Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

Issue 240: 19 March 2014

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Aidspan launches its French-language newsletter, Observateur du Fonds Mondial, to broaden its multilingual reach and be even more relevant to individuals and organizations involved with the Global Fund.

See section near the end of this newsletter listing additional articles available on GFO Live.

ARTICLES:

1. NEWS: Global Fund announces country allocations under NFM

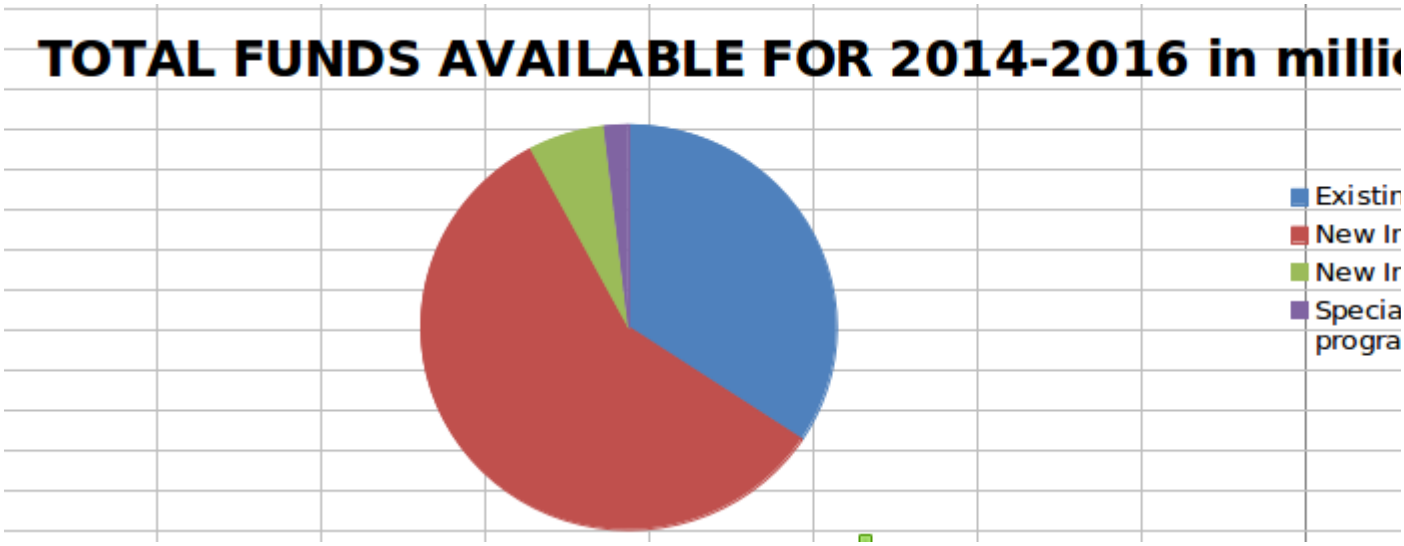
Concerns abound about allocation period, transition funding and integration of existing and new money

The Global Fund on 12 March announced the allocation of $14.82 billion dollars across the 123 countries eligible for financial support of activities in at least one disease component, timing the release of a comprehensive list of the amounts available to each country with personalized letters sent directly to country coordinating mechanisms (CCMs).

The announcement – the culmination of a more than two-year effort to develop a new allocations methodology to guide the transition away from the rounds-based approach to the 'investing for impact' new funding model (NFM) – was made with little fanfare. Some countries, after seeing their allocation, grimly wondered whether this was a function of the inevitable disappointment that accompanied sums that were much less than anticipated.

In calculating the total sum available for allocation through 2016, the Global Fund added the estimated $5.5 billion it had on hand with an initial allocation of $10.22 billion, raised during the December 2013 pledging conference in Washington, DC.

That allocation was apportioned as $9.27 billion in indicative funding – available to all 123 eligible countries in varying increments – and $0.95 billion in incentive funding, confined to those countries assigned to Bands 1-3. Additional funds worth $300 million have been reserved for special initiatives and regional programs.



The totals announced in the letters also included a recommended breakdown by disease. In most countries, some percentage of funding in each disease is projected to support health systems strengthening: another key plank in the NFM strategy. These splits were intended to be recommendations for countries, although any flexibility in modifying the split will be subject to approval from the Fund. But already, countries and disease-specific advocates, particularly in the realm of TB and malaria, are gravely worried about underfunding.

An additional complicating factor is the money that has already been disbursed but remains unspent. So, for example, if $10 million has been disbursed to a country under transitional or renewal funding during one of the recent rounds of Grant Approvals Committee recommendations to the Board and it was approved, that money – already in hand, or cash in the bank – is deducted from their total allocation envelope.

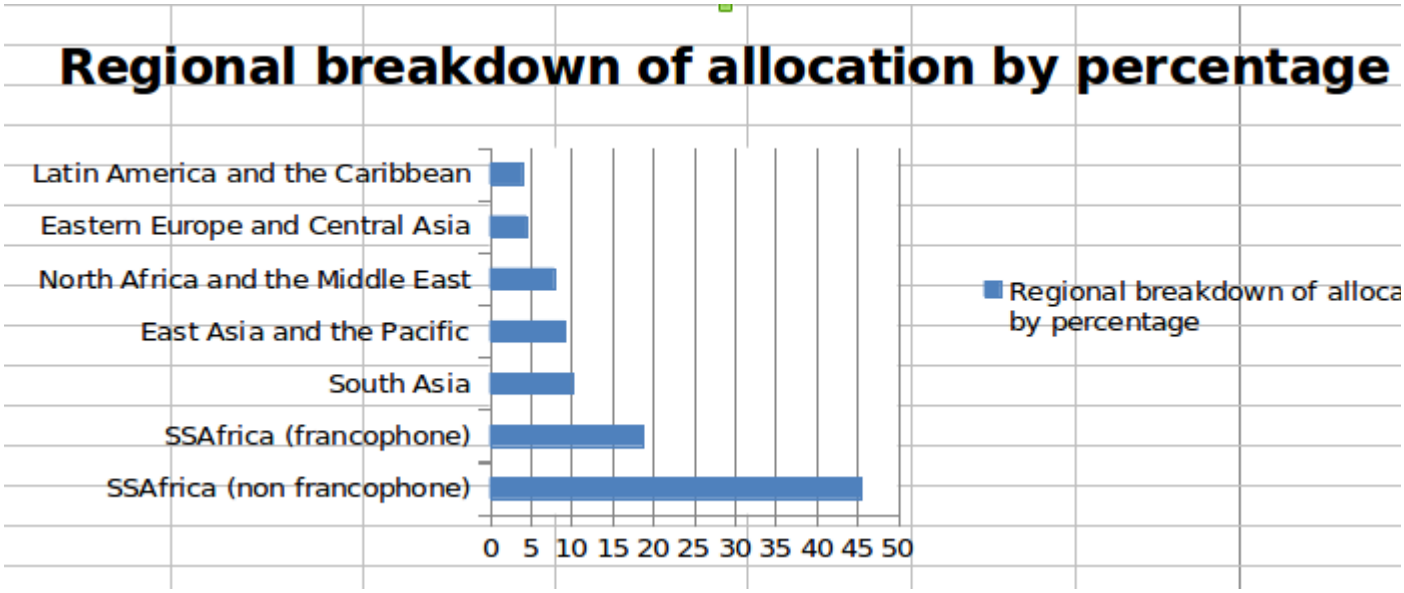
Yet another wrinkle is likely to manifest when it comes to the apportioning of resources in the 38 countries required to submit integrated HIV/TB proposals due to their high levels of co-morbidity. How that will be reconciled at the country level will likely be one of the core discussions during the country dialogue process that should be under way in eligible countries in coming weeks.

For many countries, the column in the table that identified their previous over-allocation was particularly troubling, especially since the burdens of disease and gap in unmet needs remain considerable. (See article here on over-allocation). Acknowledging that almost every country fighting the three diseases is 'under-funded' to some degree, the Fund said it was encouraging countries to prioritize key elements of national strategic plans and national health strategies for use of their envelopes while also seeking funds from other sources.

Implicit in this message is the clearly stated requirement contained in each of the allocation letters that countries must meet a 'willingness to pay' requirement in order to access 15% of funding; this 'willingness to pay' is shorthand for domestic co-financing of public health initiatives: a key demand from the Global Fund's donors that have shown themselves increasingly unwilling to shoulder the entire burden of financial responsibility for this aspect of health care in less-developed countries.

"The allocation model is the best way to address global challenges collectively," the Fund said in a document of Frequently Asked Questions. "That does not mean that every country gets more funding; it means that funds are allocated for maximum impact globally."

Breakdowns by region reflected the methodological approach to allocations that is at the core of the NFM: countries with the highest disease burden and lowest ability to pay received the lion's share of financial support. By extension, this has meant that nearly 50% of all money allocated during the period 2014-2016 goes to anglophone and lusaphone sub-Saharan Africa.



Most of the challenge around country allocations in this transitional period is manifesting itself with respect to the pipeline of existing grants, worth an estimated $9.06 billion.

In order to maintain continuity with what is in the pipeline, the Fund has had to essentially borrow 'new' money to make good on existing commitments to grants that were agreed under the rounds-based approach. This has left a smaller pool of resources available for the type of innovative investments to scale-up programs and target key populations for improved impact that the new approach is trying to encourage.

This presents countries with what some are considering a dilemma and others an opportunity. If there is significant money on hand already, a country could choose to delay its entry into the NFM, preferring instead to close out the rounds-based grant or grants it is currently implementing. That decision – about the so-called ‘start date’ – will require an additional round of discussions with the Fund about the financial needs to keep old programs going. Once a new grant is signed, using the total funding envelope available, old grants, for all intents and purposes, will be closed.

This choice is consistent with the Fund's support for country ownership: do countries integrate 'new' money into their existing programs and allow grants to run their course, or do they completely overhaul their programs and activities, using the country dialogue as a fresh start for better-targeted, higher-impact activities?

But it also represents the paradox of prescriptiveness that subtly manifests itself within the guidance provided by the Fund. It is clear that for the NFM to take root and guide countries towards high-impact, high-value targeted programming, the Fund wants them to take the whole package (the existing and additional funds) and re-program on a smart and tailored approach to infectious disease control.

The Fund's championing of this option manifests itself in its support for “strategic reprogramming” on a country-by-country basis, with a vow that requirements and guidelines that currently exist for reprogramming will be streamlined.

Irrespective of the individual or country-level disappointments (see article here for reactions), the Fund has remained steadfast in its promotion of the NFM as a new approach that matches programmatic activities to epidemics: thus the focus on key affected populations in the Fund's strategic documents, since that is where the burden of disease and the highest risk of transmission most often rests, and the emphasis on smart investment for the greatest possible impact.

The NFM is a response not only to the internal issues within the Global Fund but more importantly to what countries have said from the outset that they want: more predictability in funding, more control over how money is spent, and better coordination with the Fund's own architecture to achieve the best possible result. The current confusion and disappointment would appear to be more related to the transition and the need to confront and resolve the liabilities from the past -- including over-allocation, integration of existing and new funds, closing old grants and so on – before being able to move completely into the new approach.

Read the article in French. Lire l'article en français.

[This article was first posted on GFO Live on 19 March 2014.]

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2. NEWS and ANALYSIS: "Significantly over-allocated" countries see limits on their resources under new funding model's allocations

These countries will be limited to implementing existing grants through 2016

Countries considered by the Global Fund to be "significantly over-allocated" have seen dramatic reductions in their allocations under the new funding model (NFM), and will be limited to implementing existing grants until the end of 2016.

Modest reductions had been expected, but the situation in many countries appears to have been aggravated by the decision to include both existing and new funding in the allocations announced to countries on 12 March.

Under the methodology adopted for allocation under the NFM, those countries considered "over-allocated" in the past – receiving more than the new formula suggests they are entitled to – were to see their envelopes for the 2014–2016 period reduced by some 25%. Future allocation periods would see comparable staggered reductions until the pre-determined level was reached. This process was dubbed a "graduated reduction" in the run-up to the roll-out of the NFM. (For more information on graduated reductions, see Annex 1 in the Aidspan paper, "The New Funding Model Allocation Methodology Explained: Version 2.")

That methodology did not, however, make any reference to "significantly over-allocated" countries: a description that, when it was included in letters received by Ukraine and others, came as a bit of a shock.

Ukraine is an upper middle-income country. In the letter received by Ukraine, a copy of which was shared with Aidspan, the Secretariat said: "The allocation formula used in the new funding model indicates that Ukraine's HIV and TB components are receiving more funding than the country's fair share of Global Fund resources. This is because of the existing volume of funds in Ukraine's grants. Given the need to balance limited resources across the entire Global Fund portfolio, with focus on the highest disease burden and lowest income level countries, this allocation will need to be gradually reduced".

But Ukraine's allocation was more than "gradually reduced." Because the Global Fund considered that both of the country's disease components were "significantly over-allocated," Ukraine's funding until 2016 was limited to existing grants (see Table 1, taken from the allocation letter).

Table 1: Summary of 2014–2016 allocation to Ukraine

Disease Component	Existing Funding[1] (US$)	Additional Funding (US$)	Total Allocation as of 1 January 2014 (US$)	Proportion of allocation (percent)	Ov c
HIV	137,283,941	-	137,283,941	74	o
Tuberculosis	47,294,833	-	47,294,833	26	o
Total	184,578,774	-	184,578,774		S ov

[1] *Existing funding, as of 31 December 2013, is taken into account in the funding allocation. Existing funding includes: (1) committed funding that remains undisbursed; (2) uncommitted transition funding of the new funding model approved by the Board; and (3) uncommitted rounds-based funding (whether or not Board approved). Any such funding not yet approved by the Board will be adjusted by performance-based funding criteria and for Board-mandated savings.*

Column 2, labeled "existing funding", is misleading: while it is money to cover the costs of existing grants, some of it comes from funding that had yet to be disbursed as of 31 December 2013. Some of it also comes from commitments pledged during the Fourth Replenishment. This is because there was not enough money from 2011–2013 to cover all of the costs of the existing grants pipeline. As it was explained to Aidspan during the 31st Board meeting held 6-7 March in Jakarta, the existing pipeline was valued at $9.06 billion, whereas just $5.55 billion was available from earlier replenishment cycles. So, to cover the shortfall of

roughly $3.5 billion, the Fund has dipped into the pledged funds. See Table 2 for details.

Table 2: Estimated existing grants pipeline at 31 December 2013, showing costs to be covered by 2014–2016 revenues

Item	Cost ($ billion)
Signed into grant agreements but not yet disbursed	5.74
Board approved but not yet signed into grant agreements	+ 0.97
Approved in principle by the Board but subject to further approvals	+ 2.35
Total existing grants pipeline [A]	**9.06**
Estimated unutilized pre-2014 sources of funds [B]	- 5.55
Estimated existing grants pipeline costs to be covered from the Fourth Replenishment (2014ï¿½2016) [A-B]	**3.51**

For Ukraine, this means there will be some new funding for both HIV and TB but there will be no "additional funding" for new grants from 2014–2016 commitments: no money for scale-up without an overhaul of existing grants or an additional source of revenue.

The consequences for Ukraine run even deeper, according to Andriy Klepikov, of AIDS Alliance Ukraine. In an email conversation with Aidspan, he said that the $137 million allocated to HIV is actually $46 million less than what was "nearly fully approved" in December 2013 for Phase 2 of Ukraine's HIV grants. (The Grant Approvals Committee has not provided a final recommended amount for Phase 2.)

Also, the $47 million allocated for TB during this next cycle is approximately how much remained for disbursement under Phase 2 of grant UKR-913-G11-T: money that was to be spent by 2015. Now, however, as no additional funding has been allocated to Ukraine for TB, those $47 million will be stretched to cover activities until the end of 2016, or until the start of the next allocation period in 2017.

The allocation letter to Ukraine signed by the head of the Grant Management Division, Mark Edington, said: "While the suggested allocation for the period 2014–2016 remains at par with the level of funds disbursed over the last three years ($179 million between 2011–2013), we realise that this allocation represents an overall decrease to the expected funding levels."

"As the total allocation to HIV under the new funding model is less than the CCM requested amount, the CCM will need to review the program plans [for its existing grants]."

Suggestions from the Secretariat for the CCM to consider included a revision of Ukraine's renewals request for the HIV grants and a reprogramming of the TB grant for funding to extend through 2016. The CCM could also submit a new concept note covering all of its existing funding, which would be an integrated concept note due to the high rate of TB-HIV co-infection.

Whatever the decision, it will require some tough programming choices for Ukraine, which is also facing a

political crisis that Klepikov and other activists say is likely to have severe consequences for public health.

The effects of the political crisis could also limit Ukraine's ability to access its complete envelope. New "willingness to pay" requirements mandate a certain level of domestic co-financing of programs supported by the Global Fund, which in Ukraine will mean a significant increase of government contributions to TB and HIV disease programs. With the political future of the country still uncertain, this additional requirement could prove the most onerous for Ukraine's ongoing activities against the two diseases.

It is likely that Ukraine is not the only country experiencing this allocation shock. Of the handful of countries whose allocation letters were shared with Aidspan, two were informed that their HIV components had been "significantly over-allocated."

According to a draft working paper being prepared by the Center for Global Development, a majority of the top 25 recipients of HIV grants from the Global Fund have received funding that has been disproportionately high "relative to their need, performance and ability to pay".

The over-allocation conundrum is only one aspect of the allocations causing bewilderment within countries. Predictably, those who have been informed that they are over-allocated and have thus seen their envelopes shrink are making the most noise. Yet even among those countries that have seen increases in their allocations, there is considerable confusion about the implications of transition, the flexibility in the spending period and the timeline for integrating existing grants into the new proposal writing process. Aidspan has sought clarification from the Secretariat on all of these issues and will continue examining them in depth.

Read the article in French. Lire l'article en français.

[This article was first posted on GFO Live on 19 March 2014.]

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3. NEWS: Disappointment and concern are hallmarks of country reactions to 2014-2016 allocations

Money is not nearly enough, say most

Aidspan approached dozens of countries for comment about the allocation envelopes announced on March 12. Below are the responses received in time for publication of GFO 240 on March 19. Several countries contacted said that consultations were expected in coming weeks; Aidspan intends to collate further responses and will publish another compilation if warranted.

Senegal sub-recipient, Health Ministry's AIDS division: The sums allocated are trivial. We are very concerned ; sick people will face real difficulties.

Cameroon CCM vice-chair: The CCM will meet in the next several days in order to better understand the allocation. But those involved in the fight against TB think that the allocation for TB is insufficient

Western Pacific, grant coordinator for the Secretariat of the Pacific Community: There is not much of an issue in the HIV and TB allocations, but there is for Malaria, since the allocation is quite skewed to favor one country. The regional CCM will be seeking clarification from the Global Fund on how the allocations were determined and what's the best way forward, as a number of countries have expressed going towards national applications, and to sever ties with the regional CCM. Although the Global Fund has recommended going regional for the Pacific in order to maximize available funding and reduce transaction costs.

Burkina Faso, CCM chair: These allocation announcements are a good thing because it will allow countries to better formulate their demands for support with a better understanding. And it gives greater weight and assurance for proposing activities for financing. Naturally, for a developing country with a high disease burden and weak revenues like ours, grants like this will always be insufficient. But it will permit us to prioritize and to find complementary sources of financing.

Burkina Faso, permanent secretary for National Council for the Fight against AIDS and STI/CCM member: For the HIV disease component, there was no supplementary financing, which is disappointing, especially since we have taken into consideration the new recommendations from the WHO and thus were hoping for more resources. Our strategic plan concludes in 2015, so it means we basically have a year to relaunch activities against HIV. We were quite surprised about the total allocation and how it was split.

Burkina Faso, country director of UNAIDS: In absolute terms, the allocation for Burkina Faso is significant. I am pleased that the Global Fund is putting financial resources at the disposal of the country to fight the three diseases and strengthen its health system in the next three years. But I am concerned that the current allocation does not reserve additional resources for the HIV component, which weighs heavily on the country's ability to preserve results already achieved and achieve further gains in the next three years.

Côte d'Ivoire, head of CCM's malaria sector: It's a lot of money but it's not enough if you consider the recurrence of the illness. We would have wanted more to ensure better prevention and better management.

Côte d'Ivoire, civil society representative in CCM: Tuberculosis was neglected in this situation, especially in terms of what will be available to communities. We have to raise awareness among populations, and TB always seems to have a more meagre budget than AIDS and malaria, which is disappointing.

Côte d'Ivoire, CCM vice-chair: These amounts are limited with respect to the national needs, because there is enormous work to do, particularly with respect to HIV. There is so much work to be done in terms of behavior change, on how people relate to people who are HIV positive.

Ghana, CCM executive secretary: The CCM is very disappointed with the resources allocation letter. Malaria was doing well and the CCM anticipated an increase in resources but it did not turn out to be so. There is nothing new with the grant.

A lot of scale-up in the program implementation [will be lost] because Ghana has been dubbed to have over-allocation of funds. Its really a hard hit on malaria because malaria is doing very well and we thought we would be given much resources in that aspect to implement the strategic plans, but we have been asked to still forward proposals in anticipation for incentives which could come and be a supplement.

With HIV it is a bit better with additional funding of 88 million dollars for the next three years. The new funding is predictable. With the old funding scheme you can do a proposal and lose. Still it fell short of the expectation. This makes it difficult to implement the strategic plans that have being designed, and how to meet the strategic plans with the resources allocated by Global Fund is an issue.

Ukraine, principal recipient HIV/Aids Alliance: Ukrainian situation is a quite evident example how the country AIDS response can suffer from the NFM math. Common sense says to me that the existing grant pipeline should be as much as realistic / up-to-date. As we see it is not the case, assuming this funding level for 2014, the funding for the next year will dramatically decrease. Legally GF might have stronger arguments, but programmatically - not! And with the GF we are not battling a legal case in a court, we are jointly fighting the epidemic, and disarming us makes fighting the epidemic in Ukraine weaker.

South Sudan, CCM executive secretary: The amounts of money allocated to south sudan are very small. These funds should be for one year, not three. Civil society is trying to get organized to campaign for more funding.

South Sudan, Health Ministry malaria program: The amount is much below the previous allocations. It is not enough and it needs to be discussed, because needs are very high. The government is right now working on a strategic plan and the draft will be ready mid-April.

Moldova, CCM member: It was something expected, we got a bit more than we had in the past average and the disease split was basically accepted by the CCM. I guess we will request to have the grant in EUR in order to have a smooth transition from existing grants to new one and the deadlines for submissions have been generally agreed (pending final approval).

Mali, CCM chair: The amount allocated to Mali is sufficient for the fight against the three diseases

Georgia, sub-recipient Georgia Harm Reduction Network: The reaction was muted; everybody knew the Global Fund was planning to reduce funding and even maybe to close the program because at some point we were ineligible. We will use this transition period to convince government that they have to take responsibility not only for ART treatment but other prevention activities.

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[This article was first posted on GFO Live on 19 March 2014.]

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4. NEWS: Concern in MENA region over NFM and refugee crisis

Regional workshop on NFM in Jordan prepares participants for new financing mechanism

The introduction of the new funding model (NFM) has raised some concerns in the Middle East that it fails to consider the sweeping population movements and refugee crisis around the region and their impact on public health, particularly with respect to higher incidence of TB.

This was the key message at a regional meeting held on 2-5 March in Jordan, attracting representatives from all 15 countries classified as part of the Middle East and North Africa (MENA) by the Global Fund.

"They consider the income level and the disease burden – countries like Jordan, Lebanon and Iraq will not be eligible", El Tayeb Elamin, UNAIDS regional adviser for MENA in Cairo, told Aidspan. "This does not take into account the rapidly changing region and population mobility including refugee influx to those countries." Iraq will however be eligible for transitional funding of $10.7 million for TB.

According to the Health Ministry of Jordan, a total of 109 TB cases have been detected among Syrian refugees since 2011, among them at least four cases of multi-drug resistant TB (MDR-TB).

Millions of people have been displaced or forced to migrate in the aftermath of the Arab uprising that began in Tunisia in 2008 and swept across the entire region, culminating with the continued conflict in Syria that has lasted for three years and sent over two million people fleeing their homes.

The regional displacement has overburdened health systems struggling to cope with the complications of mass population movements, which include the outbreak of communicable diseases like TB, polio, measles and meningitis.

Jordan was in 2010 on track to achieve complete elimination of TB, in line with the Millennium Development Goal of reducing the global TB burden. But because of the high burden of TB among Syrian refugees, some of those successes have been mitigated. Prevalence in Jordan is now estimated at around 9.9/100,000: a rate unseen in Jordan since 2000, and considerably higher than the last recorded rate, in 2011, of 7.7/100,000, according to WHO.

A similar trend has been observed in Iraq where the estimated TB prevalence was at an all-time low in 2000 at 62/100,000 but rose to 74/100,000 in 2011 following years of armed conflict.

Jordan's Health MinisterAli Hyasat used the meeting to implore that the Global Fund reassess its eligibility criteria, noting that despite the glut of Syrian refugees currently in Jordan, estimated at 600,000 by the Jordanian government, the country is no longer able to receive grant support.

Countries hosting refugees should be able to use Global Fund support to minister to the needs of these vulnerable populations, he said, because of the public health implications both for the displaced populations and their hosts if disease is allowed to spread unchecked.

The meeting co-hosted with the World Health Organization and UNAIDS aimed to help eligible countries prepare to develop concept notes under the NFM. Eligibility under the new financing mechanism replacing the decade-old rounds-based approach was streamlined in November 2013 to invest a greater share of the Global Fund's resources in countries with the highest burdens of disease and least ability to pay – which has, in turn, eliminated the Global Fund as a potential source of financial support for many countries in the region, among them Jordan and Lebanon.

There has been some reprieve for some upper-middle income countries (UMICs) that are able to demonstrate a severe or extreme disease burden to be eligible for the general pool, and a high burden to be eligible for the targeted pool.

The presence of the Syrian refugees has put "enormous pressure" on Jordan, King Abdullah said in November 2013; he noted that the established figure of 600,000 refugees only considers those who have been classified as such by UNHCR and does not take into consideration an equal number of people hosted in communities by extended family. The approximately 150,000 Syrians residing in the Zaatari refugee camp, receive health support from UN and other international organizations. Zaatari, now the fourth largest city in Jordan, has been considered a concern for the spread of TB , with 40 cases reported since 2011.

Jordan is also the semi-permanent home to 30,000 refugees who fled Iraq following the fall of Saddam Hussein in 2003 . Another two million Palestinian refugees, most of whom have become citizens, also call Jordan home.

The Syrian refugee crisis has also put immense pressure on Lebanon, which has absorbed more than 900,000 people since 2011. Another 250,000 Syrians have fled to Iraq, which remains shorn of much of its public health infrastructure in the aftermath of the conflict there and continues to battle political and ethnic instability.

For Alaa Mokthar, head of Egypt's National TB Control Program , although the number of refugees in Egypt was increasing, there has yet to be a noticeable impact on the number of reported cases of TB – a challenge to the fears expressed by a number of health experts that rising poverty and sprawling slums would threaten the country's gains towards a national goal of TB elimination by 2019.

"Fortunately, the disease burden amongst the Syrian refugees is almost the same as among the Egytian population", says Mokthar. "Therefore, it does not present an epidemiological problem, but rather a

number problem. We have to treat more people with the same funds."

The UN Office for Coordination of Humanitarian Affairs estimates that Egypt plays host to some 135,000 Syrian refugees, as well as tens of thousands more from Libya and Sudan. Others place those figures much higher. Egypt will, however, continue to receive Global Fund support, at least through 2016; its NFM allocation, released on 12 March, will be $7.0 million for HIV and $11.1 million for TB.

Joseph Serutoke, the Global Fund's regional portfolio manager for MENA told Aidspan that the Fund was aware of the refugee crisis in the region and was looking at ways to respond within the existing funding structure.

"What we are looking at is a way of dealing with it within the existing grants. We are also calling for people to apply for regional grants to deal with the crisis that is not dealt with by individual country grants." At the 31st meeting of the Global Fund Board in Jakarta on 6-7 March, some $200 million was set aside for regional programs; another $30 million was placed in a humanitarian emergency fund under a separate envelope for special initiatives.

Some participants at the Jordan conference, however, were dubious that such grants would work in the diverse and sprawling region with a low level of participation from civil society.

"It is not clear through what institutions those regional grants could be administered", said El Tayeb Elamin of UNAIDS.

[This article was first posted on GFO Live on 19 March 2014.]

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5. COMMENTARY: Meaningful change or more of the same rhetoric? The Global Fund's new funding model and the politics of HIV scale-up

This week's full roll-out of the new funding model provides an opportunity to review independent assessments at the country level that recommend a significant transformation in the way the Global Fund structures its operations.

The Fund is a critical financing mechanism to achieve the goal of universal access to HIV treatment and prevention for people in low- and middle-income countries. Its continued evolution reflects the debates in global public health to reconcile the trade-offs between vertical programmes and integrated health care, or the value of achieving short-term health goals using life-saving therapies at the expense of building sustainable health systems.

The "investing for impact" strategy would seem to be an attempt to eliminate the need to make these trade-offs while also achieving bigger picture goals in terms of bringing HIV interventions to scale. A 'more focused approach' outlined in the strategy document that was at the foundation of the new funding model positions the Fund as 'a more effective and efficient funder' that is more 'attractive to donors', seeking to turn a page on the fiduciary, financial and leadership challenges that confronted it in 2012.

With greater predictability and flexibility of funding, more proactive engagement with grant implementation in recipient countries, the Fund is shifting away from its roots as merely a financial instrument. These dramatic changes to its funding mechanism are also helping the Fund to bind itself to its policy ideals, including its commitment to a human rights approach to financing and implementing grants.

But does this changing narrative really signify real change in behavior, in operations and, most importantly, in impact? In our paper, published in January in the Journal of Global Public Health (Kapilashrami and Hanefeld 2014), we conclude that while there is an explicit focus on making the funding model more flexible and committed to the principles of aid effectiveness and health systems strengthening, the emerging narrative risks amplifying some of the earlier negative effects of the Global Fund on country-level systems and health outcomes.

Health systems and governance

The new commitment by the Fund to go beyond targeted disease response and contribute to health systems strengthening is welcome as it acknowledges the need for sustainable external investment at the country level.

However, the nebulous notion of "invest(ing) more strategically" would appear to limit actions to those that align with national systems, and only in those countries that are most in-need. There is no mention of how donor-side coordination and alignment will occur. Nor is there anything in the strategy or funding model that relates to human resources, despite the widely documented impact of Global Fund funding on human resources in health (Hanefeld and Musheke, 2009).

There is a risk that the emphasis on 'value for money' and the attendant rise in performance measurement and management systems – with their complementary costs – are likely to compound problems of transaction costs and opportunistic behaviours linked to aid mechanisms of the Fund.

It is hoped that financing and retention of human resources will eventually be addressed through a better and more strategic alignment with national health plans and a comparative assessment of salary scales.

Better reporting and monitoring of the burden on human resources of absorption of Fund resources into health systems will ensure more strategic alignment, in a way that emphasizing impact and demonstrating value for money may not. It is also worth remembering that without investment in hiring and retaining capable staff within the health system, the impact of any Fund-supported intervention will be limited – a conclusion that has repeatedly emerged in country-level assessments.

Some countries have reported distortions and shifted incentives from Fund-supported interventions that have ignored or elided process- and quality-related concerns (Gulrajani, 2011). In India, there were many facility-level instances where staff fudged figures on adherence and re-registered patients under false names to show increased utilization of beds and care facilities (Kapilashrami and McPake 2013). This example highlights the tensions inherent ina system that provides incentives for ambitious targets alongside the promotion ofhuman rights principles such as equality and participation.

Both the strategy framework and the funding model place great emphasis on governance and funding in line with national plans. Where no such national health plan or strategy of sufficient quality exists, countries are expected to develop a plan as part of this process. There is a risk that such pre-conditions may lead countries to simply develop ambitious plans and strategies to meet a new requirement of the Global Fund, instead of genuinely engaging in, and developing, an integrated system.

Civil society participation

The new model demands broader participation by stakeholders, including government agencies, donors, civil society, and affected communities. In service to this priority, the Fund is requiring a "country dialogue": a process through which stakeholders, with support from the Fund's own country teams and external technical support, will draft a concept note that should serve as the basis for its detailed, disease-specific proposals.

Provided that such dialogue is a process and not a one-off meeting, drawing both national and sub-national engagement in an open and transparent and inclusive series of consultations that are not restricted to pre-existing Global Fund networks of civil society, there is an opportunity for civil society to better prepare for grant management and implementation. Now that countries will be required to explicitly state their intentions for the resources they are being allocated, civil society is likely to be equipped with critical information with which they may hold both the Fund and implementing bodies to account.

How this model will allow for community-level engagement in decision-making, particularly among vulnerable populations and groups who have hitherto remained invisible or marginalized in the decision-making and grant application processes, remains to be seen. Here again is the challenge of tremendous opportunity pitted against a historical legacy of coming up short.

Human rights and equity

One of the five strategic objectives outlined in the strategy paper supporting the transition to the NFM is to protect and promote human rights. This goal, driven again by the maxim "investing for impact" may be attained by withdrawing support to programs violating human rights, encouraging investments that address rights-related barriers to access, and integrating a rights perspective across all aspects of the Fund's work.

These noble aspirations are to some extent undermined by the absence of any concrete effort to ensure that populations specifically affected are not left behind. Focus is again constrained to those countries where the

greatest gains can be made; likewise, the funding model targets a small number of countries on the basis of epidemiological and governance criteria.

This approach runs counter to human rights endorsement by the Global Fund, as the poorest and most stigmatized populations in countries with weak governance or lower prevalence of HIV are set to lose out on funding, and consequently, access to life-saving therapeutic drugs and preventive interventions. Where this is not an explicit priority and where funds are limited, it is often the most vulnerable who lose out. Moreover, addressing the long-term determinants of vulnerabilities or the "upstream factors" demands a combination of approaches seeking to change individual behaviors as well as modifying the community structures, norms, and structural issues that underpin these vulnerabilities.

In addition, the strategy and funding model are silent on wider systemic issues such as the role of religion or societal norms. This silence extends to potential limits on access to medicines due to trade agreements.

Conclusion: the new model, a change or more of the same?

There has been a clear, albeit uneven, shift within the Global Fund towards aid effectiveness and health systems strengthening.

Amid debate on scaling-up prevention and treatment interventions to reach wider geographical regions and populations, focus on 'select regions' for 'greatest impact' runs counter to the proposed focus on human rights and a central aspect of Global Fund support: accessibility of such funding by marginalized populations everywhere.

While basing funding decisions on governance, epidemiology or disease-profile is understandable, the governance provisions are worrisome. The increased focus on maximizing impact and numerical targets sets up tension with the human rights commitment, which remains unresolved in the current strategy. New provisions may also increase transactional costs and opportunism, putting pressure on recipient organisations to adjust reporting figures.

Moreover, there is an inherent contradiction and internal dissonance in the Global Fund's operating model that raises questions around the overall intent and credibility of its latest strategy. By prioritizing short-term health goals in its targets for the three diseases, such as number of people on treatment, number of people with HIV enrolled in networks, spraying houses through IRS (for malaria), or vaccinating children, it de-emphasizes the importance of longer-term and process-related indicators, which are key to ensure effectiveness and sustainability of interventions that are brought to scale.

Even though the new strategy attempts to marry the principles of aid effectiveness and HSS with the need for scale-up, the overwhelming focus on increasing efficiency and impact merit a better understanding and scrutiny of how far the revised strategy seeks redemption or offers systemic solutions to allow for effective scale-up.

Aid effectiveness is as much about the conditions of aid, and political dynamics and power relations that impinge on aid, as it is about better management. Given the limited acknowledgement of these conditionalities and dynamics, the optimism inherent in the Fund strategy document and echoed by its advocates who view the new model as the much anticipated leap in the fight against HIV and AIDS, appears short-lived.

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Read the article in French. Lire l'article en français.

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6. NEWS: In South Sudan, debate on how to maintain HIV treatment adherence during times of war

Global Fund supported programs trying to maintain support for 6,617 people on ART

More than 700,000 people have fled their homes since conflict erupted in mid-December in South Sudan, which has compromised their safety and security and made them more exposed to the risk of illness and other public health challenges. But for the estimated 6,617 people living with HIV who are taking anti-retroviral treatment supported by the Global Fund, being far away from their home clinic has become a matter of life or death.

Many of the displaced have made their way to the Juba Teaching Hospital, in the capital, waiting patiently on worn and cracked plastic chairs to be seen, to be tested and to hopefully be sent away with the medication they need to maintain their treatment regimen. Adelina Drasa David, who coordinates treatment at the hospital said that there have been an estimated 300 new patients in her waiting room since mid-December, coming from all over the country.

Jovia Akello is one of those people. After fighting erupted in her hometown of Bor, the capital of Jonglei state and about 200km from Juba, she was among the thousands who hurried into the bush to avoid being caught in the crossfire. But her hasty departure meant that she left everything behind – including the ARVs she has been taking assiduously since 2011.

“I was so worried, because I know that stopping [the medicine] even for 24 hours is really bad,” she told Aidspan in Juba, where after more than two weeks in hiding she finally caught a ride in the back of a truck to the main hospital in town to replenish her stocks and resume her treatment regimen.

John Pitia was not so lucky. He’s been off his treatment for more than a month because his wife, in a panic because of the fighting, fled to her parents’ home up-country, accidentally taking with her his medication.

HIV prevalence in the world’s newest country is estimated at 2.6%, but fluctuates considerably by region, reaching 6.8% in Western Equatoria state – home to more than half of the people currently taking ARVs – and barely achieving 0.3% in North Barh El Ghazal. Most of the people on ARVs are concentrated in urban areas, like Western Equatoria’s capital, Yambio. But the challenge in this recent conflict is that the fighting has also been concentrated in urban areas, forcing people from their homes and into the bush – and away from their clinics.

Even at the best of times the condition of South Sudan’s health infrastructure is dire. Years of isolation and intermittent instability have left most facilities without even the basics – like refrigeration or a steady source of electricity.

Under a health systems strengthening allocation in its HIV grant, UNDP has since October 2010 been allocated some $47 million from the Global Fund to address some of these facility challenges. Of the $23 million that has been disbursed, some has been spent to equip 14 out of the 22 ART sites supported by the Global Fund with generator-powered refrigerators. But even they can’t run 24 hours per day and breakdowns remain a problem.

But beyond the structural limitations of the facilities themselves lies the more serious challenge of ensuring that drugs and equipment are distributed and available in the more remote – and more volatile – parts of the country. In towns where fighting was fierce, it's sometimes hard to know what they have, what they need and what they are running short of. Numerous NGOs and UN bases have been entirely looted by gunmen.

The challenge of stock-out is made worse both by the conflict and the delays that have been the result of the departure of international partners because of security reasons, according to Dr Emmanuel Lino, in charge of the Ministry of Health’s HIV program.

“Because of the crisis, most of the expatriate personnel for the international NGOs and the UN agencies were evacuated, so it makes coordination all that much harder,” he said.

The administrator of the Juba Teaching Hospital’s VCT clinic, Benjamin Lokio Lemi, ticked off some public facilities that were bare of medicine. “We’re looking for solutions in coordination with the health ministry, trying to figure out how to supply them,” he said. “In the meantime, we’re cobbling together ways to get drugs to the people in need.”

One way is to place trust in the drivers of commercial vehicles headed out on the dicey journey. A packet

of drugs is given to the driver, telephone numbers are exchanged and license plates noted and then, according to Drasa David of the Juba Teaching Hospital, all that is left to do is wait for the phone call announcing that the driver has reached his destination.

And even in Juba, the fighting has had consequences for treatment. The teaching hospital's ARV clinic was closed for three days at the beginning of the conflict, but has reopened despite safety concerns. And while most of the laboratory equipment is functioning, the blood chemistry analyzer has been broken since early December –just weeks after the last routine servicing on the machine covered by the Global Fund grant was conducted.

Funds to repair the machine will come from a March disbursement of some $2.8 million dollars, said Madelena Monoja, the UNDP focal point for the Global Fund grants in South Sudan. The disbursement is the latest tranche of transitional funding approved in 2013 worth nearly $12 million.

The gap has had serious consequences for patient care, said laboratory technician Francis Victor, making it difficult if not impossible to monitor patients' clinical response to treatment.

Patient care during times of crisis is complicated enough, without the additional burden of assessing unmet needs among an ever-growing number of displaced people, most of whom have arrived in Juba's temporary camps without even knowing their status.

The government has mobilized teams to discreetly offer voluntary testing in the camps, but the burden of fear, stigma and a profound lack of knowledge is preventing them from being as effective as possible, said Dr Lino. A Household Health Survey conducted in 2010 found that fewer than 10% of the Sudanese population had solid awareness of the disease, how it is transmitted, and effective ways of preventing transmission.

An equally profound lack of awareness and training among health professionals – including doctors, nurses and clinicians – means that there is limited secondary detection capacity, or automatic recommendation for HIV screening among patients presenting with respiratory illness or other maladies that would indicate the possibility of infection.

"In general, we have to do more testing," Dr Lino said. "We have to be able to provide everyone with access to services at all levels, instead of being limited only to screening centers."

Such limits are related to resources, he added, since once funds are programmed, it is very difficult to use them in a more flexible manner. Grant money from the Global Fund was consigned to ARV purchases, and cannot now be used to purchase more diagnostic tests, which had been the purview of the US AIDS response program PEPFAR until recently. The complementarity of donor funding is useful, Dr Lino acknowledged, but when there are unfilled gaps, it is very difficult to shift money around to fill them.

"We are in a state of emergency and need to respond fast," he said, "and we can't."

Read the article in French. Lire l'article en français.

[This article was first posted on GFO Live on 19 March 2014.]

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7. NEWS: Mesoamerica and Hispaniola countries meet on malaria initiative

The EMMIE program will receive $10 million from the Global Fund for 2014-2016

Ten countries included in a $10-million Global Fund regional initiative spanning Mesoamerica and Hispaniola met on 28 February to develop new ways to evolve national malaria strategies away from control towards pre-elimination and elimination of the disease. The countries have set a regional goal to eliminate malaria by 2020.

Belize, Costa Rica, the Dominican Republic, El Salvador, Guatemala Haiti, Honduras, Mexico, Nicaragua and Panama all sent representatives to the meeting co-sponsored by ISGlobal and the Council of Ministers of Health of Central America and Dominican Republic (COMISCA).

Malaria remains a significant problem in the region, with both public health and economic consequences for countries that rely chiefly on agriculture and tourism as their primary sources of income.

Central America has achieved the 2015 Millennium Development Goal target of a 75% reduction in cases, with a general decline of some 88.1% in morbidity from malaria between 2000 and 2012.

However, both sides of the Caribbean island of Hispaniola – Haiti and Dominican Republic – have reported an increased incidence since 2011. Haiti, the only low-income country in the region, accounts for the majority of the new cases reported. According to the WHO World Malaria Report, the entire population of Haiti is at risk of malaria, with nearly half (47%) at high risk.

Individual countries have developed their own strategies befitting the phase in their malaria response, with Honduras, Belize, Nicaragua, Panama and Guatemala in the control phase and others, such as Costa Rica, El Salvador and Mexico, in a pre-elimination phase. Reported malaria cases in Haiti and the Dominican Republic increased from 18,130 in 2000 to 33,664 in 2011. In recent years, most cases have been diagnosed in Haiti or have been imported from Haiti to Dominican Republic, where the numbers of reported cases has increased in the past few years (from 2,711 in 2007 to 952 in 2012).

The collection of reliable baseline data has been identified as one of the core elements of the EMMIE initiative in order to ensure that countries are on track to achieve their individual targets as well as the

regional targets of elimination by 2020.

The Global Fund Board approved a recommendation on 28 February to invest $10.2 million in the initiative including $1.2 million to be spent in six of the 10 countries to strengthen malaria surveillance systems and improve data that will be used to set new baselines and targets. A grant agreement has been sent to the current principal recipient, Population Services International (PSI) and to the various regional stakeholders for signing, which is anticipated for end-March.

Those data will be used to set national-level baselines and targets with PSI following verification by an independent external institution.

Other elements of the EMMIE initiative include:

- Supporting the standardization of case management best practice for malaria, to ensure proper diagnosis and timely treatment
- Supporting the standardization of an agreed protocol for integrated vector management
- Facilitating cross-border cooperation and regional coordination
- Establishing a regional operational research framework for guiding and facilitating the implementation of elimination strategies

Baseline data, based on key health indicators, will reflect the current context in each country as it guides program strategies for improved civil society participation in outreach and awareness campaigns: the sixth pillar of the regional initiative. Each country will be expected to report on 'confirmed malaria cases' over the course of the initiative as a way to monitor progress towards elimination.

[This article was first posted on GFO Live on 19 March 2014.]

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8. NEWS: Africa Bureau one step closer to fruition after 31st Board meeting

The hub still faces resource challenges and has not yet found a home

Representatives from African implementing countries took a step closer in March towards the inauguration of a regional bureau that will help coordinate and harmonize communications on the continent in order to be better positioned to influence decision-making by the Global Fund Board.

Meeting on the sidelines of the 31st Board meeting, held 6-7 March in Jakarta, the assembled government representatives from East and Southern Africa and West and Central Africa agreed to formally call for

expressions of interest from countries willing to host the bureau and establish a secretariat.

The seeds for an Africa Bureau within the Global Fund Board were planted during a 2012 meeting between the above representatives who saw that their voices, despite being represented as individual constituencies on the 20-member Board, were being lost when it came time for decisions to be made.

“We sought to strengthen our ability to be better and more effective representatives to the Global Fund board,” said Ida Hakizinka, the communication focal point for the ESA representatives and coordinator to the Rwanda country coordinating mechanism (CCM). “We needed to be better coordinated and knowledgeable to shape the policies and processes there.”

Under the terms of the country allocations announced on 12 March, African countries will receive the bulk of the $14.82 billion allocated during the 2014-2016 period. In total, sub-Saharan Africa will implement 64.3% of the money available: some $9.53 billion.

Once established, the Africa Bureau will work to enhance the visibility of the regional constituencies within the Board to ensure they are both present and prominent in decision-making. The Bureau will also focus on cross-cutting issues affecting the management, implementation and reporting on Global Fund grants to African countries.

The two delegations developed a governance framework for the future Bureau, for how it would serve as a central focal point for all communication, advocacy and future engagement on the Global Fund Board for the relevant constituencies.

“This framework defines how we, the Global Fund board members in these regions, our alternates and the communication focal persons, are selected and our competencies assessed,” Hakizinka said. “It also highlights our roles and responsibilities and how the bureau will be governed.”

African ministries of health have adopted the framework, which has also earned support from other voting blocs on the Board including other implementing blocs, the Developing Country NGO constituency and the Communities delegation. A task force led by Hakizinka is continuing work within the Board context to make the Bureau a reality.

Progress towards the installation of the Bureau has stalled, however, due to a lack of resources. There have also been few expressions of interest from countries willing to host its secretariat. Those gathered in Jakarta in early March have sought to use this formal call for expressions of interest to reinvigorate interest in the Africa Hub as soon as possible. Applicants have until 25 March to signal their interest.

“The Bureau will be a valuable vehicle for assessment by African implementers of processes including the [new funding model],” said Hakizinka.

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9. NEWS: Aidspan launches its French-language newsletter, OFM : Observateur du Fonds Mondial (Global Fund Observer)

With the launch on 19 March of its inaugural issue of OFM : Observateur du Fonds Mondial, Aidspan is expanding the breadth and depth of its reach among those who are keen to monitor and assess the progress being made by the Global Fund in its fight against HIV, TB and malaria. Since 2002, Aidspan has published the English-language Global Fund Observer, reaching nearly 10,000 subscribers in 170 countries.

Now, with its monthly French-language newsletter, Aidspan is looking to penetrate more deeply into the Global Fund ecology at the country level. With analysis and original reporting in French, as well as translations of key English-language articles, OFM will provide nuance and clarity to those who watch and participate in programs and activities supported by the Global Fund.

France is historically one of the most important contributors to the Global Fund, committing some $4 billion over the 12 years of the Fund's existence. French contributions to the fight against HIV, TB and malaria also include its pivotal role in the development of the drug purchasing program UNITAID, its support for the GAVI alliance for vaccines and immunization and its continued promotion of the 5% Initiative providing further financial assistance to Global Fund grants in francophone countries.

Aidspan has since its own inception produced French-language content, translating some of its guides to the Fund and its processes in French as well as articles from GFO. The launch of the French-language website in 2013 reflects Aidspan's awareness that more than 30 countries in Africa and the Caribbean miss out on important details related to the Global Fund and its processes because of the lack of comprehensive information in French.

Limited by modest resources and small team, Aidspan cannot do everything to address the French-language gap at the Global Fund. But we are cognizant of the value we can bring even with those limited resources, and look forward to providing the same credible, clear and concise information we are known for to our newly expanded francophone audience.

Subscription to OFM is a relatively simple process that will require users to create an account or modify their existing accounts to reflect their language preference. Users are, of course, welcome to subscribe to both the French and English versions of the newsletter.

We invite you to share with us your comments, feedback and subject ideas. We are excited that we can now provide a platform for francophone experts and academics to share their views and perspectives on the

Global Fund and its processes and policies. Please do not hesitate to contact us at the email addresses below.

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NEWS : Global Fund confident it will recover $103 million in losses

The Global Fund is confident it will be able to recover $103 million in funds lost under 47 separate incidents in 41 countries and, going forward, will have an appropriate risk management strategy in place to mitigate future losses.

NEWS : OIG sets course for 2014 with 14 planned country audits

The Office of the Inspector General expects to conduct audits in 14 countries in 2014, according to its report to the Global Fund Board.

NEWS : New OIG communications strategy sets timelines for audits and investigations

A new communications strategy released by the Office of the Inspector General (OIG) sets an 18-week timeline for audits and a 20-week timeline for investigations. Training for country stakeholders is planned for the third quarter of 2014.

NEWS : Global Fund to develop an ethics and compliance framework

The need for ethical leadership and a unified organizational culture with a set of overarching values and principles poses a challenge for the Global Fund, according to a consultant hired to develop an ethics and compliance framework.

This is issue 240 of the GLOBAL FUND OBSERVER (GFO) Newsletter.

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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