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1. NEWS: Global Fund Rescinds Approval of Round 10 TB Proposal from the Russian Federation

Official reason cited was that the time period for signing a grant had expired

The Global Fund has rescinded its approval of a Round 10 TB grant from the Russian Federation. The official reason advanced by the Fund was that the period allotted for negotiations of the grant agreement had expired with no agreement having been signed. However, the real reason appears to have been the fact that the Government of the Russian Federation was opposed to the country receiving any more grants from the Global Fund because it now sees itself as a donor to the Fund. In addition, the Global Fund did not want to sign a grant agreement unless the Government was on board.

The TB proposal was designed to provide treatment over a five-year period for 18,000 patients suffering from severe forms of multi-drug resistant TB, as well as 1,700 patients co-infected with HIV and TB, 60% of whom are prisoners. It is these intended beneficiaries who may pay the highest price for the fact that no grant will be forthcoming from the proposal. Russian advocacy groups fear that the government will not step in to provide the services that the proposal was designed to provide.

The proposal budget was about $127 million. The principal recipient (PR) nominated in the proposal was the Russian Health Care Federation, an NGO.

On 20 March 2012, Mark Edington, Head of the Grant Management Division at the Global Fund Secretariat wrote to the then Chair of the CCM, Professor V.I. Pokrovsky, to inform him of the Fund's decision.

When the CCM submitted the TB proposal in August 2010 – a proposal that was endorsed by most of the members of the CCM, including some government representatives – the Russian Federation was still a recipient of Global Fund grants. Then, in October 2010, the Government announced that the Russian Federation would become a donor to the Global Fund and did not wish to receive any more grants.

In his letter, Mr Edington said that on 8 October 2010, the Deputy Minister of the Ministry of Health and Social Development wrote to the CCM Chair to say that all Global Fund grants in the country were to be completed by 2011, "and that therefore Russia's participation in the Round 10 call for proposals was not considered by the Ministry."

Nevertheless, the Russian Federation TB proposal was one of numerous Round 10 grants approved by the Global Fund Board on 15 December 2010. On 11 January 2011, the Global Fund Secretariat sent the Russian CCM a routine notification letter, indicating that the Board had approved the TB proposal, and that such approval was conditional on the successful completion of negotiations of a grant agreement within 12 months of the date of Board approval.

According to the letter from Mr Edington, on 25 July 2011, the Executive Director of the Global Fund received a letter from the Ambassador, Permanent Representative of the Russian Federation to the U.N. Office and Other International Organisations in Geneva, informing him of the government's decision not to accept the Round 10 grant. Mr Edington said that the CCM Chair then requested that CCM members express their position on the TB proposal. Mr Edington noted that as of 15 November 2011, the government-affiliated constituencies of the CCM "did not express their support of the proposal."

In his letter of 20 March 2012, Mr Edington quoted the Round 10 TB proposal as saying that "the Ministry of Health and Social Development of the Russian Federation has the overall responsibility for TB control in Russia and the Principal Recipient shall collaborate and coordinate the implementation of the project with the Ministry of Health and Social Development, Federal TB Institutes and regional public health care institutions." The significance of this statement is that the Global Fund believed that the proposal could not be implemented properly without government collaboration.

As indicated above, the Global Fund requires that all grant agreements be signed within 12 months of Board approval of a proposal. The Global Fund Secretariat has the authority to extend this period by three months if circumstances warrant. According to Mr Edington, on 22 December 2011, the Global Fund informed the CCM in writing that it was granting an exceptional extension to the period for signing the grant from the TB proposal "on the condition that national stakeholders utilize the extension period to finalize grant negotiations

by defining appropriate ways and consensus among all CCM constituencies, national stakeholders to implement the Grant."

In his letter of 20 March 2012, Mr Edington told Dr Pokrovsky that on 19 March 2012, the Secretariat's Management Executive Committee conducted a thorough review of the negotiations undertaken between the proposed PR and the Secretariat. Mr Edington said that the Committee concluded that negotiations "were not at a stage which would warrant grant signature. As a result, the Global Fund Board's approval of the Round 10 TB proposal has now expired." Mr Edington added that there is no right to appeal this decision.

Had a grant been signed based on the Round 10 TB proposal, new rules adopted by the Global Fund Board might have placed the grant in a difficult situation. In November 2011, the Board decided that Group of 20 (G-20) upper-middle-income countries with less than an extreme disease burden would no longer be eligible for renewals of grants. The Russian Federation currently has a severe, but not an extreme, disease burden in TB. Had that situation prevailed at the time of a request for Phase 2 renewal, the grant would not have qualified for renewal.

Reaction from stakeholders

GFO was informed by a source within a civil society organisation in the region that on 14 September 2012, the CCM discussed the situation and voted to re-endorse the proposal, and that the representative of UNAIDS on the CCM abstained from that vote.

On 6 October 2011, the Interregional Public Organisation "Community of People Living with HIV," the International Treatment Preparedness Coalition – Eastern Europe and Central Asia (ITPCru) and Andrey Rylkov Foundation issued a statement criticising UNAIDS for abstaining. The statement said that the TB proposal would have complemented the government's efforts to fight TB.

GFO was also told that the CCM met again on 6 December 2011 and once again re-endorsed the proposal. Our source said that almost all government members either voted against re-endorsing the proposal or abstained; and that a majority was secured by virtue of the votes from the non-government sectors and multilateral partners. The source said that the Global Fund "was not satisfied with the results of the voting" because the government representatives did not vote in favour.

GFO is not aware of the outcomes of any discussion that the CCM may have had concerning Mr Edington's letter of 22 December to the CCM Chair.

There have been reports in recent months that several regional hospitals in the Russian Federation were facing stock-outs of TB medicines. Some treatment activists have said that the decision not to proceed with the Round 10 TB proposal is a contributing factor to the stock-outs.

On 9 April 2012, Sergey Golovin, Advocacy Officer for ITPCru, wrote on the ITPC listserv that what caused the decision to rescind the approval of the Round 10 TB grant was "the change of the Russian Federation's status in financing the Global Fund – Russia has become a donor and is now claiming that it doesn't need help from the Global Fund and is ready to help other countries." In his post, Mr Golovin quotes Andrey Zlobin, chairman of the organisation "Community of People Living with HIV" as saying: "The Directorate of the Global Fund had been notified about the new donor status of Russia before the approval of the grant in 2010. However, the Secretariat of the Global Fund took their words back. Unfortunately, the Global Fund, a body created with the purpose of protecting patients'

interests, took a certain place among many international organizations playing political games with Russian officials."

GFO has a copy of Mark Edington's letter of 20 March 2012 on file.

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2. COMMENTARY: Is a New Narrative Shaping the Global Fund?

By David McCoy

Following a "perfect storm" of fiduciary, financial and managerial problems which plunged the Global Fund into a crisis, the organisation is now undergoing a process of *transformation*. Both the crisis and the decision to embark on transformation are significant and surprising given that until quite recently, the Fund was generally acclaimed as a grand success.

This article argues that a new "narrative" (that is, a set of ideas and explanations) has been formed around the Global Fund's crisis and transformation, and that it is important to look critically at these ideas and explanations.

More than ten years ago, ideas and explanations played an important part in the formation of the Global Fund. They included: (a) the idea that HIV/AIDS was a global health emergency and a threat to economic and political stability (see here and here) which required an unprecedented and aggressive global health response (Kofi Annan called for a "war chest" "to fight HIV/AIDS); (b) a view that existing global health organisations, especially UN-affiliated bodies, were inefficient and inadequate, and that the use of public-private partnerships and business models would improve global health management and governance; and (c) a growing discourse around universal health rights which emphasised the responsibilities of rich countries for funding the unmet health needs of people in low- and middle-income countries.

These ideas and explanations paved the way for the creation of the Global Fund as a global health partnership, encompassing governments, donors, one multi-billionaire, multi-nationals, NGOs and affected populations. The active participation of civil society was hailed as a notable improvement to the way aid was traditionally managed. The ideas and explanations also justified developing the Global Fund as a bold and ambitious organisation that would rapidly expand the coverage of key services and treatments, mainly through vertical and selective programmes and projects whose outputs could be more easily measured.

However, when it became more widely recognised that the uncoordinated proliferation of global health institutions and vertical programmes (of which the Global Fund was a part) was undermining the health systems of recipient countries, and that strong health systems were necessary for ensuring the sustainability, efficiency and effectiveness of disease-based programmes, the ideas of "aid effectiveness" (AE) and "health systems strengthening" (HSS) became prominent within the narrative surrounding the Global Fund.

As a consequence, the Global Fund began to examine how to resolve the tensions between being disease-based and results-driven, whilst supporting HSS and AE efforts. It joined the International Health Partnership, which committed development partners to harmonise their funding and programmes and improve the alignment of health aid with national systems and plans. The creation of a dedicated health systems funding platform, and a proposal to expand the remit of the Global Fund to include maternal and child health, also reflected the emergence of AE and HSS as important issues.

But the Global Fund's crisis and transformation appears now to have created a quite different narrative. Three themes appear to be prominent.

The first is "financial austerity," as exemplified by this chilling message from the High Level Panel, that was established to investigate the Global Fund's fiduciary systems in the wake of the recent "corruption scandals":

> "The halcyon days of ever-increasing budgets for global health are over, as Governments turn their focus inward in response to domestic concerns, including unemployment and debt reduction. The Global Fund can no longer count on appealing to key political figures in large donor countries to increase their nations' contributions as a matter of pride or in the name of 'solidarity.' The economic problems are too severe, and as Governments pull back on their expenditures across the board, foreign assistance will share in the retrenchment."

Implicit in this theme is the view that HIV/AIDS is no longer a threat to the political and economic interests of rich countries. The theme also implies a shift away from associating the Global Fund with notions of global duty and solidarity, towards notions of discretionary benevolence and charitable assistance. In discussing the Global Fund's crisis, Laurie Garrett even pointed to the "fickle largesse" of rich countries having "spawned dependency" amongst poor countries, thus implying that the previously prominent rights-based agenda was an indulgence.

The second theme is "risk," which emerges from the recent "corruption scandals" that harmed the Global Fund's reputation and even caused some donors to temporarily suspend their funding pledges. The effect has been to place "financial management," "fiduciary control" and "risk management" higher up the Fund's agenda, increasingly at the expense of calls for speedy disbursements and the rapid expansion of treatment coverage. This has reinforced the theme of financial austerity. Associated with the risk theme is the current shift towards the Global Fund playing a more active role in engaging with countries to ensure better fiduciary control, extracting more "value for money," and leveraging a greater level of financial contribution from recipient countries towards HIV, TB and malaria programmes.

The third theme is the idea that the Global Fund has not been adequately efficient. This was prominent in the report of the High Level Panel. As a result, notions of "value for money" and "maximising returns from investment" have featured strongly in commentaries written by a number of global health commentators. Richard Feachem, for example, calls for the adoption of "cash-on-delivery aid" in which countries "that have proven the ability to manage funding responsibly could receive carefully calculated payments for each standard unit of verified output or outcome."

Stephen Morrison and Todd Summers call on the Global Fund to improve its "purchasing efficiency", while Amanda Glassman calls for "genuine performance-based contracts" based on the purchase of priced interventions. Glassman also encourages the Global Fund to change from being "a passive cashier" to becoming "an active and strategic investor in the shared enterprise of producing health results."

These three themes stand in stark contrast to the ideas and concepts that accompanied the birth of the Global Fund. So it is appropriate that what is occurring to the Global Fund is described as a *transformation,* rather than simply change. But ideas, concepts and explanations that become dominant are not always true or well grounded. They need to be examined and questioned.

For example, one might challenge the validity of certain aspects of the narrative. This includes the idea that the "financial losses" uncovered by the Office of the Inspector General

were so severe and shocking that they justified criticism of the Global Fund to the extent that it precipitated a crisis. In reality, the reports about alleged corruption associated with the Global Fund were often exaggerated and taken out of context. Undoubtedly, there have been cases of corruption associated with Global Fund grants and this is unacceptable. However, corruption exists almost everywhere. If anything, the Global Fund's record on transparency and rigorous auditing is commendable and the identification of financial irregularities could just as easily be portrayed as a sign of strength rather than weakness.

The idea that financial austerity must impact on the Global Fund is also questionable. In the bigger picture, there is more than enough money to support further growth in the amount of money that the Fund invests each year in countries.

Another aspect of the dominant narrative that should be challenged is the frequent portrayal of the Global Fund as a self-contained and autonomous organisation when, in fact, it is a partnership of multiple organisations and its "performance" is shaped by a larger group of actors. If the Global Fund fails, it is not just one organisation that fails, but also a broader system that includes a larger network of actors. Corruption and poor financial management are, for example, more likely when systems are weak and fragmented. And many grants have struggled because of the lack of effective and coordinated support and assistance coming from other development partners.

However, the current narrative is mostly silent on health systems strengthening (HSS) and aid effectiveness (AE). Neither the Global Fund's Consolidated Transformation Plan nor its 2012–2016 Strategy mention the International Health Partnership, nor various instruments and processes designed to improve harmonisation and alignment, such as Joint Assessment of National Health Strategies, joint financing agreements and country compacts. These are significant omissions because several of the identified weaknesses of the Global Fund result from the uncoordinated and fragmented nature of the "global health complex." But instead of seeking systemic solutions to systemic problems, the rhetoric of the new narrative appears geared towards finding Global Fund–specific solutions for its own priorities.

It is also worth noting that several aspects of the Global Fund that have been recently criticised, such as weak fiduciary control and lack of targeted investment, are merely the flipside of features that were encouraged by, and hailed as positive by, donors and other stakeholders (e.g., willingness to take risks; rapid and aggressive expansion of services; being responsive to country-led demands; and having the lightest of footprints within countries).

The Global Fund is not a perfect organisation. There are many areas where it can improve and be strengthened. But the authenticity of the narrative that appears to have become established around its fiduciary, financial and managerial "crisis" is questionable and should be challenged.

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3. NEWS: Health Centres Constructed in Ethiopia Were Not in Approved Workplan and Budget, OIG Says

Says funds taken from other services to cover cost of centres

PR and CCM dispute the findings

The Office of the Inspector General (OIG) says that 1,291 new health centres were constructed as part of the Rounds 4 and 7 HIV grants in Ethiopia, even though this activity was not part of the approved workplan and budget. The OIG also states that the Global Fund Secretariat knew about the construction, but did not follow proper procedures for what the OIG says constituted material changes to the grants.

The OIG made these comments in a report on the audit it conducted on all Global Fund grants in Ethiopia. The principal recipient (PR) for both grants was the HIV/AIDS Prevention and Control Office (HAPCO), a government agency. We reported on the main findings of the audit in GFO 183. This article deals specifically with one part of the audit report – the new health centres.

The OIG said that the health centres were constructed as part of a strategy to expand entry points to antiretroviral therapy (ART) and other services. According to the OIG, the budgets for the Rounds 4 and 7 grants included funds to renovate existing health facilities, and to construct and renovate "health posts" (small satellites of health centres) in the regions, but did not include funds to build new health centres.

The total budget for renovation and construction was $107 million. The OIG said that when the costs of 1,291 new health centres were charged to this budget line, the result was a budget overrun of $58 million.

The OIG said that monies intended to finance other services, such as ART, and drugs for opportunistic infections (OI), were used to cover this over-expenditure. The OIG reported that there was significant under-spending on these services, which impacted programme results. For example, the OIG said, "the indicator for 'Number of patients who received prophylaxis and treatment for OI' was reported as just 74% of target. Many of the planned OI drugs had not been procured."

HAPCO and the CCM disputed the OIG's findings (see below).

The OIG said that there was no formal approval from the Global Fund to add the construction of the health centres to the programme. In addition, the OIG said, the Technical Review Panel (TRP) did not review and approve the change to the scope and scale of the proposal originally approved – which would normally have been required – and the performance frameworks for the grants were not revised to reflect this significant reallocation of funds.

According to the OIG, the Global Fund Secretariat was aware of the nature and extent of the health centre construction activities. In fact, the OIG said, in 2009 and 2010 the Secretariat arranged for reviews to evaluate the construction.

The OIG also stated that a proposal containing health centre construction activities had been reviewed by the TRP in both Rounds 5 and 6, but was not recommended for approval "for a number of programmatic and budget reasons."

Finally, the OIG said that it had visited 77 of the health centres and had observed significant deficiencies (e.g., 71% had no access to water; 32% had no functioning toilet facilities).

Reaction to the OIG findings

In a section of the OIG report on how the Secretariat, the country coordinating mechanism (CCM) and the PRs responded to the OIG's recommendations, the Secretariat said that it was aware of the "reclassification of health center construction activities and agrees that the documentation should have been better formalized." The Secretariat added that it was following up with the Federal Ministry of Health (FMOH) to ensure that all health centres were completed in accordance with the ministry's minimum standards. It also said that, in March 2012, the Secretariat was told that 73 of the 77 centres visited by the OIG were provisionally accepted as having met the standards. The Secretariat added that the local fund agent (LFA) had been requested to verify this information; and that the Secretariat will ask the CCM to ensure that all defects are rectified.

HAPCO said that prior to October 2010, there was no limit on the extent to which PRs could make changes to the workplans of a grant. HAPCO also repeated some of the same comments that the Secretariat made above concerning the current state of the health centres.

When asked to comment on a draft of this article, HAPCO and the CCM told *GFO* that construction of health centres was part of the workplans and budgets for Phase 2 of the Round 4 HIV grant, and also for Phase 2 of a Round 2 HIV grant (not included in the audit). However, *GFO* was unable to find any reference to the construction of new health centres in the Phase 2 workplans and budgets for these two grants.

HAPCO and the CCM denied that there was an overrun of $58 million and that money had to be taken from other services funded by the grant to cover the costs of the health centre construction. They said that evidence had been submitted to the OIG team showing that funds were taken from non-Global Fund sources to fill any gaps in the budget. The OIG told *GFO* that it has not received any such evidence.

"The critical point here is how we have covered the cost of construction," HAPCO and the CCM said. "We didn't compromise the delivery of planned services; rather we harmonized the other external aids we got from the World Bank Protection of Basic Services Program, the GAVI Alliance's Health Systems Strengthening initiative, the Millennium Development Goals Performance Fund and the (US) President's Emergency Plan for AIDS Relief (PEPFAR) in implementing some of the activities. The expenditure figures in the OIG report are reflecting expenses from Global Fund grants only." The OIG told *GFO* that it stands by its assertion that funds were taken from other services covered by the Rounds 4 and 7 HIV grants in order to pay for the cost overruns to the renovations budget caused by the construction of new health centres.

Regarding the OIG's statement that a proposal containing health centre construction activities had been reviewed by the TRP in Rounds 5 and 6 and had not been recommended for approval, HAPCO and the CCM told *GFO* that the Round 6 proposal was not about health centre construction. *GFO* has verified that this statement by HAPCO and the CCM is incorrect.

All of the OIG reports released in April 2012 are available on the Global Fund website here. Some of the documents referred to in this article are not available on the Global Fund website; however, copies were provided to GFO.

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4. NEWS: Global Fund Must Develop a More Strategic Funding Model, Study Says

"The Fund should consider abandoning the use of income status as an eligibility criterion"

Authors call for an approach based on disease burden and financial need

Ten years after its formation, the Global Fund is now entering a phase that will require it to allocate its funds more carefully and strategically. It can only do so by addressing the tension between being a responsive, demand-driven funder and being a more directive, supply-led funder, a new study has concluded.

The study was carried out by Dr David McCoy and Kelvin Kinyua for Aidspan, and was published on 9 May 2012 in the journal *PLoS ONE*. The study described the Global Fund's pattern of disbursements in relation to total health expenditure, government health expenditure, income status and the burden of HIV, TB and malaria. It also examined the potential for recipient countries to increase domestic public financing for health.

The study covered 104 countries that received Global Fund money in 2009. It analysed data on disbursements, health financing indicators, government revenue and expenditure, and disease burden.

A total of 862 disbursements amounting to $2.6 billion were made to the 104 countries, broken out as follows: 58% to low-income countries (LICs), 34% to lower-middle-income countries (LMICs), and 7.3% to upper-middle-income countries (UMICs).

The study found that Global Fund financing constituted 0.37% of total health expenditures in the 104 countries. However, there was a wide variation among countries, ranging from 0.002% to 53.4%. The study found a similar pattern for Global Fund financing as a percentage of government health expenditure. In three countries, more than half of government health expenditure came from the Global Fund. However, the study found that levels of overall health spending within a country do not appear to influence the Global Fund's pattern of resource allocation.

The study highlighted the fact that 22 countries were, to a lesser or greater extent, "dependent" on the Global Fund in the sense that should the Fund stop making disbursements, there would be a significant financial impact on total or government health expenditure.

The authors stated that the Global Fund should reconsider its overall approach to resource allocation. On the surface, they said, income status and burden of disease are clearly reasonable criteria to use because the former helps prioritise poor countries, while the latter is designed to allocate resources according to burden of disease. However, the authors pointed out, there is now a poor correlation between (a) the global distribution of people living in poverty and suffering from the three diseases and (b) the income status of countries.

Furthermore, according to the authors, "not only is the average income status a poor marker of the burden of need," it can also be a poor indicator of the ability of a country to finance an adequate response to the three diseases. "A more sophisticated approach is required, combining an assessment of the financial need of a country *and* its burden of disease."

In discussing the concept of "financial need," the authors noted that many countries have the potential to expand domestic financing for health, and suggested that the Global Fund should assess the size of this potential. This would require examining: the adequacy of total health expenditure and government health budgets; the contribution of other donors; the potential to expand government budgets and revenue; and the potential to increase the allocation of government budgets to health. As such, "social and political factors inhibiting an adequate or appropriate domestic response to the three diseases would need to be considered."

The authors pointed out that the Global Fund's counterpart financing rules encourage the preferential allocation of Fund resources to countries that are already spending money on HIV, TB and malaria. They are not designed to get the Fund to compensate for low or poor levels of domestic funding. As a result, the authors said, the counterpart financing rules could end up punishing those most in need of Global Fund support because of the decisions of their government. "Here lies a tension for the Global Fund," the authors stated. "On the one hand, it wants to use its grant-making power to leverage greater domestic health spending on the three diseases. On the other, it seeks to respond to *people* in need which may require approving grants in spite of or because of government neglect."

According to the authors, counterpart financing rules would be more effective if they were designed not just to increase government spending on HIV, TB and malaria programmes, but to also improve a country's overall commitment to health financing and health systems development.

According to the authors, managing the tension between being responsive to country-led applications and responding to the health needs of populations and the financial needs of countries could be solved by adopting a three-track approach. One track would have the Global Fund providing assistance and capacity development for countries to produce sound and appropriate HIV, TB and malaria plans. The second track would consist of the current demand-led model of having countries apply for grants. And the third track would entail a more explicit resource allocation formula that would set country-specific budget ceilings and floors based on the Global Fund's own budget, as well as an assessment of the combined health *and* financial needs of recipient countries.

The authors noted that there have been suggestions that the Global Fund incorporate measures of financial risk in its resource allocation strategy to reduce the Fund's exposure to fiduciary problems. "In our view this would be inappropriate and potentially counter-productive," the authors stated. "While an assessment of financial risk should influence the design of appropriate financial procedures and fiduciary controls, a resource allocation strategy should be determined by a combination of health and financial need. Those countries with weak financial management systems and inadequate fiduciary controls are often those in need of *additional* development assistance for health and long-term systemic developments."

The study, "Allocating Scarce Resources Strategically – An Evaluation and Discussion of the Global Fund's Pattern of Disbursements," is available here. Dr David McCoy (david.mccoy@aidspan.org) is a public health physician and honorary senior clinical research fellow at University College London. He serves as a consultant to Aidspan and also works part-time in the UK National Health Service. Kelvin Kinyua (kelvin.kinyua@aidspan.org) is a Senior Systems Officer with Aidspan.

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We welcome suggestions for topics we could cover in *GFO*. If you have a suggestion, please send it to the Editor of *GFO* (see contact information below).

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