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Benin: System-Wide Effects of the Global Fund: Interim Findings

July 2005

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Abstract

This paper reports on interim findings from research conducted in Benin on the system-wide effects of the Global Fund (SWEF). SWEF is a collaborative research network that seeks to understand how monies being disbursed by the Global Fund affect the broader health systems of recipient countries.

The main objective of the report has been to provide an overview of key interactions between Global Fund activities and the health system in Benin at an interim stage, with the aim of informing several potential audiences in Benin, at the Global Fund, and in the broader donor community.

Findings highlight several areas of concern, such as gaps in the knowledge and participation of key health system stakeholders with respect to Global Fund activities; a lack of harmonization between Global Fund activities and existing policies on decentralization and cost recovery; and parallel systems for procurement of bed-nets and anti-retrovirals. Several positive effects on the system were also noted, such as the creation of many new public/private partnerships, as well as Global Fund training activities and infrastructure strengthening that are benefiting other health priorities beyond the three focal diseases.

The findings presented here are preliminary, and will be developed further through follow-up research as Global Fund activities are implemented further in Benin.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
CAME	*Centrale d'Achat des Médicaments Essentiels* (National Medical Stores)
CCM	Country Coordinating Mechanism
CFA	*Communauté Financière d'Afrique*
CIPEC	*Centres d'informations et de prise en charge* (Information and treatment centers for HIV/AIDS)
GDP	Gross Domestic Product
GF	Global Fund
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide-Treated Net
MAP	Multi-country AIDS Program (World Bank)
MoH	Ministry of Health
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHR*plus*	Partners for Health Reform*plus* project
PSI	Population Services International
ROBS	*Réseau des organisations non-gouvernementales béninoises de santé* (Network of Health NGOs in Benin)
SWAp	Sector-Wide Approach
SWEF	System Wide Effects of the Global Fund
TB	Tuberculosis
UNAIDS	Joint United Nations Program for HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

This paper reports on interim findings from research conducted in Benin on the system-wide effects of the Global Fund (SWEF). SWEF is a collaborative research network that seeks to understand how monies being disbursed by the Global Fund (GF) affect the broader health care systems of recipient countries. This is an important area for research in view of the magnitude of GF resources relative to national health budgets, the weaknesses of many of the health systems that are implementing GF activities, and the responsibility of those systems for other health priorities besides HIV/AIDS, tuberculosis (TB), and malaria.

While research is ongoing, the purpose of this report is to share results from Benin at an interim stage. These can be used to derive lessons for several audiences, including stakeholders in Benin, the Global Fund Board and Secretariat, and the broader donor community. Benin is one of nine countries participating in this research effort.

The report draws largely on in-depth interviews conducted with key actors in Global Fund implementation and the broader health sector. A draft was presented to stakeholders in Benin on March 29, 2005, and the comments and feedback received have been incorporated in this version. The results highlight important questions to be addressed as GF activities move forward in Benin, and when combined with other SWEF country experiences they offer an initial body of evidence on a largely unstudied issue.

Drawing on the common research protocol developed as a basis for all SWEF country studies, the report focuses on issues such as knowledge, participation, process, and policy in the context of GF activities, as well as the GF's effect on the health system with respect to financing, the public/private mix, human resources, and pharmaceutical systems.

Discussions revealed that specific knowledge of the Global Fund is not widespread within the health sector. In the Ministry of Health (MoH) there are actors who otherwise play key crosscutting health system roles who are not familiar with the GF and its activities in Benin. Certain others were knowledgeable about the GF despite having little involvement, perhaps in part because they were aware that they were not playing the same roles for the GF that they would normally play in the broader health system. The Country Coordinating Mechanism (CCM, or *Comité National de Coordination*) has broadened participation by bringing new actors to the table, although translating this representation into influence remains a challenge. Outside the government, many for-profit private sector stakeholders were not familiar with the GF.

Several respondents emphasized the pressure that they face in achieving rapid scale-up of activities and adhering to reporting requirements. Difficulties with respect to ensuring knowledge and participation among broader health system stakeholders may be a reflection of the pressure and complexity that the GF process imposes on those responsible for implementation.

Alignment of GF activities with existing health sector policies such as decentralization and cost recovery was also explored. Several respondents in the public sector at the national level believed that the GF was working in line with the decentralization policy, but the examples they provided were

only marginally related to decentralization. At the sub-national level, there was less agreement that GF processes were consistent with decentralization policies. Meanwhile, the cost recovery policy for insecticide-treated nets procured by the GF is not aligned with the usual policy, as a different price is charged and revenues are returned to the national program instead of being re-invested at the health facility. Nevertheless, there are plans for a harmonization of prices and policies, indicating that decision makers are aware of this issue.

On the issue of health financing, GF activities have raised the overall budget for health spending in Benin by about 15 percent. There was a range of opinions with respect to whether GF financing was additional to existing government and donor budgets for AIDS, TB, and malaria, or whether some reallocations could be made. Some MoH officials commented that there had not been any change in funding due to the arrival of the GF. While some budget reductions had taken place, these were applied to all sectors due to lower government revenues. All MoH respondents agreed that, hypothetically, if there had been no strings attached to GF money, they would not have spent this funding exclusively on AIDS, TB, and malaria.

Program officials viewed the impact of the GF on their funding from the national budget as an area of concern, but more emphasis was placed on the belief of certain program officials that specific international donors had reduced their funding level in Benin due to the GF. In practice, of course, it is very difficult to establish the counterfactual (what would happen to financial allocations if the GF were not present). But it did emerge that MoH and program respondents did not have the same perspective on the concept of additionality, and that the GF's policy had not been clarified to stakeholders.

With respect to public/private partnerships, several respondents in both the government and non-governmental organization (NGO) sectors viewed the impact of the GF very positively. Many stated that the range of actors and especially activities in which NGOs were participating in the health sector had grown considerably, and this had been beneficial. NGOs have acquired new competencies through the various seminars and trainings as part of their GF participation and this would be valuable to their non-GF work as well. In contrast, the private for-profit sector had very little involvement in GF activities.

On the effect of the GF on human resources, both positive and negative trends were cited. Many respondents believed that the GF has caused a significant increase in the burden on currently available human resources at the program management level, and this was affecting their non-GF work. However, the low involvement by MoH officials in the GF meant that their workload had not been significantly affected by the arrival of these additional resources. Most respondents did not believe that the burden on providers would change substantially, although one provider interviewed had been overwhelmed with activities financed by the GF.

While most training activities were considered to be quite specific to GF activities, some GF training programs also have applicability beyond the three focal diseases – that is, positive system-wide effects. An important example is the use of GF money for malaria to fund training of providers for Integrated Management of Childhood Illnesses. One respondent believed that there had been some missed opportunities to use GF money in a similar way in order to provide training in generic skills such as monitoring and evaluation, which could benefit the whole system.

A large number of respondents noted that the GF had provided the supporting infrastructure and equipment that health workers needed to better perform their duties. Specifically, many cited the motorcycles purchased by the TB program for supervision activities and the microscopes for district

hospitals as examples of GF expenditures that would enhance capacity beyond AIDS, TB, and malaria.

With regard to the effects of the GF on the pharmaceutical and commodity system, the major issue cited was the decision to bypass the national medical stores and procure anti-retroviral (ARV) drugs and bed-nets directly through UNICEF and Population Services International (PSI). Some respondents believed this would improve the speed and reliability of the procurement process, while others considered it to be unsustainable. The importation of a large quantity of bed-nets was also viewed as potentially damaging to the local private sector, which imports and markets bed-nets.

In sum, respondents highlighted a number of areas of concern regarding the effects of the GF on the health system in Benin, such as relatively weak knowledge and participation by key actors at the Ministry of Health; an insufficient harmonization with existing policies on decentralization and cost recovery; and a parallel system for procurement of ARVs and bed-nets. These challenges may reflect the pressure that many respondents have felt to show immediate results. The apparent trade-off between rapid implementation on one hand and harmonization and sustainability on the other is an important issue for discussion as Benin's GF activities move forward.

Many positive effects on the system were also noted, such as increased means and opportunities for the three programs to implement activities, the creation of many new public/private partnerships, training activities that embrace other health priorities, and the purchase of equipment that can be shared by health workers engaged in activities outside the three focal diseases. Future applications for GF grants may be able to incorporate similar system-strengthening activities.

1. Introduction

In recent years there has been a rapid increase in international commitments of resources to address global health priorities such as HIV/AIDS and malaria. Among the new mechanisms for financing these efforts are the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria (GF), the U.S. President's Emergency Plan for AIDS Relief (also known as the Emergncy Plan, and PEPFAR), and the World Bank's Multi-country AIDS Program (MAP). These resources hold the promise of saving lives among some of the most disadvantaged populations in the world, and are clearly a welcome contribution to the fight against these epidemics.

It is less clear, however, how best this money should be spent in order to have the greatest impact. In some countries the three financing sources listed above are providing a larger source of funding than the entire annual public health budget. Also, the funding is for disease-specific interventions that must often be implemented in the context of weak health systems. These systems are also responsible for addressing many other health priorities in addition to the three focal diseases, such as maternal and child health. Moreover, to be sustainable in the long run, GF interventions will require well-functioning health systems. The impact of these new funding mechanisms on health systems in low-income countries is therefore an important topic for study.

This paper reports on interim findings from research conducted in Benin on the system-wide effects of the Global Fund (SWEF). SWEF is a collaborative research network, composed of research organizations in the South and in the North. The SWEF research seeks to understand how monies being disbursed by the Global Fund affect the broader health systems of recipient countries. The SWEF network is committed to addressing these difficult policy questions in a timely, empirical, and objective manner that is sensitive to the complex policy environment within which initiatives such as the Global Fund are operating.[1] The network was launched in 2003, following consultations with the Global Fund Secretariat and other international stakeholders. A workshop was organized for country researchers, and a common research protocol was developed to serve as a starting point for research in all countries. The countries implementing part or all of this protocol are Benin, Ethiopia, Georgia, Malawi, Mozambique, Nicaragua, Tanzania, Uganda, and Zambia.

The purpose of this report is to share research results from Benin at an interim stage. These can be used to derive lessons for several audiences, including:

- Stakeholders in Benin, so as to inform policies and implementation strategies for GF-supported activities;
- The Global Fund Board and Secretariat, so as to help improve GF processes and guidelines in order to ensure that Global Fund-supported activities enhance broader health care systems; and
- The broader donor and global community regarding how best to channel efforts to scale up

[1] Further information about SWEF is available at http://www.phrplus.org/swef.php

substantially the assault upon AIDS, TB and malaria and other diseases of poverty in low- and middle-income countries.

The report is structured as follows. Section 2 provides some background on the Global Fund in Benin and SWEF research methods in the country to-date. Section 3 reports preliminary findings on knowledge, participation, process, and policy as they relate to the GF activities and the health system. Section 4 discusses preliminary impressions on the effects of the Global Fund on the health system with regard to financing, human resources, the public/private mix, and drugs and commodities. Section 5 briefly covers issues of sustainability and institutionalization. Section 6 concludes.

2. Background And Methods

Benin is located in West Africa and shares borders with Nigeria, Niger, Burkina Faso, and Togo. It has a population of about 7 million people and its gross domestic product (GDP) per capita is under US$300. The annual public sector health budget is about US$40 million, or US$6 per capita. Administratively the health sector in Benin consists of 12 departments and 34 health districts *(zones sanitaires)*. In addition to the GF (described in more detail below), Benin is the recipient of a World Bank Multi-country HIV/AIDS Program grant for US$23 million over four years. It does not receive any U.S. President's Emergency Plan for AIDS Relief spending, nor does it implement a sector-wide approach (SWAp). The prevalence rate of HIV/AIDS among adults is about 2 percent. The leading cause of health service utilization is malaria.

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

In the first round of GF grants, Benin was awarded US$2.3 million to fight malaria; the grant agreement was signed in March 2003. In the second round, it received US$11.3 million for HIV/AIDS and US$2.2 million for TB; grant agreements for these programs were signed in July 2003. In the third round, the malaria program received US$1.4 million; the grant agreement was signed in September 2004. Fourth round applications for all three diseases were submitted in April 2004, but none were approved.

Table 1 provides an overview of how the Round 1 and 2 GF money (upon which this report's findings are based) is being spent in Benin according to the grant agreements. Note that approximately 60 percent of HIV/AIDS spending is for anti-retroviral (ARV) drugs for about 2000 AIDS patients, and almost 50 percent of malaria spending for its first round grant is for the purchase of insecticide-treated nets. Training activities are also a prominent part of all three programs.

Table 1. Two-year Global Fund Budgets by Category (US$), Rounds 1 and 2

	Malaria	HIV/AIDS	TB
Human resources	11,619	363,852	81,300
Infrastructure & equipment	56,580	2,194,472	1,019,817
Training & planning	832,218	855,803	518,787
Commodities & products	1,070,502	315,405	-
Drugs	162,846	6,891,560	-
Monitoring & evaluation	62,829	76,508	141,499
Administrative costs	113,770	567,400	106,159
Other/IEC*	78,821	83,000	305,842
TOTAL	**2,389,185**	**11,348,000**	**2,173,404**

IEC=information, education and communication

The SWEF network's research in Benin, conducted through the Partners for Health Reform*plus (*PHR*plus)* project,[2] was formally launched at a stakeholder workshop held on April 1st, 2004, in Bohicon. Based on the common research protocol that served as a starting point for research in all countries, four important aspects of health systems were identified: (i) policy processes; (ii) public/private mix; (iii) human resources; and (iv) procurement and supply of pharmaceuticals and commodities. Initial discussions with key stakeholders suggested that all four of the key thematic areas were relevant in Benin, based on early experiences with GF planning and implementation. The rationale and specific research questions underlying each of these four health system issues will be discussed in the relevant sections of this report.

With respect to the methodological approach, the research protocol combines baseline and follow-up quantitative surveys of health facilities and health staff, along with in-depth interviews of stakeholders at the national and sub-national levels. Researchers are also conducting ongoing monitoring between surveys. The research aims to produce and share results in a timely fashion that allows for adjustments by decision makers.

In August 2004, baseline facility and provider surveys were carried out in Benin, covering 40 facilities and 90 providers. These surveys collected data on utilization of a range of priority services (as well as for the three focal diseases) and the availability of key pharmaceuticals and commodities. The surveys also examined issues of health worker time allocation and motivation. A preliminary analysis of baseline results has been conducted but is not addressed in this report; follow-up surveys are tentatively planned for late 2005.

In September 2004, 20 in-depth interviews were conducted with key actors in Global Fund implementation and the health sector more broadly. In the public sector these included interviews with senior Ministry of Health (MoH) officials; the directors of the national programs for AIDS, TB, and malaria; at the sub-national level with departmental and district health representatives, and a provider involved in GF service delivery. Outside the public sector, interviews were conducted with representatives of domestic and international NGOs, the private for-profit sector; the principal recipient (UNDP); and the World Bank MAP project. Interviewees were assured that their responses would be kept confidential and presented only in aggregate form. Two to four members of the SWEF

[2] PHR*plus* is a United States Agency for International Development (USAID)-financed project focusing on health policy and systems strengthening.

research team, accompanied by a note-taker, conducted all interviews. The detailed notes were coded and analyzed prior to report writing.

The interim findings discussed in the sections that follow draw largely on these interviews. In keeping with SWEF research network guidelines, results were presented and discussed with stakeholders in Benin on March 29, 2005, prior to dissemination of the report. This version reflects comments and feedback received during that meeting, but final views belong to the SWEF research team only.

While mainly descriptive in approach, the results highlight important questions to be addressed as GF activities move forward in Benin, and, combined with other SWEF country experiences, they offer an initial body of evidence on a largely unstudied issue.

3. Knowledge, Participation, Process, and Policy

Global Fund activities in Benin are still relatively new, and, as a result, many of the interim results of the SWEF research relate to issues such as knowledge, participation, process, and policy rather than evidence of direct impacts on the health system. The relevant questions identified in the common research protocol, and which were explored during in-depth interviews, include:

- How has Global Fund support affected the range and types of actors participating in policy development, and the relative balance of power between them?;
- To what extent is the GFATM supporting approaches that are in alignment with the country's existing processes and policies?

These and other issues are explored in this section.

3.1 Knowledge and Participation

The Global Fund has explicitly stated as one of its objectives to encourage greater participation from a range of actors in the fight against the three diseases. Country coordinating mechanisms are viewed as an important part of this effort. Issues relating to various stakeholders' knowledge of, and participation in, GF planning and implementation were addressed during interviews.

Discussions revealed that knowledge of the Global Fund is not widespread within the health sector, and even in the Ministry of Health there are many otherwise key actors who are not familiar with the GF and its activities in Benin. The principal recipient (UNDP) is the only entity with a thorough knowledge and global view of the entire GF portfolio. Otherwise it is the secondary recipients – the three national programs for AIDS, TB, and malaria – that have the greatest knowledge of GF activities within their specific areas.

At the Ministry of Health, while some senior decision makers had a general familiarity with the Global Fund (although not necessarily its specific activities), others in key cross-cutting health system roles at the directorate level had very little knowledge of the GF, what it is, how it works, or the scale of its resources in Benin. One individual remarked that most of their knowledge of the Global Fund was gained during the workshop organized by SWEF in April 2004 to launch the research. (It had been previously observed that the workshop played a similar role for several other stakeholders). Knowledge and participation are often closely related. The apparent poor knowledge of the Global Fund among certain actors reflects, among other things, that they are not CCM members and thus do not participate in the planning and implementation of GF activities. For example, one individual at the MoH noted that they had no direct role in the planning meetings for GF activities, although they participate at other meetings at which the Global Fund "is mentioned." But knowledge and participation do not always go hand-in-hand. For example, the national medical stores (*Centrale d'Achat des Médicaments Essentiels*, CAME) was familiar with the GF's procurement activities in

which it did not play any role, but this knowledge may have been precisely because it had been bypassed in favor of alternative channels.

Outside the MoH, it was found that key private for-profit health sector stakeholders had very little knowledge of the Global Fund's activities that relate to the areas in which they operate. A representative of the private for-profit health sector reported no knowledge of, or participation in, GF activities.

A more positive comment with respect to participation due to the GF was the observation that there is now greater involvement of UNDP in the health sector than had previously been the case. One contribution of UNDP's role has been to help the three programs (malaria, TB, and AIDS) with the planning, monitoring, and evaluation of their activities. One of the program directors specifically cited UNDP's supportive role. Noting that the program's personnel hadn't been trained to manage GF procedures and that learning was done while out in the field, they commented that UNDP is available to provide support and this has been very valuable.

A number of interviews explored the issue of participation in GF planning and implementation specifically in the context of the CCM. It was reported that the CCM has not functioned very well. When in-depth interviews for the SWEF research were conducted, it had not met for six months.[3] It was also noted that the large size of the CCM (46 members) had led to the creation of the nine-member technical group in order to streamline decision-making.[4] Although the broader CCM is representative and brings many new actors to the table, in reality this much smaller group discusses the major issues, makes the decisions, and is more influential. A non-governmental member of both the CCM and the small technical group reported that their views were not always taken into consideration, and that they have to defend their interests by raising issues and making statements "in order not to be forgotten." Thus, while the CCM has created a mechanism for some previously unrepresented stakeholders to participate, there is still progress to be made in terms of translating this into real influence.

Further issues related to participation will be discussed in a later section on the effect of the Global Fund on the public/private mix in Benin's health system.

3.2 Process

A recurrent theme in the comments of those respondents who are directly involved in the GF process itself was that it entails a lot of pressure and complexity. Such factors could make broader consultations more difficult, and could possibly explain the lack of engagement of certain key stakeholders. This pressure comes particularly from the Global Fund itself. One program representative noted, "we are subjected to a lot of pressure. It's too stressful. There's pressure from the GF, and it's too much." Much of the pressure is related to the production of quarterly reports summarizing progress, on which subsequent disbursements depend. The report writing was seen as an additional administrative burden. However, respondents also feel pressure to conduct all activities

[3] The CCM did, however, meet more frequently in the earlier stages of GF presence. For further information on the CCM in Benin, see the report conducted for the Global Fund by an independent evaluator, available at http://www.theglobalfund.org/pdf/ccms/CCM%20rep.%20Benin.pdf

[4] The members of the nine member technical group are the three program heads, the principal recipient, UNAIDS, World Health Organization (WHO), a domestic NGO group, an international NGO, and a representative of people living with HIV/AIDS.

planned within the quarter, regardless of delays in disbursement or other constraints. Another program head said that the disbursement process is long and hasn't always respected the calendar, but that there was not much to complain about in comparison with activities funded through the national budget.

The principal recipient also emphasized the pressure it receives from the GF, and that the complexity of the process poses a big challenge. It also noted that the whole process depends on showing results; if these cannot be shown, there is reluctance to disburse. Indeed, and more positively, instilling a results-based management style was identified as a key contribution that UNDP could make through the GF process.

One sub-recipient noted that the GF procedures are extremely complex and "annoying." There is a lot of money to be managed and they try to "micro-plan" but the administrative procedures cause them to lose a lot of time. They are subjected to a lot of pressure by the GF and by the programs as well. The submission of reports was cited as a particularly key source of pressure. Another actor noted that the complexity and conditionalities of the procurement arrangements for GF bed-nets was in large measure unnecessary, and was such that it effectively ruled out any domestic importer's involvement. Lastly, several respondents also mentioned the complexity of the application process to the GF as a significant burden.

More positively, some respondents spoke of the GF's flexibility. For example, the principal recipient mentioned that if another donor is found to be purchasing something, the GF is prepared to reorient its spending provided it knows early enough. The switch to Coartem for malaria treatment was also cited as an example of flexibility. A provider mentioned the GF's decision to finance operating costs at the CIPECs (testing and information centers for HIV/AIDS) as another sign of flexibility, but also noted a lack of responsiveness to specific requests as a counter-example.

With respect to harmonization, direct cooperation between MAP and the Global Fund was reported to be good, although it was based on informal and independent coordination efforts rather than through institutionalized links. An observer at the district level, however, expressed the opinion that coordination between MAP and the Global Fund needed to be improved to promote harmonization of activities.

3.3 Policy

Alignment of GF activities with existing health sector policies was an important topic for research in the SWEF context. Two important components of Benin's health sector policy are discussed here: decentralization and cost recovery.

3.3.1 Decentralization

One of the key themes of health sector reform in Benin over the past decade has been decentralization to departmental and district (health zone) levels. Implementation of this decentralization policy has been slow, but is moving forward.

Among actors at the central level, the responses often reflected a somewhat different notion of "decentralization" than what is intended by health sector and broader government policies. The decentralization policy calls for more effective decision-making power at the health zone and local government level. Health zones have responsibility for planning and implementation and more

recently budgeting. A senior official at the MoH viewed the GF as fitting well into the decentralization approach but illustrated this using the example of the emphasis placed by the GF on working with NGOs and indigent populations. The three program managers all saw decentralization in their efforts, but supported this observation with comments that their activities were not implemented entirely from the central level. They did not cite any role for the lower levels in the planning process.

At the sub-national level, views differed on the level of decentralization of GF activities. Most respondents did not believe that they had the power to make decisions or participate in the planning of GF activities, in contrast to the aims of the decentralization policy. Sub-national government actors were not involved in developing proposals or work plans for the GF. One observer said that the GF activities do not follow the decentralization policy whereby planning is done at the lower levels; this person believed that the nature of GF procedures foster more centralized decision making. One district observer said that GF activities are well integrated with decentralization. However, another commented that those in charge of GF activities do not want to use the decentralization system. He said he was not involved in the conceptualization and planning of GF activities in his district but had to submit to what was decided. One consequence is that people come unnecessarily from the departmental level to do trainings, and at the district level he doesn't even know how many training sessions have taken place through the GF in his district. He has no role in the planning of these training activities. One of the three programs in particular was deemed to be very vertical in its approach, and the district is simply expected to execute plans as instructed. He said there should be coordination meetings between the programs and the districts.

In general it appears that the three programs have traditionally been very vertical in their approach. In other words, this tendency prevailed even prior to the GF's arrival. But the large sums of money that they are now receiving could indicate that the overall health system is more verticalized as a result of the GF, as all conceptualization, planning, and implementation are managed at the central level and primarily within the three program offices.

3.3.2 Cost Recovery

An important feature of the health system in Benin is a cost recovery mechanism at the health center level following the Bamako Initiative approach. It is generally viewed as a well-functioning system, through which funds are generated to ensure continuing stocks of drugs and other supplies while engaging local communities in health-related decision making.

When asked about how well the drugs and commodities procured under the GF fit into the existing approach to cost recovery, several senior MoH officials stated that the policy applied equally to the GF. However, in other discussions it emerged that with respect to insecticide-treated nets (ITNs), GF nets are sold at 1,500 CFA francs each,[5] with all revenues returning to a special account of the malaria program in order to support the sustainability of the activity. For bed-nets purchased through the normal channels, however, the price is 2,500 CFA francs, of which the health center keeps 100 for community financing, and 50 are for the community-based worker (*relais communautaires*). It was acknowledged that the existence of parallel approaches could pose problems, and said that there were plans for a harmonization of prices and policies.

[5] The exchange rate is about US$1 = 500 CFA (*Communauté Financière d'Afrique*) francs.

One district-level observer noted that the non-participation of GF bed-nets in the regular cost recovery system represented a missed opportunity to use revenues from GF nets for re-investment by the community in other services. Such an approach could help strengthen the system more broadly. Another district respondent said they also have a different pricing strategy for so-called Abuja bed-nets. In all they sold blue, white, and green ITNs, and had different accounts for the revenues from the different categories. Finally, an international observer described yet another (donor-financed) social marketing system of bed-net pricing. Thus there are bed-nets funded through the MoH, socially marketed bed-nets, and GF bed-nets. Within these categories there is also some specific geographic and population targeting, but in many cases the existence of parallel approaches for bed-nets was due to different donor mechanisms. In sum it appears that the GF is not a second system of cost recovery for bed-nets, but rather one more added to several pre-existing ones.

With regard to ARVs provided by the GF, patients pay a co-payment of 1,000 CFA francs per month, and revenues are deposited in a special account at the central level (not maintained by facilities). It has not been decided how these funds will be spent. However, one respondent mentioned that certain patients are having difficulty even paying this fee, and the MoH and national AIDS program are now considering making ARVs available for free. The World Bank MAP program has recently started offering ARVs (subsidized by the Clinton Foundation) as well, and they are sold at 1,000 CFA francs per month for indigent populations, and 20,000 CFA francs for others, with revenues remaining at the facility level for re-investment by communities.

4. Effects on the Health System

This section addresses financing, the public/private mix, human resources, and the procurement of pharmaceuticals and commodities. While Global Fund implementation is quite new in Benin, some preliminary findings on its effects on the health system can be proposed.

4.1 Financing

Global Fund support represents a substantial increase in health funds available for Benin, and can therefore potentially affect prioritization and financing decisions for the entire system. The GF grant agreements contain an additionality clause requiring that the new funds are "in addition to the normal and expected resources that the host country usually receives or budgets from external or domestic sources." For these reasons, the SWEF research protocol identified the extent to which GF funding is really additional in practice as an important issue for study.

GF activities have raised the overall budget for health spending in Benin by about 15 percent.[6] In 2002, prior to the GF's arrival, the national programs for AIDS, TB, and malaria represented approximately a 19 percent share within the Public Investment Plan account (which excludes operating costs but includes all donor contributions). GF expenditures raise this share to almost 40 percent.

Perceptions varied with respect to the effect of the GF on financing within the health system. Senior MoH officials said there had not been any changes in government budget allocations due to the Global Fund. There have been budget cuts, but these were not related to the GF, and had been imposed on all sectors due to declining government revenues. One respondent added that, even though the GF resources were very large, they were still not adequate to satisfy the actual needs in view of the country's health problems, and as such had not led to any change in allocations.

The question of whether the required additionality of GF moneys was *desirable* was approached indirectly by asking senior MoH officials and planners whether they would have spent these funds exclusively on AIDS, TB, and malaria if there were no strings attached to how GF money was to be spent within the health sector. None of the respondents said it would have been devoted only to the three focal diseases, and they cited other priorities within the health sector.

Program officials viewed the impact of the GF on their funding from the national budget as an area of concern, but more emphasis was placed on the belief of certain program officials that specific international donors had reduced their funding level in Benin due to the GF. In practice, of course, it is very difficult to establish the counterfactual (what would happen to financial allocations if the GF were not present). But it did emerge that MoH and program respondents did not have the same

[6] In Rounds 1 and 2, Benin received approximately $16 million for two years, or $8 million annually. (Implementation of Round 3 activities began later.) The annual health budget is about $50 million, including donor contributions.

perspective on the concept of additionality, and that the GF's policy had not been clarified to stakeholders.

4.2 Public/Private Mix

One of the principles underlying the Global Fund is that it will "focus on the creation, development and expansion of government/private/NGO partnerships." The SWEF common research protocol identified several related research questions, focusing on how GF-supported activities have affected: (i) the number, distribution, and organization of different types of providers (public, private for-profit, private non-profit, informal sector); (ii) the quality of care, range of services, and volume of services offered by different types of private sector providers; and (iii) the nature, number, and quality of public/private partnerships.

Work plans for GF activities indicate that all three programs are involving private partners in their work. The malaria program is engaging NGOs in the promotion of bed-nets and is training community-based workers for the purpose of IEC. The TB program is working with community organizations, religious groups, and community-based workers in education campaigns and the treatment of patients. The HIV/AIDS program is working with NGOs in the context of home-based care, the care of orphans, and groups of people living with HIV/AIDS.

Several respondents in many different roles noted that the Global Fund had led to the creation of new partnerships with the private sector, especially with NGOs. On the government side this was viewed in a positive light, and all programs recognized new collaborations. One program noted that there was no collaboration prior to the GF, but with its arrival they had engaged with, for example, community-based workers. Another program was very positive, remarking on new partnerships with NGOs and community-based workers and teachers with whom they had not worked prior to the GF. They said they would like to continue these relationships if the GF were no longer present, and worried about their sustainability post-GF due to a lack of money, not will.

A senior MoH official noted the new partnerships as well, saying that this would benefit other health priorities as well since these same NGOs were involved in issues such as onchoceriasis. A respondent at the departmental level referred specifically to the new role of community based workers and NGOs in prevention efforts of these diseases. A district actor commented that there was indeed more collaboration between the programs and the NGOs, but this collaboration took place at the central level and excluded district-level stakeholders.

For its part an NGO representative emphasized that, with the collaboration of the GF, the range of actors and especially activities in which NGOs were participating in the health sector had grown considerably. This trend was expected to continue as they sought ways to involve traditional healers and religious groups as well. It did not believe that the arrival of the GF had led to the creation of new NGOs, but it had perhaps led more of the existing NGOs to apply for membership to the main NGO network (ROBS). With regard to the quality of the new partnerships, the NGO representative remarked that many of its members had acquired new competencies through the various seminars and trainings as part of their GF participation. Management capacity, for example, had been enhanced, and this would be beneficial to their other, non-GF work as well. However, the quality of the collaboration was often strained, especially at the beginning, as the programs adjusted to working with new partners for the first time. Lastly, an international NGO was asked to provide technical assistance regarding bed-net procurement for the GF, a task for which the government usually tapped into WHO support.

As noted earlier, the private for-profit sector has virtually no involvement in GF activities in Benin. Faith-based health facilities are another private constituency with a still relatively small role. One observer noted that, in the health system generally, most AIDS patients go to the religious sector, while most money went to public centers, which was a problem. The issue of a lack of involvement of the private pharmaceutical sector will be discussed in a later section.

4.3 Human Resources

The issue of human resource constraints is increasingly recognized as one of the most important obstacles to scaling up priority health services in low-resource countries. While most GF programs have significant in-service training components, broader systemic issues such as motivation and retention are rarely addressed. Important research questions identified in the common protocol include the following: (i) How have Global Fund-supported activities affected the total number and distribution (geographic, public/private, level of health care system) of health workers in the country? (ii) How well is training for the focal diseases harmonized with non-focal disease delivery practices, and broader health system policies? (iii) What is the range of salaries/incentives (such as allowances) paid for by GF-supported activities, and how do they compare to existing salaries/incentives paid by government and other donors? This section will consider several aspects of human resources, including workload, motivation, salaries, training, and capacity development through improved availability of infrastructure. Issues of motivation and time allocation will be explored in greater depth through provider surveys to be described elsewhere.

Human resources and training represent almost 20 percent of GF expenditures in Benin. Many respondents emphasized training activities as a positive element of GF work in the country. According to April 2004 work plans, the AIDS program was using GF money to directly hire 23 people (about half are doctors or lab technicians, and half are managers or administrators), the TB program was hiring a total of nine doctors, nurses, and lab technicians, while the malaria program was hiring just one manager. These individuals were hired directly by the programs on short-term contracts, and the director of human resources in the MoH did not play a role in these decisions. In the TB program, the majority of new GF hires were drawn from the private for-profit sector, not from elsewhere in the public system.

Respondents had mixed opinions as to whether Global Fund activities represented a large additional burden on human resources. The problem appeared more serious at the management level. One program stated that GF activities had distanced them from their routine activities, particularly caring for the sick. However, additional doctors hired under the GF had helped in this regard. Another program representative also cited the heavy workload due to GF activities as a major issue. A key player in the HIV/AIDS sector said that it believed the national AIDS program was overburdened with juggling its daily activities and its coordinating role. On the other hand, since few individuals at the Ministry of Health outside the three programs are significantly involved in Global Fund activities (as discussed in an earlier section), individuals in these positions did not report any distractions or additional burden on themselves due to the GF.

Departmental and district-level actors did not perceive an increased human resource burden due to the GF among their providers as activity levels had not changed significantly. However, in the unique case of a provider directly delivering GF services at a major Cotonou hospital, a much greater burden was noted. In addition to a large patient volume, this person is also responsible for accounting, budget forecasts, personnel, statistical reporting, training, and other tasks. In order to cope, this provider had to delegate some medical duties to a secretary and requests to the principal recipient to provide additional technical personnel were not adequately addressed. It was noted by this provider

that many doctors are reluctant to work with HIV/AIDS patients because of the perceived overload of work.

A perceived additional workload can have an impact on worker motivation. A key MoH figure cited this as one of the greatest challenges facing the health workforce in Benin. The issue of motivation was most commonly raised in the context of salaries and incentives. One program representative spoke of a much greater workload due to the GF and identified motivation as an important issue, and, citing themselves as an example, said they received no supplemental pay despite the extra work. The provider cited above had similarly received no additional pay despite all the extra responsibilities, had received no training to carry out the new tasks, and hadn't even received an honorarium for the training that they had conducted in the context of GF activities.

Both of these individuals held their posts prior to the GF and are paid out of the national budget. However, the programs that have hired new personnel directly using GF money both acknowledged that these individuals were being paid higher salaries than generally paid by the public sector. However, one of them said that per diems paid through the GF were lower than those customarily paid by the government (this is also the case with other donor per diems), and this had an impact on motivation to conduct fieldwork.

Motivation stems from more than just salaries, however. One respondent believed that training programs had an important impact on health worker motivation as they became better trained to carry out their duties.

With regard to training, while most training activities were considered to be somewhat program-specific, some GF training programs also have applicability beyond the three focal diseases – a clear example of positive system-wide effects. A senior MoH official and one of the programs spoke of the transferability of skills obtained through GF trainings beyond AIDS, TB, and malaria. A key example is the use of GF malaria money to finance training programs in the Integrated Management of Childhood Illnesses (IMCI). Such use of funds was justified because malaria is one of the major health problems addressed by the IMCI approach (which also includes nutrition, diarrhea, respiratory illnesses, etc.). This was done at the behest of the WHO. Thanks to the GF, IMCI training is now conducted in all regions of the country. Despite lobbying by a key official, however, this training was done exclusively as in-service rather than pre-service, which he said raised concerns about sustainability.

According to a district-level observer, however, there were also missed opportunities to use GF training for broader applications, particularly the fact that more generic skills such as monitoring and evaluation were not included in GF-funded trainings. This person believed these skills were one of the most important missing links in human capacity in the health sector in Benin.

A large number of respondents noted that the GF also meant that health workers were better equipped to perform their duties due to improvements in supporting infrastructure. Specifically, many cited the motorcycles purchased by the TB program for supervision activities (and the accompanying fuel and per diems), and the microscopes purchased for district hospitals as examples of GF expenditures that would enhance human resource capacity and broader systems capacity beyond AIDS, TB, and malaria. For example, one respondent said that the motorcycles would allow for more vaccination and antenatal consultations as well.

However, other TB program laboratory strengthening activities and the equipping of the virology laboratory for HIV/AIDS were being implemented at program-specific facilities (the national TB hospital, which is a stand-alone facility, and the virology lab), where additional capacity would be

less readily applied to other health priorities. Thus, capital investments financed by the GF have the potential to support the health system more broadly, but this depends critically on the applicability of new equipment or buildings to non-focal disease work as well as on how they are deployed geographically and across facility types.

4.4 Pharmaceuticals and Commodities

About half of all GF expenditures worldwide are allocated to drugs and commodities, and, as indicated in Table 1, spending in Benin has followed this trend. Anti-retroviral drugs and insecticide-treated nets are the largest components of Global Fund expenditures in Benin. The common research protocol identified issues such as the following:

- How have Global Fund-supported activities affected the way in which pharmaceuticals are managed, including (a) procurement, (b) distribution, (c) utilization, and (d) monitoring processes?

- How have Global Fund-supported activities in the areas of commodities affected the growth of private markets?

Other issues related to the availability of pharmaceuticals at facilities are being addressed in facility surveys.

Despite the large proportion of Benin's GF spending allocated to ARVs and ITNs, the national medical stores are not involved in the procurement of these products. Following an assessment of CAME, it was determined by the Global Fund that UNICEF and Population Services International (PSI), respectively, would procure these products instead. The procurement plan for malaria explicitly cited the need for rapid scale-up as the reason for bypassing CAME, which is the traditional procurement agency for ITNs in Benin. Some respondents challenged the rationale of pursuing an alternative procurement mechanism, on the grounds that CAME was capable of fulfilling this role adequately, that using UNICEF and PSI was less sustainable, and that efforts to provide capacity building to CAME in the form of an information technology specialist were poorly targeted since a lack of storage space was seen as the more important challenge.

In terms of impact, two respondents perceived the existence of parallel structures for procurement and the lack of any single entity with an overarching view of procurement processes as potentially damaging. It was believed to make the task of forecasting needs more difficult, since it was harder for actors to know how much of a given product (the example of chloroquine was cited) that other importers would be procuring. As a result, an importer such as CAME would become more cautious in its forecasting, which meant that there would be stock-outs if others did not execute their own procurements. Moreover CAME believed that in the public eye any stock-outs would be viewed as CAME's fault regardless of who was responsible for procurement. It was claimed no clear mechanism had been put in place to ensure dialogue between the principal recipient and CAME on issues of procurement.

With respect to the impact of the GF on private sector pharmaceutical wholesalers and retailers, the procurement of ITNs through PSI was seen as a threat to the viability of private ITN importers and marketers who previously supplied the MoH.

5. Sustainability and Institutionalization

The issue of the financial sustainability of GF activities in Benin was a widely held concern. The general opinion that emerged among respondents was that no real preparations have yet been made with respect to sustaining GF activities over the long term. Two respondents expressed concern that a sudden GF withdrawal would leave the health system in a worse condition than it had been before the GF's arrival.

Regarding broader issues of institutionalization, the principal recipient emphasized that the GF's objective was to make all structures fully autonomous and to put in place systems of planning, reporting, accountability, and mechanisms of monitoring and evaluation to encourage this. Introducing health sector actors to the approach of results-based management was also a key goal.

More broadly, many of the findings suggest a difficult trade-off between sustainability and the speed of implementation. It was noted that pressure to implement was the most commonly cited feature of GF processes, and this emphasis on rapid implementation and results may partly explain several observations, such as the lack of harmonization with existing policies on decentralization and cost recovery; the absence of participation by key cross-cutting health system decision makers at the MoH; and the GF's decision to bypass CAME for procurement.

6. Conclusion

The main objective of this report has been to provide an overview of key interactions between GF activities and the health system in Benin at an interim stage, with the aim of informing several potential audiences in Benin, at the Global Fund, and in the broader donor community.

To summarize, respondents highlighted several key areas of concern, such as gaps in the knowledge and participation of key actors at the Ministry of Health; a lack of harmonization with existing policies on decentralization and cost recovery; a parallel system for procurement of ARVs and bed-nets; a heavy burden on program managers; issues of additionality; and questions about sustainability. Many of these challenges may reflect the pressure that many respondents have felt to show immediate results. The apparent trade-off between speed on one hand and harmonization and sustainability on the other is an important issue for discussion as Benin's GF activities move forward.

Several positive effects on the system were also noted, such as the creation of many new public/private partnerships, training activities that embrace other health priorities, and the purchase of equipment that can be shared by health workers outside the three focal diseases. Future applications for GF grants may be able to incorporate similar system-strengthening activities.

The findings presented here are preliminary, and will be developed further through follow-up interviews as well as by insights from the facility and provider surveys in late 2005.