



Friends of
the Global Fund
Europe

STUDY TOUR ETHIOPIA OCTOBER 2014

SUPPORTED BY:



The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Things
To Do

THE AIM:

See first-hand the impact of the Global Fund, comprehend the progress, understand the challenges,

- Witness the hard work of doctors, nurses and health workers in the field
- Connect with the Global Fund and its Partners
- Touch base with the European Union Delegation to Ethiopia
- Share insights and perspectives with the Ministry of Health
- Exchange views with representatives of the African Union

STUDY TOUR OVERVIEW

Thursday, October 2

7.05 - Arrival ADDIS ABABA (ETHIOPIA)

7.30 - Transfer to the Hotel RADISSON BLU

8.00 – Arrival at the Hotel

10.30 – Meeting : Overview of the Global Fund and Global Fund funded programs in Ethiopia

12.30 – Lunch meeting hosted by EU delegation to Ethiopia, at the hotel

14.30 – Visit of ALERT hospital which boasts ART and TB clinics

16.30 – Briefing at the Ministry of Health regarding different programs and initiatives by MoH and the results achieved till date and discussion with the delegation

19.30 – Dinner hosted by MoH

Friday, October 3

7.45 – Meeting in the lobby

8.30 – Meeting with H.E. State Minister Berhane (TBC)

10:30 – Meeting with leadership of African Union; followed by meeting with AIDS Watch Africa, about Domestic Funding.

12:30 – Lunch Meeting with HPN Partners at Radisson Blu

14:00 – Visit to Health Post/Health Centre (Koka Health Post and/or Mojo Health Centre)

19:00 – Dinner at Radisson Blu

Saturday, October 4

8.30 – Visit to Safe House in Addis, for women, victims of violence

11:00 – Visit to Civil Society Programs is the Negem Lela Ken New (NLK) Income-Generating Program for women living with HIV/AIDS

14:00 – Visit to Equal Opportunity People Living with HIV (PLHIV) Association

18:30 – Debriefing

19:00 – Dinner

21.00 – Transfer to the airport

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Ethiopia at a glance

The Federal democratic Republic of Ethiopia has a population of 93 million (2013) and is the 13th most populous country in the world. Ethiopia is a landlocked country in the Horn of Africa, divided into nine ethnically

based and politically autonomous regional states and two governing city administrations (Addis Ababa and Dire Dawa). The regions are sub-divided into 68 zones, and then further into over 800 woredas (administrative divisions). Ethiopia is a multilingual and multi-ethnic society of around 80 groups. The majority of the population is Christian (62.8%) and a third of its population is Muslim. The Ethiopian calendar is seven years and about three months behind the Gregorian calendar. Ethiopia's Human Development Index (HDI) value for 2013 is 0.396 which puts the country in the low human development category, lower than the average for sub-Saharan African countries (0.475). From 2000 - 2012, Ethiopia's HDI value increased from 0.275 to 0.396, a 32.0 percent increase. Life expectancy has improved by 7.6 years to 59.7 years in 2012, and expected years of schooling doubled from 4.4yrs to 8.7 yrs.

HEALTH CARE

Access to health services at the district and zonal level has been challenging. In 2005 only 60% of the population lived within 10 kilometers of a clinic or other health service delivery point. Furthermore, health workforce to population ratio in Ethiopia is among the lowest in the world at 0.84 per 100,000 population, while the doctor, nurse, and mid-wife ratio is 0.3 per 1,000 population, far below the estimated benchmark of 2.28 required to achieve 80% coverage of live births. Poor infrastructure and facilities further skewed the urban-rural distribution of health workforce.

Systematic efforts under the Health Sector Development Program (HSDP) implemented by the government of Ethiopia over the last fifteen years have yielded positive results, in improving access to health services. The first three HSDP programs contributed to the expansion of health care infrastructure and manpower and improvements in health service coverage, including HIV, TB, malaria, maternal and child health services and other programs. The fourth HSDP program (2010/11-2014/15) aims to sustain the reductions in morbidity and mortality by focusing on three strategic themes: building excellence in health service delivery and quality of care, leadership and governance, and health infrastructure and resources.

There has been a liner increase in the three tier health care delivery system and infrastructure over the four HSDPs: over 15,000 health posts were built (1/3,000-5,000 population), nearly 3000 health centres (nearly 5 fold increase since 1998, 1/15,000-25,000 population), and over 125 hospitals have improved access to health services to over 90% of the population.

Ethiopia has made marked progress towards health-related MDGs in the past decade and has achieved MDG 4 (67% reduction in child mortality since 1990), and reported to be on track to achieve MDG 6, with additional efforts required to improve maternal health (MDG 5).

The country continues to face the challenge of high morbidity and mortality due to communicable diseases and maternal and child health conditions. Sustaining the gains and further scaling up of health programs are highly dependent on health systems capacity to deliver patient-centered, accessible, and affordable quality services.

HEALTH FINANCING

The investments in health and prioritization are guided by the national development programs such as the Sustainable Development for Poverty Reduction Program (SDPRP) and its successor, the Plan for Accelerated and Sustained Development to End Poverty (PASDEP). Aligned with these policy frameworks, the government has developed the five-year Health Sector Development Plans, starting from HSDP 1 (1996/97) to the current HSDP IV (2010/11 – 2014/15).

Health services in Ethiopia are financed from the (1) federal and regional governments, (2) grants and loans from bilateral and multilateral donors, (3) NGOs, and (4) private contributions.

Per capital health spending in Ethiopia has increased five-fold from US\$ 4.50 in 1995/96 to US\$ 20.77 in 2010/11. In absolute terms, government expenditure has increased from 1.3 billion Ethiopian Birr (ETB) in 2004/05, ETB 2.4 billion in 2007/08, and ETB 4.2 billion in 2010/11.

Despite the continuous increase, the health sector remained underfinanced when compared with the World Health Organization (WHO) Commission on Macroeconomics and Health's recommended minimum spending of US\$ 34 per person per year, as needed to provide basic health care services in developing countries (WHO, 2001). However, by source of funding, the government accounted 15.6% of total health expenditure (21% in 2007/08), with external partners (rest of the world) accounting for 49.9% (40% in 2007/08), and households (private out of pocket) for 33.7%. Government accounts for 14.1% of HIV funding, 7% for malaria and 12% for TB.

In 2012/13, the overall health financing has grown to an estimated US\$1.6 billion of annual expenditures, but the sector remains underfunded. In 2012/13, US\$ 531 million was channelled by Development Partners through the Ministry of Health (excluded direct support to implementing partners), where the Global Fund was the largest contributor accounting for 31% of funding, followed by UNICEF (20.5%), DFID (20.2%) and GAVI (15.8%).

During the period 2004/05 and 2007/08, the government spent 4.5% of its GDP on health, and the share of public health spending from the total government spending was 5% (below the Abuja target of 15%). Based on the 2010/11 National Health Accounts, as a proportion of overall government budget, health allocation has stagnated at 8.5% in recent years.

Recent HMIS reports of the MoH suggest that regional governments spend approximately 10% of their budgets on health (contributions from regional government are 80% of the government sources). Government contribution to the Health Sector Development program for 2013-2018 is projected to be around 31% of total need. External donors contribute 50% of overall health expenditures, while the government of Ethiopia accounts for 16% and out-of-pocket represents 34%. In the three disease programs, USG and the Global Fund represent the largest donors.

ETHIOPIA AND THE GLOBAL FUND

Ethiopia is the Global Fund's largest recipient of grant funds with disbursed funds of almost USD 1.6 billion since 2002. There are six active grants managed by the Federal Democratic Republic of Ethiopia as well as by two national non-governmental organizations:

- three for HIV and AIDS
- one for TB
- one for malaria
- and one for Health System Strengthening

The total lifetime allocation for Ethiopia is **USD 1.74 billion**:

Component	Lifetime Allocation	Percentage	Total cumulative disbursement	Percentage
HIV/AIDS	1,080,889,770	(62%)	1,011,353,751	(94%)
Malaria	489,623,770	(28%)	477,138,771	(97%)
TB*	150,193,141	(9%)	93,709,436	(62%)
HSS	20,512,223	(1%)	16,565,891	(81%)
Total	1,741,218,209	100%	1,598,767,850	(92%)

* TB Phase 2 signed in Aug 2014 for the period July 2014 – Dec 2016

NEW FUNDING MODEL

The NFM allocation is **USD 591.2 million**, and includes USD 233.7 million from existing funding

Component	CCM/GF Agreed Allocation, June 2014
HIV/AIDS	334,349,657 (57%)
MalariaTB	59,542,335 (10%)
HSS	144,026,276 (24%)
HSS	53,265,094 (9%)
Total	591,183,361 (100%)

The Global Fund's funding model enables strategic investment for maximum impact. It provides implementers with flexible timing, better alignment with national strategies and predictability on the level of funding available. There is active engagement with implementers and partners throughout the funding application and grant implementation to ensure greater global impact. All eligible countries receive an allocation communicated by the Secretariat. The allocation amount is based on funds available following the Global Fund's replenishment meeting for 2014 to 2016.

At the beginning of the allocation, the Secretariat apportions the total available resources among the three diseases. For the 2014-2016 period, the following distribution was set by the Board: 50 percent for HIV/AIDS, 32 percent for malaria and 18 percent for tuberculosis.

The initial inputs used to determine an individual country's allocation are disease burden and ability to pay (income level). The preliminary allocation is calculated based on disease burden and income level, along with adjustments for other external financing and the minimum required level. This is to ensure that a country that has received overly-high funding in the past is gradually adjusted to a lower allocation over time.

The Global Fund will then use qualitative factors to adjust the indicative funding amount for each country. These qualitative factors include previous grant performance, impact, increasing rates of infection, absorptive capacity and risk. These factors could lead to both upward and downward adjustments to the amount that is initially derived by the allocation methodology. A final adjustment is made during country dialogue. Once a country confirms increases to its national funding commitments for health (called "willingness-to-pay"), it must increase its commitments beyond the Global Fund's counterpart financing policy to access 15 percent of their allocation.



4 Child health:

Achieved
47% reduction in Under 5 Mortality rate (2000-2011)
[67% reduction since 1990]

5 Maternal Health:

Making Progress
Maternal mortality is estimated to have reduced by 64% in the last decade.

6 Combating HIV/AIDS, malaria and other diseases:

On Track
40-50% reductions in HIV and malaria related deaths, 30% reductions in TB related deaths.

BRIEFING:

GLOBAL FUND SUPPORTED DISEASE PROGRAMS IN ETHIOPIA

AIDS/HIV

Ethiopia has been one of the countries most affected by the HIV epidemic, with an estimated 2 million citizens living with HIV. The 2011 Ethiopia Demographic and Health Survey shows HIV prevalence among adults aged 15-49 to have stabilized at 1.5%. The prevalence is higher in urban areas (4.2%), which accounts for 62% of the total PLWHA (People Living with HIV and AIDS) in the country, while rural HIV prevalence is 0.6%.

The Global Fund supports 100% of ARV commodities and a majority of costs related to testing and counselling, through three grants:

- One implemented by the government Principal Recipient (PR), the HIV/AIDS Prevention and Control Office (HAPCO), which is focused on continuing a successful scale-up of prevention and treatment activities and aims to achieve near universal ARV coverage with a target of reaching approximately 484,000 people on ART by 31st December 2014.
- Two civil society PRs: the Network of Networks of HIV Positives in Ethiopia (NEP+) and the Ethiopian Inter-Faith Forum for Development, Dialogue and Action (EIFDDA). The NEP+ grant focuses on supporting people living with HIV/AIDS through nutritional support and general care services. The EIFDDA grant focuses on the provision of shelter, food & clothing for orphans and vulnerable children. It also supports income generating activities.

RESULTS

Ethiopia has seen a 25% decline in new HIV infections, 82% decrease in HIV prevalence among the 15-24 age group, and AIDS-related deaths fell from 99,000 in 2005 to 45,000 in 2009;

There's been a fifteen fold increase in patients enrolled in ARV treatment from 19,000 in 2005 to over 323,106 by end of Dec 2013.

Prevention of Mother to Child Transmission (PMTCT) coverage increased to 55% with new infections among children declining by over 50%.

TB

TB is recognized as a major public health problem in Ethiopia since the 1950s. Ethiopia is the ninth highest TB burden country in the world, with an estimated 230,000 new cases occurring annually (247 per 100,000 population).

The country has a high TB-HIV co-infection rate (10%), and is one of the 27 high MDR TB (Multi-drug resistant TB) burden countries (MDR prevalence of 1.6% among new cases and 12% in retreatment cases). Based on the WHO estimates for 2012, the TB incidence, TB prevalence and TB mortality rates are estimated to have declined by 33%, 47% and 63% respectively between 1990-2012, suggesting the country is on track to achieve the TB related MDG/Stop TB targets by 2015.

In spite of the significant progress, the TB burden continues to be high, with an estimated prevalence rate of 224 per 100,000 and TB accounting for over 16,000 deaths annually (18 per 100,000). TB notification rate (per 100,000 population) has steadily improved from 45 in 1995 to 175 in 2011 (4 fold increase) with implementation of DOTS (TB treatment), and the TB case detection rate, all forms is estimated at 68% based on current estimates of incidence. This has more than doubled from 33% in 2000.

The current TB grant focuses on reducing the burden of tuberculosis through expansion of DOTS, MDR-TB and TB/HIV services to the general population and population at increased risk in prisons and among migrants. The Global Fund supports primarily first-line, second-line drugs, laboratory equipment and supportive supervision, and program management costs. The grant also has a Health Systems Strengthening (HSS) component.

RESULTS

33% reduction in TB incidence rate since 1990, 41% reduction in prevalence and 56% reduction in TB mortality rates from 1990 to 2010.

Malaria

Approximately 60% of the Ethiopian population lives in areas below 2000 meters of altitude that are considered to be at risk of malaria. There were 1.69 million confirmed malaria cases reported in 2012, and over 35 million residents are at moderate-high risk of malaria transmission. Malaria prevention and control in Ethiopia is guided by the five-year Ethiopia National Strategic Plan (NSP) for malaria prevention control and elimination (2011-2015).

The current Global Fund grant for malaria is being implemented by the Federal Ministry of Health. Planned activities include the procurement and distribution of long-lasting insecticide-treated bed nets, implementation of indoor residual spraying through a Health Extension Program, Rapid Diagnostics Tests and ACTs (malaria treatment), the establishment and/or strengthening of sentinel malaria surveillance sites, and training for health extension workers and health centre staff. The program targets children under the age of five and their mothers and other population groups at risk.

RESULTS

In-patient malaria deaths fell by 43% in all age groups and by 60% in children under-5; five-fold increase in facilities providing malaria diagnosis and treatment; parasitological test confirmation of malaria cases increased from less than 10% to 83% and malaria surveillance reporting completeness increased from less than 20% to over 80%.

Domestic Funding for Health

- Share of health expenditure as % of GDP is 5.2%, up from 4.5% in 2007/08
- Per Capita health Spending in Ethiopia increased from USD 16 in 2007/08 to USD 20.8 in 2010/11. Continues to be below the recommended level of USD 34
- Government accounts for 34% of health sector financing; rest of the world (donors) for 50%, and household account for 16% of health spending
- By disease – AIDS, TB and Malaria accounts for 37% of total NHA
- HIV accounts for 19% of total health spending
- 83% of HIV/AIDS response is financed by donors; government 14%
- Malaria accounts for 15% of health spending
- 79% is donor financed; government accounts for 7%
- Tuberculosis accounts for 3% of national Health expenditure
- 51% is donor financed; government 12%; households 36%
- High burden on households
- Households account for 14% and 36% of total health expenditure for malaria and tuberculosis respectively. For HIV it is <5%.
- In the context of medium to long term sustainability, country preparing Health Care Financing Strategy

Achieving the ambitious goals and targets set out in the Global Fund Strategy for 2012-2016 requires increased efforts to mobilize additional resources. In particular, implementing country governments must fulfill their obligations, such as the Abuja Declaration, and sustain and grow contributions to the national response against the three diseases.

To establish the basis for future sustainability of national disease programs, the Global Fund has incorporated mandatory counterpart financing requirements for its financial support. To further incentivize additional co-investments by the government in disease programs, the Global Fund has incorporated 'willingness-to-pay' as a qualitative factor for adjusting the country allocation. The allocation shared with the country includes a 15% allocation for willingness-to-pay that can be availed by applicant countries based on additional government commitments for the next phase.

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Government

The Government of Ethiopia has shown a strong commitment to fighting HIV and AIDS, malaria and TB by showing strong leadership and the setting relevant policies. Dr Tedros, the Global Fund's former chair of the Board, was the former Minister of Health and succeeded by Dr. Kesetebirhan Admasu, in Nov 2012. Ethiopia's leadership remains committed to working with the Global Fund to ensure the successful implementation of the programs.

Ethiopia established a MDG Performance Fund and a Joint Financing Arrangement (JFA) for the Fund that enables the FMOH to access and make use of pooled funds. The Pooled MDG Performance Fund is primarily supported by DFID, UNICEF, Irish Aid, AusAID, Netherlands Embassy, Spanish Embassy while other UN and bilateral partners account for 25% of development partners' support. Recently the World Bank's Program for Results funding for USD 120 million has also been aligned to the MDG performance fund.

Global initiatives like GAVI (16% of funding in 2012/13) and the Global Fund (31% of funding in 2012/13) are channelled as ring-fenced allocation to the health sector for specific projects and/or programs.

The Global Fund continues to work closely with the Federal Ministry of Health and its agencies, including the Pharmaceutical Fund and Supply Agency (PFSA), Ethiopian Public Health Association (earlier EHNRI) to strengthen quality and coverage of health services to the population in need.

Civil Society

Civil society is also intimately involved in the implementation of Global Fund grants. Both civil society PRs (NEP+ and EIFDDA) have successfully strengthened their management capacity. The two civil society PRs were sub-recipients (SRs) of the Government's HIV grant where they received funding and training through HAPCO. The Global Fund grant to the Faith Based Organisation (FBO) network EIFDDA is for USD 29.7 million. EIFDDA implements the program through 9 Sub-Recipients and focuses mainly on OVC support and social mobilization. The Global Fund grant to NEP+, an umbrella of PLWHA's networks is for USD 23.2 million. NEP+ disburses to 16 SRs. Main services delivered are capacity building for PLWHA's organizations, income generating activities and food support to PLWHA.

Donors

Partnerships with other donors have also strengthened the programmatic and funding efforts of the Global Fund under the three disease profiles. The collaboration has extended to bilateral and multi-lateral partners working on HIV and AIDS, TB and malaria through existing in-country partnership frameworks, and also through the MDG Performance Fund partners.

Active engagement in the Country Dialogue under the New Funding Model country concept preparation and submission is expected to further strengthen alignment and harmonization of partner efforts in the fight against HIV, TB and malaria and strengthening health system investments.

Some of the examples and existing methods of donor and technical partnerships in Ethiopia are listed below:

- A Memorandum of Understanding (MOU) aimed at maximising the use of resources was signed on 7 February 2006 between PEPFAR and the Global Fund PR, HAPCO. The MOU details the national targets to be met: including 210,000 persons on ART and support to 500,000 OVCs to be achieved through joint planning and collaboration.
- IHP+: Ethiopia was the first country to sign the IHP compact. The compact builds on the 2005 Harmonization and Alignment Code of Conduct. The country has pledged to work with all the partners including GF and PEPFAR within the framework of the signed IHP.
- Seven agencies DFID, Spanish Development Cooperation, IrishAid, UNICEF, UNFPA, the World Bank and the World Health Organization signed a Joint Financing Arrangement in April 2009 for pooling their support to the health sector.
- DFID provides support for Ethiopia's Health Sector Development Plan. DFID provides direct financial support to some NGOs, in addition, it has also provided a 3 year fund for a capacity building project for the government HIV PR (HAPCO). HAPCO's 3 year funding is coming to an end. In the future, DFID intends to channel its funding through the government.

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WHO IS WHO AND WHO DOES WHAT

Friends of the Global Fund Europe (Friends Europe) is a non-profit organisation founded in April 2005, under the high patronage of the President of the French Republic, to engage with Europe's political and institutional decision-makers, public opinion, media, civil society organisations and private sector on the task of combating AIDS, tuberculosis and malaria, and more specifically to mobilise support for the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund). Its actions include political advocacy to support investment in the Global Fund by the international community and to succeed in eradicating three of the most devastating pandemics affecting the developing world.

**Friends
Europe**

Our Objectives

Raise the awareness of States, political decision-makers, civil society, public opinion and the media as regards the issues involved in combating the three pandemics on a global scale, and as regards the Global Fund's strategy, actions, operating model and funding needs;

Support and increase the resources dedicated to fighting the three pandemics, through the Global Fund in particular, and find innovative means of financing development and world health;

Mobilise public and private sector stakeholders and encourage the development of partnerships between business and the public sector to combat the three pandemics.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria is an international financing institution that supports countries in their fight against three of the world's most devastating diseases.

Created in 2002, the Global Fund is a unique partnership between governments, civil society, the private sector and affected communities. The Global Fund channels approximately US\$ 3 billion a year to health professionals to treat and prevent AIDS, tuberculosis and malaria in their countries. The Global Fund does not implement or manage programs on the ground, relying instead on local experts to select and administer the programs that save the most lives.

The success of the Global Fund relies on the financial pledges of donors, the technical guidance of multilateral partners, and particularly on the devotion and hard work of implementers at the country level.

The Global Fund is primarily supported by donor countries, led by the United States, France, the United Kingdom, Japan and Germany. We also seek funding from private sector companies, private foundations, and individuals. A full list of donors and amounts pledged or contributed can be found on the Global Fund website.

Global Fund financing is intended to be in addition to – and not in replacement of – national health budgets. We insist that middle-income countries contribute a portion of program costs. In this way, available funding can be directed to those most in need and those who can make the most effective use of it and those decisions take into account a country's ability to contribute.