be greater than anticipated.

Somali region, one of the least developed, has a chronic problem of human resources and capacity to implement programs and faces significantly greater problems than the other regions studied, as these two different regional voices explain:

> *We are focusing on building human resource especially in the health and education sectors. The Region has few hospitals and health centers. All of them are under-staffed. We have serious problem of health providers. The health posts are almost empty. There are 40 health posts without any heath provider and equipment. It is only the buildings standing. The infrastructure is poor. Some weredas are difficult to access. There is also security problem. Now, there is this idea of decentralization, the wereda being the focal point of government activities. But there is no human resource to work in these weredas. We started assigning people from the region to the weredas. Almost all left their jobs. The weredas have no facility to attract professionals or educated people.* Regional official

[7] IUS$= 8.7Birr

Human resource in health is a serious problem. More than 40 health posts are empty, no human resource assigned to them, just buildings. We have started training extension health workers, for a period of six months. The other problem is that salaries are not paid on time. We ask for experts, but they do not like to come here, even if they come we cannot provide the salary we promise them. Regional official

These human resource constraints in Somali appear to be delaying implementation; for example, the regional HAPCO has not employed focal persons in all the GF weredas and only three weredas out of 33 selected are actually implementing GF activities.

5.2.3 Systemic Factors Contributing to Human Resource Constraints

Donors, private organizations, and NGOs think that the problem of human resources in the government health system arises at least partly from poor management, lack of incentives, and poor working conditions.

MOH health professionals in key positions leave their jobs. Of course, MOH has shortage of other health providers, too. Nurses head most health centers. Shortage of human resource is there. But it is caused by the poor management system of MOH, for it doesn't create suitable conditions such as motivating its staff by giving incentives. It doesn't create attractive environment for others to come and work in the public institutions. These cause human resource shift from public health institutions to the private and international organizations. Health specialist

Another argument that respondents put forward was that the "verticalization" of the health system (as discussed in the previous section) contributes to the shortage of human resource and failure to make the best possible use of the resources that are available.

In addition, vertical programs cause human resource shift. For example: During polio campaign, many health providers shifted to give polio vaccine from EPI department. This made vaccination rate to become very low at that time. Thus, vertical programs encourage the shift of human resource from one service to the other. Donor respondent

5.2.4 Salary Top-ups and Staff Retention

To date, the number of professionals hired on GF support is small and unlikely to create any major concerns among staff about salary differentials. However, the question of how best to create financial incentives to retain good staff was a really thorny and hotly debated issue. There was a widespread perception that current government salaries were insufficient, and that, without addressing the issue of incentives, government would not be able to retain good staff to deliver GF-supported and other services.

Government is planning to give training for 3,000 health officers and 5,000 nurses. But they will shift to private institutions if government doesn't pay them a good salary. Private sector representative

This section summarizes some of the diverse views that the researchers heard about issues regarding salary top-ups, and staff motivation and retention.

MOH officials fear that as GF activities scale up, some health providers with more training and job experience may leave the public sector and seek employment in GF projects in order to secure better salaries. In areas that need specialized skills and knowledge, the MOH recommends the employment of consultants and contractual staff. An MOH official elaborates:

> *The hiring of a consultant at a rate of US$ 1000.00, which is about Birr 8,600.00 a month is possible with GF money. GF gives emphasis to the quick implementation of activities. Therefore, we can employ on contractual basis new staff at a rate acceptable to GF. We are now hiring consultants at a monthly pay of Birr 7,000.00 and procurement officers at a rate of Birr 4,500.00. These salaries are triple of the salaries of regular employees with similar qualifications and duties. We know that the disparity creates undesirable insinuation in that regular employees would like to leave their regular jobs and apply to work as consultants. We have these experiences. High-level medical professionals are asking for release from their regular jobs since the coming of GF was heralded. We have no any other option apart from hiring staff on short-term basis. There are departments that asked for top-ups of salaries of regular staff in the focal departments. We cannot allow this because it will create a huge discontent on staff working in other departments. If there is salary increment it has to be done nationally for all civil servants.* MOH official

Some officials think that it is time to revise the salaries of civil servants, especially of health providers and other higher professionals working in the public sector. They think that the country is not paying adequate salaries to professionals and, even given the state of the Ethiopian economy, could afford more.

> *The issue of salary is a serious problem. Government staff, especially health providers, are not paid according to the service they render. We are discussing this matter in our cabinet. We are trying to identify those who do more work and execute their responsibilities effectively and find mechanisms of rewarding them. We are aware that the working environment and the leadership need be examined and improved. We need salary increment, good management, and recognition mechanisms as incentives without making a huge salary change, a sort of bonus for good work done. We are discussing on ways of managing the civil service…. we recognize that the salaries of all health providers have to be revisited and improved. I believe that health providers are not paid even according to what the Ethiopian economy can offer. They are underpaid. But you should know that I am reflecting what I think. Things are not yet settled.* Regional official.

At the regional level, there were diverse opinions as to what were the best strategies to attract and retain staff. Some organizations in Addis Ababa followed the same strategy as articulated by the MOH:

> *We were asked to top up the salaries of staff involved in GF activities. However, we resisted this because it creates disparity and discomfort in staff that are working in other health services. We have very good staff in all the departments and if we top*

up salaries of those working on HIV/AIDS, malaria and TB, there will be a lot of dissatisfaction in our staff. If there is any top-up of salaries it must be for all. We want to employ new staff to run some of the additional activities. It is not yet decided. We have not employed new people yet. We need experts in data and information management. Regional official

However, another entity in Addis Ababa stated that it had to compete with big NGOs and international organizations if it were to hire new staff. This is difficult considering the government salary scale and accordingly respondents within this organization supported the top-up of salaries for focal staff who take on additional assignment to implement GF activities. The respondents believed that this would motivate staff to work more, stay in their job, and help prevent staff turnover.

The issue of human resource is a critical one. We are still debating it. I am of the opinion that we should not employ new staff for any project. We can use our existing staff… and top up their salaries. They can work efficiently if they are given such incentives. Employing a new staff means training new personnel that you lose them at the end of the project. It requires us to look for more offices and office furniture. I am still arguing on this point, but the Administration is insisting on employing new staff. The employment of new staff when compared to making top-up on salaries of staff is not economical…But I have experts in monitoring and evaluation, IEC/BCC, care and support. These are wonderful people in their fields and what I need is to engage these people in executing GF activities and top up their salaries. Regional official

In Oromia it was suggested that using GF money to strengthen the capacity of the existing staff by giving training and incentive and employing in positions that are vacant and that can not be filled with the internal staff would help in solving the human resource problems:

The GF has not reached the region as planned. We are anticipating that the activities identified in the GF need more human resource to implement them on time…what we need is to develop our regular staff by giving training and incentive. Consultancy work is short period and a gap is created when the consultant leaves. We cannot employ a consultant for longer period, for this creates dissatisfaction among regular staff with similar skills being paid almost one third of that of the consultant. I think creating incentive for regular staff is far better than depending on consultants. It may have disadvantages. It would be useful to retain highly skilled staff that also aspires to work as consultants by leaving their jobs. Regional official

Another entity in Oromia also suggested better salaries for new employees and top-up of salaries for existing staff working to implement GF activities. However, the regional government refused to accept the suggestions on salaries and employing new staff: An official explains:

We have hired very few, otherwise we agreed to top up salaries of existing staff working on GF. However, the regional government resisted any top-up of salaries. Initially, we wanted to employ one focal person for each wereda using GF fund with better salaries. However, the government used its budget for the employment of focal persons. Regional official

Some regions like Amhara and Somali have made top-ups of salaries of key staff in the head offices. Amhara has hired 166 middle-level personnel for its 83 weredas at a salary ranging between Birr 800-1200. All regions report that the employment of new staff and the salary offered to them did not affect the regular staff, in that the employment is temporary and has the provision of losing the job on the basis of one month's notice.

In Amhara, human resource strategies include (i) employment of new graduates, (ii) transfer of very efficient staff from those already employed, and (iii) top-up of salaries of most needed professionals, mainly health professionals working in public health facilities. Salaries paid from the GF grant are better than regular salaries. A technical advisor to a region can get up to Birr 6,000 a month, which is 2-3 times greater than the head of the office. A respondent in Amhara stated that the GF has to be implemented with maximum efficiency and as quickly as possible. He did not think salary differences would affect the system, since the best and most capable people are selected to implement the project. He also thought that very few people selected are existing employees and most are newly hired staff.

> *GF allows the employment of higher experts with a salary of up to Birr 7,000 and 8,000. The reason given for not allowing us to employ new staff is that the new salary would motivate government employees to leave their jobs and seek GF employment. We are asked to use existing staff to implement GF activities. We suggested a top-up of salaries of existing staff that are doing extra work. However, this was rejected. The regional board is against it. So, there is no new employment and no top-up of salaries. There is a big workload on us such as approving and reviewing proposals, monitoring and evaluating implementation of activities.* Regional official

In Somali, one regional organization has strengthened its capacity by employing experts with higher salaries and allowing top-ups of salaries of focal staff.

> *M&E is paid Birr 6,000, system specialist Birr 4,000, project appraisal officer Birr 3,500, data clerk Birr 2,000, regional health bureau GF officer Birr 3,500. But there is high risk in that the employment is at most one year, of course is renewable if there is the need and budges available. The regular staff may feel the salary differentials, but they know the risk one entails to work in a project. The focal staff have top-ups of their salaries.* Regional official

5.2.5 Staff Training

The MOH emphasizes the training of existing staff within the health system in order to be able to implement GF activities.

> *We are training doctors, nurses as counselors and on the management of ART. We are strengthening the management system of the services and we have to build capacity in this area. Training is an ongoing process and we have to respond to capacity demand in the process of GF implementation. We will continue to train focal persons for the three diseases working at different levels. We are shifting to new drugs for treatment of malaria, which also requires giving training in the*

administration of such new drugs. We also need to train health extension workers on sanitation and use of ITNs. MOH official

Ethiopia is trying to scale up its training of multiple cadres; nurses, health officers, laboratory technicians, and health extension workers. The private sector is also involved in the training of clinical nurses and laboratory technicians.

Scaling up of activities would not be a problem when it comes to human resource. We can avail the required human resource. We are expanding on the training of health professionals at all levels. We have health extension program workers, about 700 of them, who can help in the prevention of diseases. They are working at the grassroots. Other 3000 will graduate and are being prepared to work in the health extension package prepared for all kebeles in the region. When it comes to curative and treatment services we are training clinical nurses and doctors. We are encouraging the private health colleges to focus on the training of nurses and laboratory technicians… We run training programs to build the organizational and systemic capacity of institutions and the health sector is a beneficiary in this respect. Moreover, we try to help the private sector and civil organizations to develop their organizational and human resource capacity by organizing trainings and workshops. We have helped the regional hospital to improve the organizational capacity, for example. Regional official

Again, however, the situation in Somali was worse than that in other regions.

In terms of training, there is the Jijiga School of Health. It started as a school for training junior nurses. It used to accept about 60 candidates. Now, it is upgraded to a diploma because the training of junior nurses is abandoned nationally. Although it is upgraded to the College of Health Sciences, it is still the name with regards to equipment, teaching staff and facilities. The Health Bureau is giving a six-month training for health extension workers. I really do not know how this would address the problem we have. Regional official

The above data on human resources, as reflected by different informants, demonstrate the lack of shared understanding on how to deal with the issue. Since GF activities have not been scaled up as planned, the human resource problem is probably not yet fully felt. However, the lack of shared vision and strategy in tackling the problem of capacity and human resources leads to a situation where responses are spontaneous instead of being systemic and planned. Regional entities are already taking steps to address the human resource crisis, with only limited guidance and consultation with the center.

5.3 Public/Private Mix

As noted previously, the GF explicitly promotes approaches that encourage the participation of private sector actors, and requires that the private sector is represented on the CCM. In Ethiopia, HSDP II also states government's willingness to work with the private sector. However the interviews showed clearly that the relationship between public and private sectors was filled with tension and a degree of mistrust. Given the difference in perspectives on this issue between those working in

government and those working in the non-state sector, these perspectives are presented in two different sub-sections.

5.3.1 The Perception of NGO and Private For-Profit Respondents on the Public/Private Mix

Private sector informants largely welcome the impetus that the GF has given to working with the private sector, but say that given the history in the country it has proved very difficult to make this relationship work effectively.

> *GF wants government, NGOs, and private organizations to work together on HIV/AIDS…But the system is not as successful as expected because it is new to our country.* NGO/private sector respondent

> *The idea of GF to eradicate poverty by working together with different institutions was good. It doesn't succeed as expected, because the system is new to our country.* NGO/private sector respondent

Informants in the private sector (non-profit and for-profit) (and some donors) suggest that there is not much trust between the sectors. Their perception is that government believes that private sector actors will misuse funds and not implement activities as laid out in proposals.

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

> *There seems to be lack of trust particularly between NGOs and the government. Maybe some NGOs relate their activities to political processes in country: maybe some NGOs are blamed for misusing funds. Anyway the big problem of the public/private mix is lack of trust.* Donor representative

> *Government's negative attitude might be the main obstacle for lack of involving the private sector because they are blamed for squandering funds. When it comes to theory the Government says it is willing to involve the private sector, but this is not true.* NGO/private sector respondent

One informant stated that under EMSAP private entities performed well, while government was only able to implement 30 percent of the funds over a three-year period.

Private sector respondents were critical of the composition of the CCM saying that even though there was private sector representation on the CCM, NGOs had a very weak voice on the CCM (see 4.1.1). Apparently the NGO HIV forum has asked for membership in the CCM but to date has not received any response from the CCM.

Private sector respondents also questioned government's definition of NGOs, stating that those NGOs with which the government claims to be working are actually part of the political wing of the

government in power: youth associations, women associations, religious groups, and regional development associations, and not members of the Christian Relief and Development Association (CRDA).

The historical mistrust between public and private sectors in Ethiopia appears to have been exacerbated by misunderstanding over the amount of funding available under the GF and how these funds would be used. At an early consultative meeting, apparently it was stated that NGOs would get a 30 percent share of GF support. However, this did not conform with the proposal submitted, which dedicated a large share of resources to the procurement of drugs and commodities and therefore made it difficult to direct 30 percent of funding to NGOs.

NGOs also complained about the funding process under the GF. They stated that funds allocated to civil society were too small to make an impact or run programs for a reasonable period of time. Respondents cited instances of it taking more than a year for the private sector to get funding from NHAPCO, while government bodies could more readily get funds. Also the GF funding processes prohibited long-term activities because grants were awarded in a piecemeal fashion, and this made the GF an unreliable source of funding for private sector actors. Every six months NGOs had to report on funds spent and initiate new funding requests.

High staff turnover in the public sector also affects NGOs' partnerships with government. Joint programs agreed upon with the government get disrupted because the government fails to meet its commitments due to restructuring that takes place regularly, leading to staff turnover.

Private sector actors provided concrete examples of how they felt that poor public/private relations were damaging the implementation of programs:

> *I think that referring people to the government institutions for ARV treatment is discouraging PLWHA after they take the test in the NGOs or private clinics. …Government controls TB medicine but it is found in the market through contraband and sold at an expensive price. I think controlling TB medicine with a monopoly does not prevent TB.* NGO/private sector respondent

5.3.2 The Perception of Government Respondents on the Public/Private Mix

Government perceives that the major interest of the private sector is in HIV/AIDS and says that it is working closely with NGOs and private for-profit organizations in this area. While a few government respondents cast cautionary notes about working with non-state entities, saying that they were unreliable or focused only on money, most seemed to accept the necessity of working with the private and NGO sectors. HAPCO officials at the center and regional levels state that NGOs and civil society organizations are partners in the implementation of HIV/AIDS activities in prevention care and support to PLWHA. Moreover, PLWHA associations also work closely with HAPCO. Numerous examples from the regions illustrate this:

> *We have the public institutions…we have NGO-supported clinics and HIV/AIDS programs such as Hiwet HIV/AIDS protection that trains home-based care givers, we have ESAPSO that works on IEC/BCC, we have private for-profits like Africa Promotion that works on HIV/AIDS adverts and communications. We advertise activities and people submit proposals on the activities and we select the best*

proposal. We have also clients that have been working to our satisfaction and we give them some activities; these are the non-profit making privates (NGOs). Out of 230 activities, government institutions do 40 of them and the rest by NGOs civil societies, professional associations and privates. Regional official

The NGOS and civil societies still receive GF funds to run IEC/BCC activities. The private sector is involved in training and promotion activities, but very limited. At the initial stage we were asked to make all providers alert of the GF. However, the plan did not include all these stakeholders as promised. This has created conflict with NGOs in particular. The MOH is promising to include all stakeholders in the planning process for the next GF. Regional official

The private sector participates in the implementation of IEC/BCC activities, care and support such as orphan support programs. NGOs submit proposals and those selected get financial support from the office. However, GF is earmarked and is not as flexible like EMSAP. Therefore, it does not attract NGOs and other privates very much. CRDA has been complaining about the activities and the plan, but we cannot help it and we have to work according to the plan. Regional official

The last two quotations above suggest that part of the problem is a mismatch between expectations on the part of NGOs and private sector providers, and what is feasible under the GF grant. Another respondent also alluded to this problem.

Now people are opening up and are asking for help. GF has generated a big expectation. The mass media is propagating about GF. The people know about this and are insisting they get the help that is promised to them. Civil societies, NGOs, and interested groups would like to have money allocated to them from GF. On the other hand, the GF plan does not show this. There is a big uproar on the side of civil societies and NGOs. Regional official

The scenarios described above with regards to the public/private mix in the health system shows that there is no clear-cut description of the roles of all these stakeholders. Moreover, there seems to be a problem in defining what is an NGO. Government officials complained that CRDA only counts an entity as an NGO if it is a "CRDA member." While private sector actors criticize the political nature of some NGOs receiving support, government appears concerned that some NGOs have their own political agendas. The GF process has made this subtle issue underpinning public/private relations more apparent.

5.3.3 Subsidies for Drugs and Commodities and Implications for the Private Sector

In Ethiopia, unlike some other countries, the private for-profit sector has not historically been involved in HIV/AIDS, TB, and malaria. Very few private clinics have started offering VCT services. The government manages TB programs. Malaria activities are almost entirely run by the government, although some private pharmacies sell malaria drugs. Accordingly, informants in the private sector did not think they would be affected by GF subsidy to drugs and treatment for HIV/AIDS, malaria,

and TB. Some private health facilities engaged in VCT are being subsidized by NHAPCO to run their programs.

> *As far as drugs are concerned, the private sector would be receiving drugs from HAPCO that should be given free of charge to clients; of course, such private facilities have to qualify to be able to administer ART. We have some already; St Gabriel Hospital and Beta Zata get funds from HAPCO. We can pay them the management fee, but we are aiming at availing drugs free to clients, especially the poor. In our plan, we have considered 12 rental VCTs hoping the private would apply, but no one has submitted any application so far."* HAPCO official.

Amhara region reports that the GF would not affect the private for-profit sector through drug subsidies.

> *ART is going to be free and the private sector is not involved in this service and it would not be affected. If treatment for opportunistic infectious is free, this may affect the private sector…The private sector as such is not involved in TB and not really significant in malaria treatment. Our major worry is that, if drugs are made free and if ITN is given free, people may not take them seriously. We are suggesting that there should be nominal payment at least to ensure commitment. For those that are absolutely poor, we can give them freely.* Regional official

The effect that the subsidization of drugs and other commodities would have on the private for-profit sector does not seem to be a serious issue for the moment. However, if the subsidy is to include the purchase of antibiotics (which looks inevitable, as treatment of opportunistic infections entails the taking of antibiotics) the impact may be far greater than anticipated, and this would affect private importers, drug distributors, and retailers.

5.4 Drugs and Commodities Supply System

GF monies are mainly seen as resources to fill the logistical gaps in the health program. Globally, more than 50 percent of the monies are allocated for the purchase of drugs and commodities. In Ethiopia, 85 percent of TB and malaria funds are requested for the purchase of drugs and commodities, and the fourth round HIV/AIDS grant has a very large allocation to ARVs. Central and regional officials agree that the GF thus represents an opportunity to strengthen the drug supply systems.

Informants in government and NGOs agree that procuring large quantities of GF drugs and commodities is a major undertaking, with bureaucratic and other obstacles. PASS, in charge of procurement of supplies and commodities for the MOH, is assigned to implementing this huge task. While the GF action plan stated that all procurement for the first plan year be accomplished within six months, PASS was neither well prepared nor equipped to do so. PASS has limited human resources and depends on external staff to help it in the bidding stages, especially in preparing specifications and evaluating bids. This has delayed the processing of bid documents, invitation for bids, evaluation of bids, transporting of drugs and commodities from ports to inland, and distributing such drugs and commodities to regions.

5.4.1 Effects of Delay in Procurement on GF Activities

Slow procurement processes have created considerable problems for the timely implementation of the GF program in Ethiopia.

> *Procurement is taking time and it looks that we may not implement our activities according to our five-year plan. For example, we have not received the fourth quarter disbursement of US$ 517,000.00 for TB of the first year. The disbursement for the second year, US$ 3,944,600.00, should have started now. We have asked GF Geneva to send us the money of the fourth quarter of the first year and that of the second year. But it refused because we have not achieved 75 percent liquidation of the first year. The reason is that the commodities that are procured have not reached here to show our balance of our financial use and prepare statement of expenditure. The same applies to malaria. The fourth disbursement is US$ 2,291,442.00 and the disbursement for the second year is US$ 17,71,980.00. The money is still in the custody of GF. We could not ask for its release because we could not release a statement of expenditure due to delays in procurement.* MOH official

Oromia and Somali regions report that delay in the procurement of drugs and commodities has affected their activities greatly. The Somali Regional Health Bureau also complains that procurement at MOH is not transparent. The MOH does not report to the region on how much it has purchased and at the time of the interviews no commodities had yet arrived.

Some informants believe that problems are at least partially due to lack of innovative thinking about how to accelerate the procurement. For example, PASS could have involved other agencies to facilitate the process; instead, it keeps control.

> *The problem with procurement is related to lack of a system and leadership that lends itself to innovative ideas where procurement could be involving different stakeholders. PASS may be in charge of processing the bid document and evaluation of the bids presented after being announced. The other activities should be given to other stakeholders with experience in the purchase of drugs and commodities. There are international organizations, local companies that can help in locating sources of drugs and commodities, transport drugs and commodities from the ports and distribute such products to the regions. At present PASS is doing all these things with limited human resource and experience.* NGO/private sector respondent

Government informants, however, report that it is difficult to find reliable partners in procurement, citing problems like misuse of money by contracting agencies and companies they have used in the past. A regional official explains:

> *We have serious problems with procurement and contractors. Purchasing is a big problem. Let alone for a huge amount of money as the GF, even with small amount of money procurement remains a problem. We give training in supply management. But the graduates are not employed. We can train procurement officers and people with related professions. But still the problem of procurement would not be easily dealt with. For example, people suggest outsourcing. It is possible that people who do not have the capacity can apply to be subcontracted to do procurement. But it is money and it has to be dealt carefully. It is really difficult to get a reliable*

procurement company. You see, we have problems with contractors who are delaying finishing of work they agreed to do in a given time because they do not have the capacity. Some even disappear. We lost about Birr 3 million in such a deal. If there were established companies we could outsource them to do procurement. Because of the free market, many companies get formed and soon disappear. There are a lot of problems with newly formed companies. One cannot outsource to such companies. But, I still believe that we have to do something to address the problem of procurement. Regional official

5.4.2 PASS's Experience with GF Procurement

PASS has been overburdened with the procurement of GF-funded drugs and commodities. PASS has learned that the action plan for procuring commodities and drugs within six months was misconceived. International competitive bidding takes more than a year.

However, PASS reports to have developed a new system for making procurement fast and effective. It has started outsourcing and giving bids to companies, and bilateral and multilateral organizations to procure drugs and commodities. It has outsourced WHO to purchase drugs and will allow regions to procure their own office furniture. It is involving other companies in the purchase of other commodities. However, GF regulations that require all pharmaceutical manufacturers to meet Good Manufacturing Practice standards have prevented PASS from purchasing drugs locally.

According to recent discussions with PASS, drugs and commodities are now arriving. TB and malaria drugs are in stock and are awaiting redistribution to the regions. About 80 percent of the procurement costs have been paid. Amhara and Harare region have started receiving pickup cars and the rest are available in the central garage.

Regarding Coartem, from the assigned US$ 1.8 million, we already have received US$ 1.2 million, which is about two thirds. For malaria, we use direct procurement. But the company we contracted had a problem and this delayed the arrival of commodities ordered. We already have opened LC. The commodities are still in Djibouti. We are now planning to shift to WHO…. The purchase of equipments for HIV/AIDS was delayed because of GF requirements and lack of knowledge on the specifications of commodities to be purchased. 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 equipment was our responsibility. We had to hire experts from EHNRI to help us with the specification of HIV medical equipment and all these took time. At present, we are distributing reagents to the regions. Furniture and vehicles are bought locally. Thus, everything is prepared for 2005. We now have changed the procurement strategy. Regarding ARV, we contracted UNICEF to deliver the drugs every three months. MOH official

The GF challenge stimulated the MOH to be more responsive and look for innovative procedures to speed up procurement. Decision-making has been reported to have become faster. The Director of PASS says that the procurement process has improved significantly.

> *Now, we have learnt that we should outsource procurement. We are now focusing on management and controlling the process and on subcontracting potential organizations to do the purchasing of drugs and commodities for us. In this way, we will be able to procure drugs and commodities for 2005 on time.* MOH official

The management of PASS also has considerably improved. The office has employed three additional staff using GF salary: one for pharmaceuticals, another for motor vehicles, and the remaining person for computers/furniture and miscellaneous items. Other units within PASS, such as storage and logistics, believe that they have been neglected because of the recent GF emphasis on procurement. PASS leadership sees a positive side to this however, stating that the PASS director has learned to delegate responsibility better.

While it seems that the GF has stimulated the FMOH to improve its procurement performance, all the recent improvements are also addressed in the Civil Service Reform. The problem was lack of understanding and inability to run the system already in place.

> *GF is now alerting the leadership about quick decision making, and the system has started to become responsive. GF has also brought awareness changes and sensitization. ...Now, we are accountable for any failure…If GF had not come, the weakness of our system would not have been tested and we would not have developed the present capacity we have now established: we have hired new staff, we have learnt to delegate responsibility and speed up work, our computer system is now well established.* MOH official

6. Findings from the Baseline Facility and Provider Survey

6.1 Introduction

As noted in Chapter 3, the primary benefit of the facility and provider survey will be apparent once the follow-up survey has been conducted, and it will be possible to assess how the new funds for HIV/AIDS, TB, and malaria have affected service availability, staffing, drug availability, management, and service use at the facility level. This chapter provides some selected highlights from the facility survey, largely so that the reader can appreciate what this data source will be able to show once the study is complete.

Sixty health facilities at the primary care level were included in the survey (see Table 3.1). The facilities included 21 government health centers, 25 government clinics/health posts, and 15 private clinics.

The health provider section of the survey included 335 respondents, of which 35.5 percent were in Oromia, 33.7 percent in Amhara, 24 percent in Addis Ababa, and 6.6 percent in Somali regional state. Of them, 58.8 percent worked in health centers, 41.2 percent in health posts and clinics. Seventy-one percent work in government facilities, 17.9 percent in private for-profit and 11 percent in non-profit NGOs. Regarding gender, 51.3 percent are male and 48.7 percent female. Ninety-four percent have permanent positions and 6 percent work on a temporary basis.

6.2 Facility Survey Findings

6.2.1 Facility Infrastructure and Staffing

Eighty percent have electricity supply, 75 percent use piped water, 83.3 percent have waiting rooms, 93.3 percent have toilets for clients, and 57.1 percent use incinerators to dispose of waste. However, 75 percent do not have generators to use if the central electricity supply fails.

Table 6.1 shows mean and median staffing numbers by cadre and type of health facility. It is clear that private facilities typically have more physicians than government facilities, which rely more on health offices and nursing staff.

Table 6.1. Mean and Median Numbers of Staff by Cadre and Type of Facility

	Health center	Health post/clinic	Private facility (for-profit & NGO)
Physician	0.76/0	0/0	3.67/1
Health officer	0.90/1	0/0	0/0
Staff nurses	2.05/1	0.29/0	1.6/1
Clinical nurses	2.14/2	0.96/1	0.67/0
Midwives	1.29/1	0.25/0	0.6/0
N	21	24	15

Note: '0' are included in the calculation of means.

There is a formal system for reviewing management or administrative issues at 88.3 percent of the facilities: 60 percent use a suggestion box, 15 percent use client surveys, and 28 percent conduct client interviews. Forty percent of the facilities had made changes on the basis of client opinion.

External supervisory visits were made to 93.3 percent of facilities during the last six months. In 69 percent of these cases, it was stated that the visit of the supervisor concerned a particular service at the facility: 51.2 percent of supervisory visits focused on child health, 19.5 percent on HIV/AIDS, 26.8 percent on TB, 19.5 percent on malaria, 12.2 percent on family planning, and 31.7 percent on maternal health.

Sixty percent of the health facilities (primarily health centers and private facilities) have laboratory facilities. Of these laboratory facilities, 91.7 percent can administer blood tests for malaria, 86.1 percent sputum tests for TB, 75 percent blood tests for HIV, 94.4 percent stool tests for parasitomology, 77.8 percent hematology tests, 50 percent serology tests, 80.6 percent urinalyses, 27.8 percent pregnancy tests, 19.4 percent bacteriology tests. However, few facilities had good records of the number of test provided during the last three months.

All facilities charged fees for curative consultation services.

Of the 60 facilities surveyed, only two private NGO facilities apparently received any financial support from the Global Fund and none of the facilities were aware of receiving any benefits in kind (drugs, vehicles, bednets, training, etc.) from the GF. None of the facilities stated that they had received financial support or support in kind from MAP or PEPFAR. These findings may indicate that the facility survey was conducted before external resources for HIV/AIDS arrived; it may also be possible that these facilities had actually received support from one of the funds, but, as it came via government, they were unaware that it was not government financed.

6.2.2 Services Offered

Only 30 percent of surveyed facilities offered inpatient care or were able to observe patients overnight and the average number of beds was small (8.4). Table 6.2 shows the percentage of facilities offering different types of services. Preventive and priority services are generally more available in public than private facilities.

Table 6.2. Range of Services Available in Study Facilities

% of facilities offering service	Health center	Clinic/ health post	Private	All facilities
Curative inpatient	57.1	0	40.0	30.0
HIV/AIDS services				
VCT	85.7	4.2	53.3	45.4
TB dx and treatment	95.2	91.7	80/0	90.0
Palliative care management	52.4	50	60	53.5
Dx and treatment of opportunistic infections	100.0	75.0	93.3	88.3
PMTCT counseling	61.4	58.3	46.6	50.6
PMTCT	57.1	45.8	40.0	48.3
Pyscho-social services	95.2	62.5	86.7	80.0
Counseling/training HBC	47.6	50.0	53.3	50.0
Other priority services				
Consultation for sick child	95.2	100.0	80.0	93.3
Growth monitoring	95.2	91.7	53.3	83.3
Child immunization	100.0	95.8	26.7	80.0
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	75.0	93.3	88.3
N	21	24	15	60

Priority services are available at least five days a week (see Table 6.3).

Table 6.3. Mean Number of Days per Week for which Priority Services were Available

Priority services provided at facility	Mean number of days per week
1. Child health	
1.1 Consultation for sick child (N=56)	5.54
1.2 Growth monitoring/promotion (N=50)	5.22
1.3 Child immunization (N=47)	4.77
2. Family planning (N=54)	5.13
3. Maternal health services	
3.1 Antenatal care (N=56)	5.23

Table 6.4 shows the number of visits for different types of services by type of facility.

Table 6.4. Utilization of Focal and Non-focal Services in Study Facilities

Number of visits	Health center	Clinic/ health post	Private
No. of visits by children	4237	1622	3090
No. of visits by adult	23529	22271	9449
No. of visits for TB	17253	2335	3544
No. of visits for malaria	3556	847	983
No. of visits for VCT	991	1719	2416

In terms of the pharmaceutical supply system, 93.2 percent of facilities get drugs from government and 25.4 percent get them from the private for-profit sector. Government facilities tend to get drugs from government whereas private providers procure from both government and private sources. Sixty-one percent of facilities determine their own needs and decide on order of supplies. Most facilities (61.1 percent) order medication every three months.

Table 6.5 shows the availability of selected drugs in the study facilities. As can be seen, stock-outs are prevalent across all drugs types and all facilities, but particularly in the public sector.

Table 6.5. Drug Stock-outs in Study Facilities

Item	% facilities with stock-outs during past 6 months			% facilities currently without drug		
	Health center	Clinic/ health post	Private	Health center	Clinic/ health post	Private
Oral pill w/estrogn	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
DPT	21.7	8.1	10.0	4.3	2.7	10.0
Measles and dilutant	8.7	5.4	NA	4.3	8.1	10.0
Amoxicillin oral	47.8	45.9	10.0	8.7	13.5	NA
Chloroquine oral	26.1	13.5	10.0	17.4	2.7	10.0
Cotrimoxazole oral	30.4	35.1	NA	4.3	21.6	NA
Iron with folic acid	30.4	32.4	10.0	8.7	16.2	NA
Mebendazole oral	26.1	35.1	NA	4.3	24.3	NA
Metronidiazole (FLAGYL)	17.4	40.5	NA	4.3	32.4	NA
Paracetamol oral	47.8	35.1	NA	NA	18.9	NA
Sulphadoxine/pyrimethamine (FANSIDAR) oral	26.1	10.8	NA	4.3	5.4	NA
Oral rehydration salts	13.0	32.4	20.0	8.7	27.0	10.0
Tetracycline ointment	8.7	21.6	10.0	4.3	13.5	NA
Benzathine brnzyl pen Inj. (IM) OR (Procaine pen IM)	43.5	35.1	NA	17.4	27.0	NA
Ergometrine/oxytoxin injection	4.3	21.6	10.0	NA	13.5	NA
Dextrose and saline	13.0	16.2	10.0	4.3	10.8	10.0

Protocols/guidelines for reproductive health, syndromic diagnosis and treatment of STIs and IMCI (Integrated Management of Childhood Illnesses) are available in less than 35 percent of the facilities and, for PMTCT, in less than 15 percent of the facilities.

6.3 Provider Survey Findings

Staff responding to the provider survey stated that, on average, they work 178 hours per month. The average number of hours worked was similar across government health centers (mean hours worked = 176.5), government clinics (mean hours worked 178.0), and private facilities (mean hours worked 181.2) – although the impression of the research team was that workloads are lightest at government clinics.

Table 6.6 shows the percentage of individual providers who said that they are involved in different types of service delivery, and their estimate as to how much time, on average, was spent on different types of services. Besides the category "other," the three types of services that took up most time were general outpatient, child health, and maternal health.

Table 6.6. Types of Service, Percentage of Providers Involved, and Average Number of Hours Served in a Month

Type of service	% of providers offering service	Average number of hours served in one month (each)
General outpatient	32.2	30.5
General inpatient	11.6	6.6
Child health	30.4	17.3
Maternal health	29.3	14.8
Family planning	26.9	12.7
STI counseling	7.8	1.2
STI testing	9.9	2.7
HIV/AIDS testing	9.9	5.4
HIV/AIDS counseling	9.3	4.3
Malaria prevention and care	8.7	2.7
Outreach services	15.8	4.1
TB care	13.4	7.3
Other services at facility	60.3	68.0
Average total number of hours worked	100	178.1

The provider section of the survey included questions on training. The data show that the number of staff receiving training on different health services remains low. The three topics on which providers received the highest number of hours of training are maternal health, HIV/AIDS counseling, and child health. Table 6.7 shows the percentages of staff trained in different health-related services and the duration of training.

Table 6.7. Percentage of Staff Receiving Training during Past Year and Duration of Training by Service

Service	% of staff receiving training	Average duration of training (days)
Maternal health	4.2	14.9
HIV/AIDS counseling	10.4	12.4
Child health	8.4	9.5
Family planning	6.3	9.2
HIV/AIDS testing	9.0	6.5
STI counseling	3.0	5.3
STI testing	2.4	5.6
TB care	4.8	5.6
Malaria prevention	6.0	4.1
General outpatient	0.6	10.5
General inpatient	0.3	5
N	335	335

Regarding supervision, the majority (52.5 percent) say that supervisors are based at facility and 69.9 percent say they receive feedback from supervisors.

A majority of providers like their work: 74.9 percent agree that the facilities where they work have a good reputation in the community; 58.5 percent say that they were proud to get a job in the facility; 44.2 percent are proud to work at the facilities; and 71.3 percent express pride in the services they render to the community.

More than 93 percent (93.3) say are confident in their abilities to do the job they are assigned to do; 81.2 percent say they are able to cope with the challenges they face at work. But only 43.3 percent say that things at work are going the way they would like them to be.

Regarding salary compensation, 71.3 percent of provider staff think that they are not paid according to the service they render to the community; 55.2 percent think that the pay, nevertheless, is adequate as compared to the pay in other jobs; 67.8 percent think that the pay they get is not adequate to cover their basic needs; and 63.3 percent say they worry if they are able to meet their family needs. The majority of the respondents (over 60 percent) complain that the lack of medical supplies and equipment prevents them from rendering quality service to the community.

Fewer than 1 percent say that they get additional income by working in private clinics and other private areas to supplement their salaries.

Providers suggested the following actions to motivate staff to offer better and quality services:

i. Facility-related: improve supply of drugs and lab equipments, employ more staff, upgrade facilities with rooms for each service such as delivery rooms and VCT facilities, improve sanitation, and upgrade management skills of facility leaders.

ii. Provider-related: increase salary, training, and opportunities; develop and use incentive mechanisms.

The facility and provider surveys are only briefly presented in this report. Once the follow-up survey is conducted it will be possible to see the impact of the GF and other HIV/AIDS financing initiatives on the services delivered at the primary care level.

7. Discussion and Recommendations

7.1 Discussion

Although the earliest Global Fund grants were signed over two years ago, GF-supported activities in Ethiopia are still in the early stages of implementation. The findings of the SWEF study will be more conclusive once further follow-up data collection is completed in early 2006. However, the GF is a rapidly evolving entity, and actors on the ground in Ethiopia are also constantly adapting their strategy and way of working in order to respond to the challenges that the GF has placed upon them. In this quickly unfolding context, it is important to provide feedback and draw conclusions as findings become available rather than wait for the completion of the study.

To date, much of the action around the GF has taken place at relatively high levels of the health system: federal- and regional-level actors have been involved in applying for funds, developing the work program, procuring drugs and commodities, and determining how best to proceed with implementation. It would appear that little has changed at the peripheral level of the health system. Accordingly many of the findings reported here relate to higher levels.

While it is too early to see effects – positive or negative – upon the broader health system, this report suggests that the GF is already revealing underlying weaknesses in the health system including: lack of experience and tools for managing public/private sector relations, limited human resources for health, complex and perhaps overly bureaucratic procurement systems, and tensions in the relationship between federal-level actors and decentralized entities. Many of these issues are already known in Ethiopia – and Ethiopia shares many of these problems with other countries on the continent. The four principal themes of the study (policy processes, public/private mix, human resources, and systems for procuring and distributing drugs and other commodities) seem to reflect well the main concerns held by stakeholders in Ethiopia.

Principal recipients, the CCM/E and the MOH have already been challenged by the pressures of implementing GF-supported activities and have done much to respond to these challenges. Their task is made more complex by structural transformation within Ethiopia, such as decentralization and plans to reconfigure the number of levels and types of facilities within the public health system. This final section of the report provides suggestions as to what type of strategies and actions could be pursued by key stakeholders in Ethiopia in order to respond to the issues identified in the body of the text. These suggestions require further discussion and elaboration by the key actors.

The Global Fund, together with PEPFAR and EMSAP, other global health initiatives, and, more broadly still, the international community's desire to scale up effective health services, present a major opportunity for the Ethiopian government and the people of Ethiopia. The big challenge is how to make use of this opportunity, not only to scale up service delivery rapidly but also to build lasting institutions and capacities, such as the following:

i. Strengthened leadership at all levels of the health system

ii. Effective mechanisms for mobilizing both public and private stakeholders to achieve health goals

iii. Improved accountability of both public and private actors – both directly to civil society and through governance structures (as indicated in the policy of decentralization and the civil service reform)

iv. Harmonized efforts by multiple development partners in order to ensure complementary activities

v. Strengthened human resources for health, with adequate, equitably distributed, and effectively motivated personnel

vi. Efficient and transparent procurement mechanisms.

There is currently immense pressure upon the key individuals and organizations in Ethiopia to deliver rapid results on GF-supported programs. There is a danger that this pressure for timely implementation prevents more strategic consideration of obstacles and challenges. The suggestions below may help stakeholders consider the broader picture and move the Ethiopian health system closer to the goals articulated above.

7.2 Recommendations

i. Promoting participation and ownership by stakeholders at the regional and sub-regional level

The GF has exposed the existing tension between centralization and decentralization in the health system. Although shortage of time was a reason for not involving the regions and other decentralized stakeholders in the planning process, concerns were voiced that the GF continues to operate in a very centralized manner. This centralized approach has contributed to a lack of ownership and a feeling of indifference on the part of some key regional stakeholders, as well as concrete problems in terms of implementation.

The centralization of the GF process has also contributed to the verticality of GF planning and implementation, making it more project oriented in approach rather than being well integrated into existing workplans and processes. It is important for the country that the GF be planned in such a way that it positively impacts other health services such as broader reproductive health, and maternal and child health.

Finally, lack of transparency about how GF resources are allocated among regions is also contributing to a sense of suspicion and distrust.

- Even greater efforts need to be made in the future to consult with, engage, and communicate with decentralized stakeholders in the GF.

- The CCM/E and PRs need to make it clear how decisions are being made about how to allocate GF resources among regions and communicate this clearly to regional staff.

ii. Creating greater clarity and consensus on public and private roles

If the public/private mix is to work as the GF envisages, there is a need to revisit the roles and responsibilities of private actors (non-profit and for-profit) in the health sector. There is currently no shared understanding of the strengths and weaknesses of different types of actors: NGOs believe they are more effective and work closely with the people, whereas the government believes that working with private sector actors can be risky as they may put their interests ahead of those of the public. Sometimes there seems to be some subtle politics going on that hinders coordinated and harmonized work. Underlying this situation is a problem of lack of trust between government and non-state actors.

There is a need to create clearer understandings between the sub-sectors and work on clearly articulated and defined roles, responsibilities for non-governmental organizations and private for-profit organizations as development partners in the health sector. Government has an important role to play in terms of creating an enabling environment for private sector actors while exercising sufficient regulation of such actors to protect consumer rights. The relationship needs to be legal, procedural, and non-political. Open discussion and debate about these issues might also help build trust between the sectors.

Problems of lack of trust have been exacerbated by poor communication between those involved in the GF and private sector actors interested in the GF.

- Develop an organizational development process to create greater understanding on the part of all parties as to roles for public and private sectors.

iii. Strengthening the role and composition of the CCM/E

The CCM/E currently is perceived to be a body with somewhat narrow influence within the broader national health system architecture. The CCM/E is in a difficult position – although it is a structure required by the GF, it appears to have limited power and no clear position within the national architecture. This is increasingly recognized as a problem for CCMs throughout the world.

The CCM/E clearly has a role to play in promoting the harmonization of GF plans with national and donor plans and policies. We suggest that the CCM/E needs to be strengthened so that it can help ensure that GF activities fit into and support national plans and policies, as articulated in the civil service reform program and the policy of decentralization.

To be effective, the CCM/E cannot derive its power solely from the government actors who sit on the committee. It needs to derive its authority from the composition and legitimacy of its membership, as well as its effectiveness in overseeing large amounts of resources.

- We suggest that the CCM/E broaden its membership to include additional members from the regions and key non-state actors.

- We also suggest that the roles of the CCM/E, PRs, regions, and implementing agencies be revisited, so as to ensure that they are clearly defined and harmonized.

- The CCM/E could play an important role in promoting greater communication and exchange between different stakeholders involved in the GF. By pro-actively linking to ministries outside of the health sector, regional stakeholders, and civil society actors, including the media, the CCM/E could assert itself and promote greater awareness and transparency about the GF.

iv. Strengthening leadership and management skills

To date, implementation of GF-supported activities has depended largely upon the commitment and hard work of a relatively small number of high-level health sector staff. In some cases, their energy and enthusiasm has led to reforms, which will undoubtedly strengthen the sector and facilitate GF implementation. However, for effective roll-out of GF-supported activities, a broader change in the work culture of the health sector is needed. Risk-averse, rule-bound approaches must be replaced by greater entrepreneurism. Staff at all levels need to be motivated and given the necessary management skills to ensure quick and effective implementation of GF-supported activities.

- Serious investment must be made in developing a management cadre within the public health sector, at both federal and regional levels, to build a larger and stronger group of skilled professionals with responsibility for planning and implementing GF-supported and other programs. This should be viewed as an integral part of the process of scaling up.

- Furthermore this management training should address not only the skills needed to ensure efficient and timely implementation but also aspects of work culture that inhibit effectiveness.

v. Creating more understanding and more exchange about GF

The information gathered shows that officers at different levels have still not understood how to work with the GF, and, on the part of key stakeholders (such as the Ministry of Finance and Economic Development) there is indifference. NGOs, bilateral and multilateral organizations, and heads of public health facilities reported that they have no or only vague ideas about what is happening under GF-supported programs. Referral hospitals have heard of the GF from the media although they run programs in the three GF focal diseases. Informants typically stated that there were few opportunities for sharing experiences about the GF. Without more exchange among all the stakeholders involved in the GF (and other HIV/AIDS initiatives), successful implementation is unlikely to occur.

- Despite the concern about excessive meetings, the interview data reveals a real need to promote more exchange. The CCM/E should explore means to promote such exchange, in an efficient manner, among the broad group of stakeholders involved in the GF and related programs. While workshops may be one options, newsletters, a website, and regular media briefings should also be considered.

As well as engaging a broader range of actors in communication, there is also a need to improve communication within government leadership and with the GF Secretariat. PRs complain of communication problems with GF Geneva. Most communications require accessing the Internet. This is not easy for PRs to work with. They suggest face-to-face communication on a regular basis to enhance understanding and better ways of doing the work of the GF, in addition to other channels of communication. The “light touch” to which the GF Secretariat has aspired, has proved to be a handicap in the timely and effective implementation of the Ethiopian grants.

- The GF Secretariat should be requested to enhance its ability to conduct face-to-face communication with GF actors within Ethiopia.

vi. Building a Strategy for Human Resources

At all levels of the public service, decision makers are puzzling as to how best to attract and retain staff, particularly the highly skilled staff needed to implement GF grants. Regions and different institutions are experimenting with top-ups and short-term contracts. Government needs over the course of the next year or two to put in place a more comprehensive human resource strategy that addresses not just the need for larger numbers of health workers, but also the complex question of how best to manage and motivate staff. The various experiments which now occurring in the field need close monitoring so that the country can learn which strategies work best.

- The government should consider developing a comprehensive human resource strategy that covers not just the number of health staff needed to scale up service delivery, but also how such staff can best be motivated and retained.

The GF Round 4 focuses on ART. This requires a large number of trained health providers, counselors, and health educators. The funding allocated to human resource training is limited compared to the amount of money allocated to the purchase of drugs. If possible this balance of funding needs to be shifted so that more money can be invested in the scarce human resources in the country.

- The CCM/E and NHAPCO should review the GF Round 4 grant to ensure that there is an appropriate balance between funding for pharmaceuticals and for human resource training, bearing in mind the significant shortage of skilled human resources in Ethiopia.

vii. Strengthening M&E

In general, informants were of the opinion that M&E for the GF was extremely weak; however, this was not directly attributable to the nature of GF support, but rather underlying weaknesses in the country's monitoring and evaluation system.

- Given the performance related nature of the GF grant, higher priority needs to be given to rolling out the M&E approaches that have been developed, within the Three Ones framework.

viii. Building on the lessons learned

All the various actors involved in the GF processes to date have learned lessons. For example, PASS is now in a better position to meet its responsibilities and has become one of the more dynamic departments within the MOH: it has started to outsource procurement and share responsibility, and is exploring what is available in the local market. NHAPCO has learned lessons on the management of items to be purchased, prioritizing of activities, and flexible use of the GF. Both MOH and HAPCO think that their GF-supported activities in the 2005 budget year and subsequent budget years will show marked improvements.

- A brainstorming workshop, perhaps using some of the findings of this report, should be used to help stakeholders recognize (and celebrate) the achievements so far, and share lessons learned. Such workshops need not focus exclusively on the GF but could productively also reflect on MAP and PEPFAR experiences.

7.3 Next Steps

The study team organized a dissemination workshop to share baseline findings with a broad set of national- and sub-national-level stakeholders in Ethiopia in October 2005. The workshop provided an opportunity for wider discussion of the study findings, and dialogue about the implications of the findings for future efforts in Ethiopia. A brief summary of the workshop outcomes is provided in Annex B.

Follow-up SWEF research is planned in Ethiopia, allowing for more in-depth consideration of systemwide changes related to the influx of resources from the GF. This will enable comparative analysis, and assessment of the impacts upon utilization for non-focal disease services such as immunizations or family planning, pressures on health workers, and resource availability. Findings and final reports from this study will be available in mid-2006.

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

Annex A. Malaria Commodities and Supplies Distributed to the Regions as of March 2005

i. Commodities and products

- ICT (immunochromatographic test), 192,000 tests
- Micro slides, frosted (tropical), 5,000 packs.
- Gloves, latex, box of 50 pieces, 1,000 boxes
- Blood lancets, box of 200 pieces, 3,000 boxes
- Differential counter, 58 pieces
- Cotton roll of 500g.B.P. 232 rolls

ii. Drugs

- Chloroquine 150 mg base, tin of 1,000tabs, 113,3000 tins
- Chloroquine syrup, 195 ml bottle, box of 200, 10,400 bottles
- Paracitamol, 500 mg, tin of 1,000 tabs, 44,889 tins
- Quinine, 300 mg base, tin of 1,000 tabs, 25,860 tins
- Quinine, 300 mg base, box of 100 ampules, 150,000 boxes
- 50% dextrose, 50 ml, box of 25 vials, 10,340 boxes
- Giemsa powder, bottle of 25g, 115
- Glycerol (neutral anhydrous), bottle of 500 ml, 114 bottles
- Methanol, A.R., jar of 25 liter, 115 jars
- 75% ethanol, jar of liter, 350 jars
- Immersion oil, bottle of 100 ml, 115 bottles

iii. Equipment

- Microscope binocular, 100

- Laptop computer complex set with printers, 80
- Portable colorimetric minilabs for one health facility per region, 8
- Vehicle single cab pickup truck, 55
- Motorcycles for health posts, health stations, and health centers in 87 priority districts, 870.

iv. Amount of ACT (Coartem) distributed to regions (March 2005)

- Coartem 4x6 (10289x30), 308,670 treatment doses
- Coartem 3x6 (2052 x30), 61,560 treatment doses
- Coartem 2x6 (3984x30), 45,360 treatment doses
- Coartem 1x6 (1512x30), 45,360 treatment doses.

Total= 535,110 treatment doses

Annex B. Workshop Notes

Research on the Systemwide Effects of the Global Fund (SWEF) in Ethiopia Dissemination Workshop

October 11-12, 2005

Summary of Proceedings

A dissemination workshop involving over 80 participants from the Federal Ministry of Health, regional health and HAPCO bureaus, representatives of the private and NGO sectors and bilateral and multilateral organizations was held from October 11-12, 2005, at the Ghion Hotel in Addis Ababa, Ethiopia.

The objectives of the workshop were:

- To disseminate the findings and observations of the baseline study on the system wide effect of the GF in Ethiopia and inform stakeholders of the opportunities and constraints of GF in the health system;
- To deliberate on the findings and recommendations made in the study and decide on what needs to be done next;
- To open an opportunity for identifying areas of focus in the follow-up study and what needs to be done both from the program and research points of view.

The workshop was designed to assure that participants would play an important role in generating ideas on the basis of the research findings and their experiences in working with the GF. Thus the presentations are followed by question-and-answer sessions and small group work on key areas identified in the discussion. The sequence of workshop activities was organized as follows:

- Presentation of research findings by researchers and discussions happened first.
- Discussion groups were organized according to research themes and participants conducted in-depth discussion and presented their views and recommendations in a subsequent plenary session;
- Panelists representing the government, bilateral-multilateral, FMOH, regions and civil societies were selected for a discussion on the second day of the workshop
- Groups were formed on the basis of the key themes that came out from the panel discussion and they discussed the themes in-depth and presented their views and recommendations.

The workshop started with an opening speech by the current head of Planning and Programming of FMOH, representing the then Minister of State for FMOH. In his address, he stressed that the FMOH is expanding its health services in the rural and urban areas focusing on prevention. The GF is a great opportunity to help MOH and other stakeholders to implement HSDP. He thanked the effort made by the research team and organizations and USAID for funding the study and the dissemination workshop, which he described to be as important and timely.

Following the opening speech of the FMOH representative, the researchers presented their key findings on the systemwide effect of the GF focusing on the four key areas of study: (i) Policy (ii) human resource (iii) public/private mix and (iv) procurement of pharmaceuticals and commodities

and a summary from the facility survey describing prevailing conditions of health facilities included in the survey. The presentations were followed by questions and comments. Groups were formed according to the four research themes to give participants the opportunity to reflect more and to forward recommendations on the basis of both the research findings and discussions that followed. On the following day, the panelists focused on the four themes focused on in the study because they themes to be key issues for the health system. They also forwarded suggestions on what could be done with GF to help strengthen the health system. The participants forwarded comments and questions to each panelist. Discussion groups were organized according to themes drawn from the panelists' remarks. A fifth theme came from participants. The themes are: (i) the planning process of GF; (ii) the human resource needs; (iii) the public/private mix; (iv) the procurement of pharmaceuticals and commodities; and, (v) the use of the GF to mainstream Gender and HIV/AIDS. The summaries of the points and issues that came out from the discussions and group presentations are given below by theme.

Policy and Planning

1. Processes

- Participants agreed with the baseline study that GF planning was done under time pressure and did not adequately involve stakeholders as desired. The strategic plans and management of regions were not considered. In the future, GF planning should involve all stakeholders including implementing sub regions. However, the participants said that the proposals reflect HSDP and SDPRP priorities. HIV/AIDS, malaria, and TB are priorities in both programs. Still, GF planning has to be "MDG-ized" (i.e., made consistent with the Millenium Development Goals planning process).

- They said that HSDP program has various fora to make the planning of GF participatory and reflective of the needs of the health system. Stakeholders are represented in these fora and can make use of the fora to influence the planning process and make it multi-sectoral and more participatory and harmonized. Bilateral and multilateral organizations are well represented. The findings would be useful for raising the issues in these fora.

2. GF structures

- CCM/E is an opportunity for the government, the private sector, and bilateral and multilateral organizations to deliberate together on health issues of the country. They, nevertheless, stressed that CCM/E should be connected with the regions and be able to make site visits to see implantation of GF activities. CCM/E has to be strengthened. But it is not a "rubber stamp" body. It is still active in its own right.

- PRs have problems of capacity. All agree that the capacity of PRs need be strengthened with highly skilled personnel and resources.

- The technical review panels have problems as addressed in the baseline study. The selection and composition of the technical review panel should be revisited.

- The local fund agent (LFA) although stationed in Nairobi, is not a problem as it used to be at the initial stage of GF implementation, and should continue its work.

3. Monitoring and evaluation

M&E has been mentioned as an overarching problem in the health system. It was reported that there was a problem of human resources, absence of or unknown M&E framework, absence of uniform formats for M&E, lack of knowledge and promotion of GF, fragmented reporting. Participants suggested:

- Reorganizing the system of information management so that uniform indictors can be used at regional, federal levels including donors;
- Strengthening capacity of onsite supervision and promoting supportive supervision;
- Giving timely feedback on activities monitored and evaluated to implementers and policy makers and donors and strengthening reporting systems;
- Promoting positive attitude towards M&E and reporting - this requires making stakeholders understand that M&E is for the benefit of all. GF does not give technical support. The MOH and stakeholders should work together to devise and use effective M&E mechanisms that lead to the generation of effective reports.

Human Resources

Human resource and capacity is a major problem in the health system. Thus,

- Human resource development strategy of MOH needs a complete revision by including issues of staff retention, attraction, and development;
- Different mechanisms must be sought that GF could use to address retention, attraction, and development of human resource at different levels, especially with experts that have specialized training and professional skills. Such an endeavor can look into:
  - Salary improvement on regular basis;
  - Use of GF funds to give incentives for staff members involved in extra activities to implement GF activities;
  - Free access to post exposure prophylaxis of health providers working in HIV/AIDS and other communicable diseases;
  - The need to examine regional variations and working conditions to give salary compensation according to hardships and working environments;
  - The need to have a career structure; the right to be transferred after serving for some years in one area; creating opportunities for training and education through giving scholarship, distance education, on-the-job training and not limiting the aspiration of staff to achieve higher aspirations in their education;
  - Fringe benefits consistent with those provided to individuals who return to their country from abroad (buying goods like cars free of tax; access to loans, safety and insurance; etc.);

- Putting a mechanism in place for the regular assessment of human resource and staff needs. In doing so, the experience of countries in the same socio-economic level should be considered.
- GF funds should be used for for capacity building, particularly of human resources. In addition, working conditions at facilities need to improved with GF monies.

Public/private Mix

Participants agreed that the public/private mix in the health system is a new experience and that the presence of representatives of the private sector at the CCM/E level is an achievement in the public and private mix for which credit GF should be credited. All agreed that GF has given opportunity to the private sector to be involved in the implementation of HIV/AIDS activities in the regions.

All agreed that the private sector is generally weak and it has just started involving in the health development sector. A work relationship based on transparency, accountability, and efficiency needs to be considered to build trust between the public and the private sector in order to strengthen the public/private mix. Participants suggested the following:

- The government should give equal recognition of the private and public sectors;
- Barriers that hinder public private partnership should be identified and dealt with;
- The government should give incentives to the private sector to involve in the health system such as allowing it to purchase commodities free of tax;
- There should be clear terms of reference and areas of work and accountability of the private sector;
- There should networking both vertically and horizontally of the public/private mix;
- The community has to be aware of the need of the public/private mix in order to create an environment for better understanding. Both CCM and the PRs have to ensure that the private sector is a partner in GF planning and implementation.

Procurement of Pharmaceuticals and Commodities

The challenges for procurement are: (i) lack of expertise during specification both at FMOH as well as at the regions; (ii) absence of workable logistic management system from a health facility up to FMOH; (iii) global scarcity of drugs (ARV, for example) and longer time needed to get drugs from international suppliers. Representatives of bilateral and multilateral reported that they are working closely with MOH to develop the capacity and management of procurement of pharmaceuticals and commodities. Participants agreed that the FMOH should improve the procurement processes and build the capacity of PASS.

Other Issues

- The need to develop the data management and reporting system has been mentioned as an area of inquiry by itself in connection to system strengthening. It has been reported that the

MOH is working on it and is assisted by a specialist hired by the Italian government.

- The gender and HIV/AIDS mainstreaming is suggested to be an area worthy of discussion by itself. Participants agreed that Gender mainstreaming should be strengthened with GF funds if the health system is to be strengthened. A feeling was aired that women should be represented in the CCM/E. GF should be used in the alleviation of female vulnerability, to assure access to reproductive health, PMTCT, and to promote women's sexual and reproductive health rights. Amhara region reported that considerable activities on gender are being supported by the GF.

Way Forward

- Participants said that the research report should be taken seriously by all stakeholders to address the issues raised. It is very important that further studies focus on the key issues: policy/program, human resource, public/private mix, and procurement of pharmaceuticals and commodities.

- MOH experts and regions said that the report has enlightened then with the issues that affect GF implementation. "It was more than a dissemination workshop," remarked a senior expert of FMOH. They all said that they would work on the recommendations put forward in the baseline study and the suggestions made by workshop participants.

- Regions and private sectors reported that their problems have been reflected in the report. The workshop has created opportunities for deliberation and clarification on GF and its implementation activities. They agreed to do their level best to enhance communication and sharing of ideas on GF matters and other related health matters.

- Participants said that such a study should be done regularly and inform stakeholders on the situation. This study as it stands is a baseline. It cannot assess impact. Since research is a continuous process the work has to continue to see the impact of the GF on the health system. They said:

    - Future studies should give due emphasis to efficient utilization of the fund with a multi-sectoral approach and involving stakeholders such as PLHA. TB and malaria victims.
    - Studies should give special attention to access to testing and ART and stigma.
    - More harmonization of donor funds is important in the context of Ethiopia, and future studies should give feedback to GF Geneva to think of harmonization GF with other funds. The issue of verticalization and harmonization needs to be explored more in future studies.

The workshop was closed by head of the FMOH TB section, who remarkd that "the workshop was more than a dissemination workshop." It was educative and ferreted out the problems in GF planning and implementation. FMOH experts, he said, would take the document as a reference in their deliberations on the fund and would collaborate with the researchers in the follow-up studies.

Annex C: References

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