Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

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interventions worth $379 million were placed in the registry of unfunded quality demand.

6. NEWS: Testing of a training curriculum to enhance the advocacy skills of the PWID Community in the EECA has been completed

A three-day training session in Tbilisi, Georgia in September completed the testing of a training curriculum designed to enhance the skills of people who inject drugs to advocate for domestic funding of harm reduction programs in Eastern Europe and Central Asia.

7. NEWS: Global Fund's decision to stop providing new funding for HIV in some EECA countries threatens the future of harm reduction programs, report says

A case study conducted by the European Harm Reduction Network found that there was a lack of transition planning when the Global Fund decided to stop funding HIV programs in Serbia. The network expressed concern about the future of harm reduction programs in Eastern Europe and Central Asia.

8. NEWS: NFM poses a threat to harm reduction, researcher say

Despite the fact that the Global Fund is committed to promoting harm reduction, elements of the new funding model threaten future investments in this area, according to the authors of a recent study.

9. NEWS: Summaries of eight regional concept notes that have been approved for grant-making

This article provides summaries of eight of the 13 regional concept notes that were submitted in 2015, that have been reviewed the Technical Review Panel, that have completed the first of two reviews by the Grant Approvals Committee, and that were approved for grant-making.

ARTICLES:

1. NEWS: Programs supported by the Global Fund saved 17 million lives through the end of 2014, Fund says

This is almost double the figure of 8.7 million lives saved announced in July 2012

Other results also reveal strong momentum

David Garmaise *21 September 2015*

Programs supported by the Global Fund have saved 17 million lives up to the end of 2014, according to the Results Report 2015 released by the Fund on 21 September. The Fund says that it is on track to reach 22 million lives saved by December 2016, the end of the current replenishment period (see graphic).

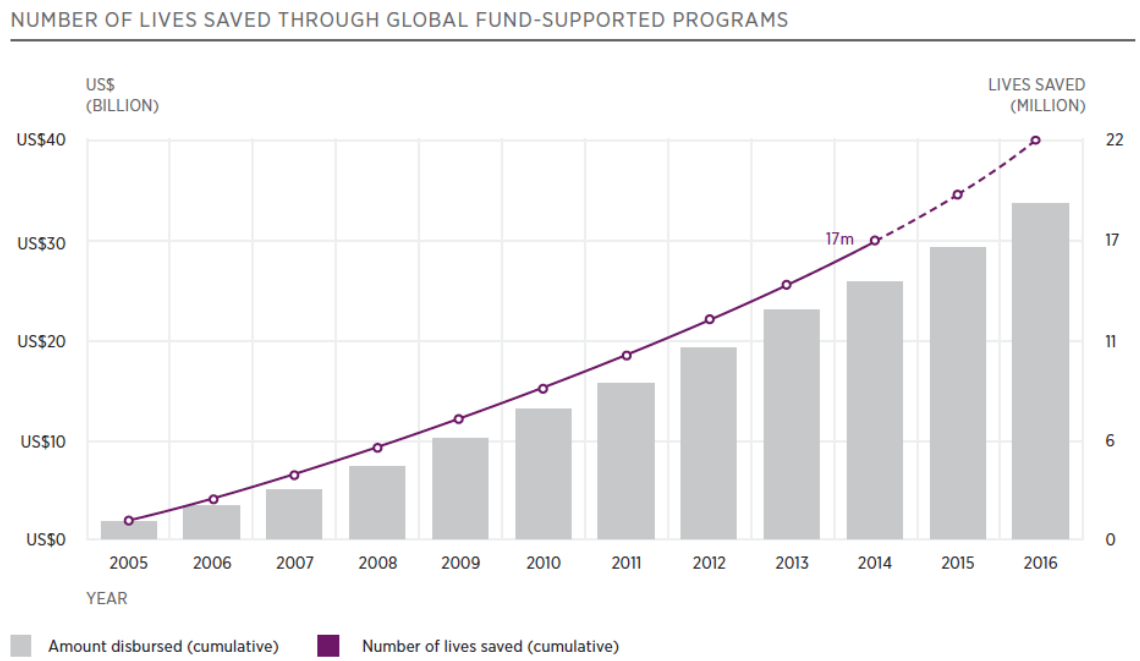
This is the first time since July 2012 that the Global Fund has included a lives saved figure in its results announcements. At that time, the Fund estimated that through programs it had

supported, 8.7 million lives had been saved. Since then, the Fund has been working on refinements to its methodology for estimating lives saved.

In a Q&A that accompanied the results report, the Global Fund said that the increase in the number of lives saved is partly due to improved data collection and methodology and partly due to scientific advances, innovative solutions and increased global support.

The report said that by the end of 2014 programs supported by the Fund also resulted in 8.1 million people receiving antiretroviral treatment (up 22% over the previous year, according to a news release on the Fund's website); 13.2 million people receiving TB treatment (up 11%); and 548 million mosquito nets being distributed.

The results report is an important tool for the Fund as it launches its replenishment campaign for 2017-2019.



Source: Results Report 2015, Global Fund to Fight AIDS, Tuberculosis and Malaria

"Advances in global health are transforming communities in ways that go way beyond what the numbers show," said Mark Dybul, Executive Director of the Global Fund, in the news release. "More people on treatment means parents can actually care for their children and be productive members of a community. Fewer infections means health centers can serve people with other ailments."

The results reported for the period ending in 2014 are different from the results that the Global Fund originally reported for 2014. (The Fund reported 2014 results on 30 November 2014, just prior to World AIDS Day; see GFO Article.) For example, originally the Fund reported that by the end of 2014 it estimated that programs supported by the Fund had put 7.3 million people on ART, had treated 12.3 million TB cases; and had distributed 450 million mosquito nets.

The Global Fund Secretariat told GFO that the reason for the discrepancies is that in the past when the Fund reported year-end results, there was actually a six-month lag in the data. The results announced for 1 December 2014 were based on data that was current in July 2014 because it takes a few months to sort through the data, which comes from many sources, discuss it with the Fund's partners, and determine what is reasonably accurate.

When the Fund reported mid-year results in July 2015, in reality these were end-2014 numbers. The numbers reported in July 2015 correspond to the numbers reported in Results Report 2015 released on 21 September.

For the last few years, the Fund has been reviewing its methodology for calculating lives saved. In the results report, the Fund said that it is using an improved methodology "better aligned with methods used by partners." The Global Fund said that, as in the past, the methodology uses models that analyze raw data. The models yield sophisticated estimates, not scientifically exact figures. The Fund said that a group of independent technical experts confirmed the credibility of the modeling and the estimates used by the Fund.

According to the results report, an important improvement to the methodology was the inclusion of impact of all interventions for TB and malaria, instead of limiting the data to the impact of mosquito nets and TB treatment. "This is leading to higher estimates of lives saved compared to what was recorded in previously published reports," the Fund said.

The Global Fund said that is continuing to work with partners to further improve the methodology. This will include factoring in the impact of HIV prevention on the number of lives saved, which is currently not part of model. "This may indicate that the Global Fund underestimates the number of lives saved through its investments," the report said. At the same time, the Fund and its partners will review some limitations in the methodology for estimating lives saved from TB and malaria which might over-estimate lives saved in certain settings.

Other results

Other highlights from the results report include that by the end of 2014 programs supported by the Global Fund have:

- provided counseling and testing to 423 million people;
- distributed more than 5.1 billion condoms;
- treated more that 22 million people for STIs;
- provided services to 3.1 million HIV-positive women to prevent transmission of HIV to unborn children;
- treated 515 million cases of malaria;
- averted 155 million cases of malaria; and
- conducted indoor residual spraying in 58 million structures.

The Fund said that the number of people being treated for multidrug-resistant forms of TB has increased four-fold since 2010, reaching 210,000.

The results report said that between 2000 and 2014, the number of new HIV infections declined by 36% in countries supported by the Global Fund. “Partners express optimism that the rate of averting infections can accelerate more sharply if funding continues to grow,” the Fund said.

In addition, in countries where the Global Fund invests:

- the number of people dying from HIV, TB and malaria has declined by one-third;
- access to ARVs increased from 4% coverage in 2005 to 21% in 2010 and to 40% in 2014; and
- people at risk for malaria who gained access to mosquito nets grew from 7% in 2005 to 36% in 2010 and 56% in 2014.

The Global Fund estimates that more than one-third of its investments support building health systems; and that 55-60% of its investments benefit women and girls.

The Global Fund projects an increase of $4.5 billion (or 52%) in domestic investments in health for the period 2015-2017 compared to what was invested in 2012-2014.

According to the report, in the last two years, the Global Fund has achieved savings of more than $500 million through more effective procurement, with on-time delivery improving from 36% in 2013 to 81% in 2015.

The results report includes some country case studies. In Tanzania, for example, the number of identified TB cases rose sharply between 1995 and 2005, prompting the country to declare a national emergency in 2006. The Global Fund began supporting TB programs in 2007, the report said, and joint efforts have averted 328,000 cases and saved 195,000 lives since 2000. “Tanzania has implemented a strong focus on joint TB/HIV interventions, building resilient and sustainable systems for health and improving TB detection and treatment rates,” the Fund said.

The Global Fund said that programs it supports currently save more than two million lives a year. According to the results report, the number of lives saved in a given country in a particular year is estimated by subtracting the actual number of deaths from the number of deaths that would have occurred in a scenario where key disease interventions did not take place. “For example, in a country where studies show that 70% of smear-positive TB patients will die in the absence of treatment, if 1,000 smear-positive TB patients were treated in a particular year, yet only 100 people were recorded as dying from TB, the model can conclude that 600 lives were saved. Without treatment, 700 would have died.”

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2. ANALYSIS: Turning a funding crisis into an opportunity in Cambodia

Nathalie Abejero *22 September 2015*

Cambodia has made headlines with its successful fight against HIV. According to UNAIDS, between 2005 and 2013, new HIV infections dropped by 67% and more than two-thirds of the 75,000 persons living with HIV have access to ARVs. This success draws in large part on two decades' worth of sustained funding from international donors to support HIV prevention, treatment, care, and support programs. But with external resources declining, Cambodia is looking to new and cost-effective ways to maintain the gains and make further progress to eliminate new infections.

With the Global Fund's transition to the new funding model, this exercise was unexpectedly fast-tracked. Early in 2014, the Phase II agreement of the existing Round 9 HIV grant was signed, covering a period of two years through December 2015. However, due to the formula used for allocating resources under the NFM, the country coordinating mechanism (known as "CCC" in Cambodia) was informed in March 2014 that no additional funding will be available for its HIV component until the end of 2017; Phase II funds would have to be stretched to cover almost four years of activities, not two.

The national program and its partners were suddenly faced with critical choices in its AIDS response. The concept note for the HIV grant reprogramming was due, critical for ensuring the continuity of prioritized services until end-2017. Initially planned for October 2014, it was finally submitted at the end of January 2015 after intensive reprogramming.

An invitation was cast sector-wide for participation in the country dialogue from July 2014 on – beyond the usual stakeholders in the three diseases. The dialogue allowed participants to brainstorm where synergies can be had and how to best optimize resources to last for a longer timeframe. Examples of synergies discussed include integration of HIV into broader health community systems that advance other medium term agenda, such as in sexual and reproductive rights and sexual and gender-based violence.

"It was an abrupt decline in available external funding," said Dr. Ouk Vichea, Deputy Director of the National Center for HIV/AIDS, Dermatology and STD (NCHADS). "There needed to be strict prioritization of services and interventions."

In the absence of other new funding, a massive overhaul and downsizing of the complement of interventions was required. This was achieved through collaboration among stakeholders such as NCHADS, CCC members, implementers, civil society, and partners, resulting in a lot of tough choices and a lot of disappointment.

The government has had to increase its own budgetary allocation to HIV. In order to comply with the NFM rules on counterpart financing, the government agreed to an investment that will gradually increase over the life of the HIV grant. In addition to covering some operational costs, the government committed an additional $1million in 2015, $1.2 million in 2016, and $1.5 million in 2017 for HIV treatment.

The process of reprogramming triggered strategic and epidemiological analyses and discussion on how to optimize resources.

The belt-tightening also prompted closer engagement between NCHADS and civil society, specifically in finding, testing and treating hard-to-reach populations at higher risk of HIV: people who inject drugs, men who have sex with men, transgender people and those in the sex work industry known as "entertainment workers," where the epidemic is concentrating.

This aligns perfectly with the NFM's emphasis on engaging civil society and key populations, which has helped not only to encourage dialogue between government and non-government entities, but also to give civil society the clout and standing it needed to become equal partners in decision-making. Positive steps were taken in finalizing Cambodia's Harm Reduction Strategic Plan.

Yet, challenges remain in relation to the low coverage of prevention services for PWID, and, in particular, low uptake and retention rates of the methadone program.

Another priority was to find financing synergies. From the country dialogue came the idea of lining up with the national push for universal health coverage and building on the existing Health Equity Fund and other social protection mechanisms. With external funding reduced, the HIV home-based care model had to be redesigned: PLHIV who were stabilized on antiretroviral treatment were registered to benefit from broader health and social protection allowances (e.g. for travel, food, care, vocational training, peer support and funeral costs), while the most vulnerable PLHIV will continue to receive more dedicated HIV-specific care support.

Ultimately, it was an intensive exercise by stakeholders in forging national consensus for a more sustainable response. Partners, government and civil society had to act decisively and quickly on the austerity measures, so as to maintain the hard-won momentum in the program even as Cambodia reached a new phase where national funding will have to progressively take over from external resources.

Cambodia appears to have successfully backed away from a financial cliff, instituting cost savings and becoming bolder about looking for other sources of funding.

The HIV/AIDS community can only hope that the government and development partners will continue funding the national response. In the face of decreasing funding from its largest donors, all parties must work together to ensure continued and sustained progress. The reprogramming was a factor in introducing, scaling up and/or strengthening creative approaches to HIV prevention, treatment and care. It united stakeholders in a common goal: sustaining gains and, with less funds, optimizing resources. It triggered new opportunities for integration and efficiencies. In the end, a few building blocks were set for a more sustainable future response, but as a low-income country with a high disease burden, Cambodia still needs continued support from donors.

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3. NEWS: Global Fund will launch its replenishment campaign as a high-level event during the UN General Assembly annual meeting

This is the start of a series of events and activities that will culminate at a pledging conference in mid-2016

GFAN will be lobbying donor governments to increase their contributions to the Fund

Anna Maalsen and David Garmaise *22 September 2015*

The Global Fund will launch its 5th Replenishment Campaign on the 28 September 2015 in New York as a formal high-level event during the 70th UN General Assembly. The event, "The Path Towards Universal Health Coverage: the promotion of equitable global health and human security in the post-2015 development era," is part of several events that will coincide with the adoption of the Post-2015 Development Agenda and the Sustainable Development Goals (SDGs) at a summit meeting on 25-27 September.

It is anticipated that the Prime Minister of Japan, His Excellency Shinzo Abe, will preside over this high-level event, a precursor to the formal Global Fund replenishment preparatory meeting that the Government of Japan (the Global Fund's fifth largest donor) will host on 17 December 2015.

The high-level event is being co-hosted by the World Health Organization (WHO) and The World Bank, as well as France, Liberia, Senegal, and Thailand. Other distinguished speakers expected include Her Excellency Ellen Johnson Sirleaf, President of Liberia; Dr Margaret Chan, Director General, WHO; Dr Mark Dybul, Executive Director of the Global Fund; and Dr Babatunde Osotimehin, Executive Director of UNFPA.

The Fund is also co-organizing a number of other events during the UN General Assembly including:

- The Equitable Access Initiative briefing on the 24 September as part of the technical consultations to develop a more differentiated approach than the traditional country classification by income.
- A round table discussion on *Financing Health and Education: Girls Driving Development*, on 26 September.
- A youth-led event on the 24 September discussing how young people can play a central role in the implementation and accountability of the SDGs.

A full list of civil society events that are coinciding with the UN General Assembly can be found here.

These side events and meetings are critical for continuing to build the financial support for the Fund in the lead up to the replenishment preparatory meeting on 17 December. Over the coming months senior officials from the Secretariat, Board and partners will be meeting with

donor countries to continue to advocate for funding by highlighting the major accomplishments and successes that the Global Fund has achieved in terms of global health goals (see GFO article on the Global Fund Results Report 2015).

It is expected that the Fund will release an assessment of financial needs to fight the three diseases in the next replenishment period (2017-2019) one or two weeks prior to the preparatory replenishment meeting. The needs assessment prepared in April 2013 for the previous replenishment suggested that $87 billion was required. However, given the Vancouver Consensus, and recent developments in the fights against TB and malaria, the resources required for 2017-2019 are anticipated to be significantly larger. (See GFO articles on the build up to the previous replenishment here and here.)

The 5th replenishment conference is likely to be held in June or July 2016. The location has not been announced. It is at this conference that the majority of the Fund's donors announce their pledges. However, as past actions have demonstrated, some of the Fund's largest donors such as the U.S and the U.K will likely announce their pledges in advance in order to generate momentum.

In the period between the pre-replenishment meeting and the replenishment conference, the Fund is expected to announce pledges from some high net worth individuals.

The Global Fund Advocates Network will be actively campaigning in donor countries in support of strong financial commitments to the Global Fund and the health SDGs. GFAN will be virtually launching their Speakers Bureau on 28 September as part of the upcoming SDG events, The GFAN advocates are focused on creating policy changes for positive enabling environments with the aim to increase domestic investments in health and to encourage collective engagement in their advocacy to governments and decision-makers.

The adoption of the SDGs by the UN General Assembly presents the opportune time for the Global Fund to demonstrate its successes and the impact that it has had upon the global health goals and to campaign to secure the much-needed resources for countries to work towards a world free from the burden of AIDS, TB and malaria.

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4. NEWS: Performance-based financing to be introduced in health centers in DRC

One of the Fund's goals is to harmonize interventions among donors

Stéphanie Braquehais *21 September 2015*

A new performance-based financing system will be implemented in the Democratic Republic of Congo, through a partnership involving the Global Fund, GAVI, Unicef and the World Bank. In 2016-2017, the Global Fund will allocate $20 million to finance health centers and their staff on the basis of the quantity and the quality of services provided.

“There are so many challenges in DRC, ranging from managing the supply chain to reporting and to the quality of treatment, that we need to try new methods,” said Nicolas Farcy, the fund portfolio manager for DRC. “It is a new business model which involves encouraging staff to work more and work better. The need to motivate staff is at the heart of the problems with health systems in DRC today.”

The goal of this PBF system is to improve the quality of treatment and to increase the number of patients. Instead of using the standard indicators associated with Global Fund grants, the results will be based on an evaluation of a minimum package of services that have been defined in agreement with the Ministry of Health. The operational manual, finalized in March 2015, identifies a minimum package of activities for the health centers (including new outpatient consultations, minor surgery, and pre- and post-natal consultations) and a “complementary” package of activities for hospitals (including major surgery).

Hadia Samaha, director of the World Bank’s health project in the DRC, told GFO that health centers will receive an initial investment of funds when they sign a contract. “They will have to devise a business plan to identify the interventions they want to carry out to improve access to treatment,” she said. These interventions will then be assessed.

The evaluation will be carried out at three different levels. First, independent public service institutions will audit the health centers every month to assess the volume of services provided. Second, the provincial directorates of health will visit the centers every quarter to determine whether the patients were well taken care of. Third, community associations will “cross-check” this information.

Under the PBF system, it is possible for a service provider to fake the information by, for example, inflating the results to get more money. To help prevent this, the operational manual includes guidelines on how to prevent fraud, such as by ensuring a “clear separation of roles to avoid conflict of interest and a credible system of sanctions (financial and administrative).”

The Global Fund sees this partnership as a way to harmonize donors’ interventions which are very fragmented in DRC. (The other partners – GAVI, Unicef and the World Bank – have not decided yet whether they will provide separate allocations or pool their money.) “What will be their approach?” asks Nicolas Farcy. “Will they be conservative and only finance certain services in certain zones? Or will they take a more progressive approach and agree on a package of services financed by all? This is yet to be determined. I hope they go for the more progressive approach.”

Despite the good intentions, some observers fear that the PBF system might reinforce inequities. “Health centers can only achieve results if there is already a basic service in place,” the manager of an NGO told GFO. “But in the DRC, the centers lack everything. I am afraid that this system is going to leave behind the health centers that are performing poorly. How can a health center that lacks everything perform well? It could be a vicious circle.”

According to Nicolas Farcy, the problems are so profound in the DRC that donors don’t have a choice. They need to try a new approach. “There might be negative effects, but we need to

remember where we are coming from. Right now, it is less urgent to fight inequities than to get as many centers as possible to start providing quality treatment."

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5. NEWS: Global Fund approves funding of $1.5 billion for 35 grants

This is the largest amount approved at any one time under the NFM

Incentive funding of $123 million included

David Garmaise *15 September 2015*

On 11 September 2015, the Global Fund Board approved $1.52 billion in funding for 35 grants emanating from concept notes submitted by 15 countries and three regional organizations. This is by far the largest amount approved at any one time under the new funding model. The Board was acting on recommendations from the Grant Approvals Committee and the Technical Review Panel.

Included in the $1.52 billion was $123.0 million in incentive funding. In addition, the Fund placed interventions worth $379.2 million in the registry of unfunded quality demand. Of the $1.52 billion total, $730.6 million was for countries in Africa (see Table 1) and $785.0 million for countries in other regions (see Table 2).

The country that received the most funding was India: $541.9 million for seven TB/HIV grants (including $55.5 million in incentive funding), and $116.4 million for two malaria grants. Kenya received $367.6 million for four TB/HIV grants (including $34.3 million in incentive funding), and $77.2 million for two malaria grants.

In addition, the Board approved an increase of $1.4 million for a previously approved HIV grant to Burkina Faso (BFA-H-SPCNLS). The additional amount represents funds from the undisbursed balance of a prior HIV grant.

India

The goals of the India TB/HIV grants are to reduce new infections by 50%; provide comprehensive care and support to all persons living with HIV; provide HIV treatment services for all those who require it; and achieve universal access to quality TB care and control, with a specific focus on vulnerable and marginalized populations. The grants include capacity-building for civil society organizations that provide prevention services for populations at risk for HIV; India expects to provide 60,000 people in key populations with treatment and care services in the first year of the grants.

Table 1: Funding for grants approved by the Global Fund, September 2015 – Africa

Country or region (component)	Grant name	Principal recipient	Approved Funding ($ million)			Of which, incentive funding	Added to UQD register
			Existing	New	Total		
Burkina Faso (HSS)	BFA-S-PADS	Programme d'Appui au Dév. Sanitaire	NIL	19.5 m	19.5 m	NIL	NIL
Burkina Faso (Malaria)	BFA-M-PADS	Programme d'Appui au Dév. Sanitaire	6.6 m	59.9 m	66.5 m	N/E	NIL
East Africa (HIV)	QPB-H-KANCO	Kenya AIDS NGOs Consortium	NIL	5.6 m	5.6	N/E	0.2 m
Guinea (HIV)	GIN-H-CNLS	ES of the NAC	9.9 m	38.7 m	48.7 m	23.5 m	13.7 m
	GIN-H-PSI	Pop. Serv. Int'l	3.6 m	10.5 m	14.1 m		
Kenya (Malaria)	KEN-M-TNT	National Treasury	49.4 m	19.1 m	68.4 m	NIL	NIL
	KEN-M-AMREF	African Medical and Research F. Kenya	4.4 m	4.4 m	8.8 m		
Kenya (TB/HIV)	KEN-H-KRCS	Kenya Red Cross	20.6 m	17.9 m	38.5 m	34.3 m	96.0
	KEN-H-TNT	National Treasury	224.7 m	34.7 m	259.4 m		
	KEN-T-AMREF	African Medical and Research F. Kenya	3.8 m	18.9	22.6		
	KEN-T-TNT	National Treasury	16.8 m	30.3 m	47.1 m		
SADC (Malaria)	QPA-M-E8S	Elimination 8	NIL	17.8 m	17.8 m	N/E	2.3 m
South Sudan (HIV)	SSD-H-UNDP	UNDP	2.3 m	40.2 m	42.4 m	5.6 m	14.3 m
Sudan (HSS)	SDN-S-FMOH	Ministry of Health	NIL	20.4 m	20.4 m	NIL	11.5 m
Togo (TB/HIV)	TGO-H-PMT	Office of the PM	15.8 m	24.4 m	40.1 m	3.2 m	0.0 m
	TGO-T-PMT	Office of the PM	0.3 m	4.7 m	5.0 m		
Zanzibar (Malaria)	QNB-M-MOH	Ministry of Health	3.0 m	2.7 m	5.7 m	0.4 m	4.1 m
TOTALS			**361.2 m**	**369.7 m**	**730.6 m**	**67.0 m**	**142.1 m**

The grants to Burkina Faso and Togo were in euros which we converted to dollars at the rate of 1.12243
Discrepancies in totals due to rounding.
NE = Not eligible

According to the GAC, current prevention activities will continue to be managed by a civil society principal recipient through March 2016, "to allow for a smooth transition to government ownership from the next government fiscal cycle, which starts April 2016." The Global Fund Secretariat informed Aidspan that what is being transitioned are the prevention activities that the India HIV/AIDS Alliance has been implementing and that the government has obtained a loan credit from the World Bank to cover the costs of these activities.

With respect to India's malaria grants, the GAC said that India will participate in a pilot program designed to strengthen financial management capacity.

Table 2: Funding for grants approved by the Global Fund in September 2015 – Other Regions

Country or Region (component)	Grant name	Principal recipient	Approved Funding ($ million)			Of which, incentive funding	Added to UQD register
			Existing	New	Total		
Belize (TB/HIV)	BLZ-C-UNDP	UNDP	0.2 m	3.3 m	3.5 m	NIL	0.4 m
Cambodia (HIV)	KHM-H-NCHADS	N. Center for H/A, Derm. and STD	35.4 m	0.7 m	36.1 m	NIL	NIL
Cambodia (HSS)	KHM-S-PRMOH	Ministry of Health	4.8 m	7.8 m.	12.6 m	NIL	NIL
EECA (TB)	QMZ-T-PAS	Center for Health and Policy Studies	NIL	6.1 m	6.1 m	N/E	NIL
India (Malaria)	IDA-M-NVBDCP	National V-B Disease Control P.	46.4 m	61.1 m	107.5 m	NIL	98.9 m
	IDA-M-CARITAS	Caritas India	3.1 m	5.8 m	8.9 m		
India (TB/HIV)	IDA-H-NACO	National AIDS Control Org.	51.0 m	189.5 m	240.5 m	55.5 m	136.6 m
	IDA-H-IHAA	India HIV/AIDS Alliance	14.8 m	7.0 m	21.8 m		
	IDA-H-PLAN	Plan India	NIL	8.0 m	8.0 m		
	IDA-H-SAATHII	Solidarity & Action Against HIV Inf.	NIL	4.6 m	4.6 m		
	IDA-T-CTD	Central TB Division	39.4 m	195.9 m	235.3 m		
	IDA-T-IUATLD	Int'l Union Against TB & Lung Disease	13.0 m	11.9 m	24.8 m		
	IDA-T-WV	World Vision India	1.2 m	5.7 m	6.9 m		
Korea DPR (TB)	PRK-T-UNICEF	UNICEF	2.6 m	26.2 m	28.8 m	NIL	NIL
Lao PDR (Malaria)	LAO-M-GFMOH	Ministry of Health	4.3 m	5.8 m	10.1 m	0.4 m	0.5 m
Sri Lanka (TB)	LKA-T-MOH	Ministry of Health and Indig. Med.	0.4 m	8.0 m	8.4 m	NIL	NIL
Suriname (TB/HIV)	SUR-C-MOH	Ministry of Health	0.2 m	3.8 m	4.0 m	NIL	0.7 m
Tajikistan (HIV)	TJK-H-UNDP	UNDP	0.1 m	17.0 m	17.1 m	N/E	NIL
TOTALS			**216.9 m**	**568.2 m**	**785.0 m**	**55.9 m**	**237.1 m**

Discrepancies in totals due to rounding.
NE = Not eligible

Kenya

The concept note submitted by Kenya described a significant reprogramming of the country's malaria program. The GAC said that the reprogramming was the result of "broad engagement of local and international stakeholders in a consultative country dialogue process."

With respect to Kenya's HIV grants, the GAC noted that during grant-making additional resources were allocated towards HIV interventions for girls and young women. The GAC commended Kenya for improvements in performance in recent years in programs supported by the Global Fund, including improvements in absorptive capacity and fiduciary controls. The GAC said that this presents an opportunity to document lessons learned for dissemination to other countries.

Other countries

Regarding the TB/HIV grant to Belize, the GAC said that the strategic focus of the program is to halt the spread of HIV and TB/HIV co-infections among men who have sex with men and among other populations at risk, as well as to effectively detect and treat all forms of TB, MDR-TB and TB/HIV co-infections. The GAC said that activities supporting these goals are largely focused on key populations and on addressing systemically embedded stigmas. "These include advocating for the modification of policies that penalize health care providers for working with key populations; training for health care providers to reduce stigma against key populations; … and creating a system for the monitoring and reporting of human rights violations."

In its comments on the Cambodia HIV grant, the GAC noted that for the first time the Government of Cambodia is purchasing antiretroviral drugs ($3.7 million). The Global Fund had been financing 100% of the costs of the ARVs.

Guinea's $48.7 million HIV grant included $23.5 million in incentive funding, which will be used to fund services for men who have sex with men, transgender people, and sex workers and their clients, as well as for the scale-up of ARVs, prevention of mother-to-child transmission, and TB/HIV coordination.

Commenting on the HIV grant to South Sudan, the GAC said that "in light of the unresolved issues around human rights protections," the Community, Rights and Gender Department of the Global Fund will be supporting the training of judiciary and law enforcement officials, among others, to create a more enabling environment for key populations in the period before the grant is signed.

Concerning the Sudan HSS grant, the GAC noted that during grant-making, "the applicant took actions to address the TRP's comment on reaching underserved populations, specifically women and girls, by planning the recruitment, training and deployment of additional community health workers, strengthening the civil society organization network and expanding the reach of trained primary health care providers."

The Suriname TB/HIV grant includes a plan to establish a human rights desk, create an inventory of human rights complaints and develop a human rights database.

The Tajikistan HIV grant aims to expand ARV coverage by 178%. Some of the funding for the grant will be used to expand the opioid substitution therapy program from six to 12 sites by 2017, and to remove legal barriers to access to OST. In addition, human rights guidelines and accompanying monitoring tools will be developed.

The GAC noted that the program management unit for the Togo TB/HIV grants will operate from the Office of the Prime Minister.

Regional grants

Included in the funding approvals were grants for three regional applicants:

- **Center for Health and Policy Studies (PAS).** The focus of the PAS regional TB project is to improve TB and drug-resistant TB outcomes in 11 Eastern European and Central Asian countries through a health systems strengthening approach. The approach involves using patient-centered models for the provision of TB and drug-resistant TB prevention, treatment, and care services. The 11 countries are Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan..
- **Southern African Development Community.** The focus of this Elimination 8 regional program is to support the malaria elimination effort among eight of the 15 SADC member states to reach zero local transmission by 2020 in the four "frontline" countries of South Africa, Botswana, Namibia, and Swaziland.
- **Kenya AIDS NGOs Consortium.** The focus of this regional program is to increase access to essential HIV and harm reduction services for people who inject drugs in eight areas in Eastern Africa (Burundi, Ethiopia, Kenya, Tanzania, Mauritius, Seychelles, Uganda, and Zanzibar).

Information for this article comes from the Report of the Secretariat's Grant Approvals Committee to the Board (GF-B33-ER09). This document is not available on the Fund's website.

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6. NEWS: Testing of a training curriculum to enhance the advocacy skills of the PWID Community in the EECA has been completed

The final training session was in Tbilisi, Georgia

Tinatin Zardiashvili *22 September 2015*

The Eurasian Harm Reduction Network has completed testing of a training curriculum designed to enhance the skills of communities of people who inject drugs in Eastern Europe and Central Asia to advocate for domestic funding of harm reduction programs.

The testing initiative is part of a regional program called "Harm Reduction Works, Fund It."

The final training session was delivered to the Georgian PWID community by the Georgian Harm Reduction Network in Tbilisi on 15-17 September. Since start of the program in April 2014, similar trainings have been conducted in the other four countries involved in the program: Belarus, Kazakhstan, Moldova, and Tajikistan.

The training explained how to do advocacy. It was designed to help local communities develop individual country advocacy plans and the skills necessary to dialogue with government officials to convince them of the effectiveness of the harm reduction programs and the need to increase domestic funding of those programs – especially in light of the anticipated forthcoming gradual reduction of Global Fund support to the whole EECA region.

Asked how the training has benefited her, one middle-age woman representing the PWID community responded: "We learn to speak the same language as state officials do, and we learn how harm reduction programs work in the country and how they are financed. As a group, we discuss what are the gaps, challenges, and opportunities; and then together we come up with potential solutions that we have to offer our governments, in a comprehensive, persuasive manner."

The methodology of the advocacy training for the PWID community was developed by two program experts, Olya Belyaeva and Maria Tvaradze. The results, observations and lessons learned from all of the training sessions will be now inventoried and reflected in the final methodology document, which will be soon be published for use by a wider audience.

One of important goals of the Tbilisi training was to support the PWID community to prepare core messages for the forthcoming high-level regional dialogue organized by the EHRN, to be held in Tbilisi on 28-30 September. The dialogue, which is about successful transition from the Global Fund to domestic funding, will bring together representatives of local governments, communities, NGOs from across the region, the Global Fund and other international donors. One day will be devoted to the CSO sector, so the PWID community should be well prepared to talk about harm reduction program problems, gaps, and needs.

"Harm Reduction Works, Fund It!" is a three-year program which aims to strengthen community advocacy for increased domestic funding by creating an enabling environment for investments in harm reduction programs and by empowering local PWID communities with advocacy skills and relevant knowledge allowing them to protect their own rights. (See the latest GFO article on this program here.)

The regional program has been operating for about a year and half. In addition to the training sessions and the development of national advocacy strategies, the program has conducted two important assessments: one on the financing of harm reduction programs and one on the quality of the services. The latter was performed by local PWID communities.

The assessments were conducted in six countries: Belarus, Georgia, Kazakhstan, Lithuania, Moldova, and Tajikistan. A draft report of the assessments has been developed; the final report will be published in the near future.

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7. NEWS: Fund's decision to stop providing new funding for HIV in some EECA countries threatens future of harm reduction programs, report says

Case study conducted in Serbia reveals a lack of transition planning

Tinatin Zardiashvili *21 September 2015*

According to a case study conducted by the European Harm Reduction Network, the Global Fund's decision to stop providing new funding for the HIV program in Serbia as of 2014 happened without any transition planning to ensure that harm reduction (and other) programs would be able to continue.

A report on the case study was published in August 2015. The 12-page report, entitled "The impact of the Global Fund's withdrawal on harm reduction programs," was prepared by a mixed group of experts representing EHRN and Serbian civil society organizations. The report described the initial results of the Global Fund's withdrawal and presented recommendations for local governments, CSOs, the Fund itself, and other donors on how to avoid similar complications in other countries which might soon also become ineligible for Global Fund support.

As a result of changes to the Global Fund's eligibility criteria in 2011, a number of upper-middle-income countries in Eastern Europe and Central Asia with low or moderate disease burdens became ineligible for new HIV funding. Serbia was one of the countries affected, having been classified as a UMI country in 2012. Although Serbia continued to receive funding for existing HIV grants until 2013, the country did not receive an allocation for HIV for the period 2014-2016 under the new funding model.

The report said that the status of harm reduction and other programs from 2014 on depends on the readiness, willingness and ability of the Government of Serbia to fund the programs. In this environment, the report said, "politically unpopular" groups such as people who use drugs are at risk of being neglected.

The Global Fund financed harm reduction programs in Serbia between 2006 and 2014, covering needle exchange, opioid substitution therapy and outreach activities. By 2013, OST was available through methadone centers in 29 health facilities, with the Global Fund providing most of the financing in 26 of them. The government has continued to provide OST in 23 of the centers.

However, what will happen to the 4,285 clients of needle exchange outreach programs is up in the air. The programs were funded almost entirely with Global Fund money and were provided by CSOs. According to the report, up to 50 grassroots organizations providing outreach services to key affected populations lost up to 90% of their funding after the Global Fund withdrew its support. No alternative financing mechanisms have been put in place to ensure sustained funding for the grassroots organizations.

Although the case study report warns about the risks for increased HIV and hepatitis C rates, there are no figures presented to estimate the public heath–related impact of stopping HIV prevention activities among key populations.

The report states that

"As Global Fund support to the EECA region decreases, it is critical to ensure the transition to domestic financing takes into consideration a country's readiness, willingness, and ability to assume greater responsibility for HIV and AIDS programming. Serbia's experience clearly illustrates that if the cessation of Global Fund support is not accompanied by credible government sustainability plans and financial commitments, years of investments are threatened and the health and well-being of marginalized communities endangered. This could result in the reversal of hard won gains in HIV prevention and treatment and lead to spikes in HIV, hepatitis C, and AIDS."

Although in 2015 the Global Fund reclassified Serbia's HIV disease burden to "high," the report said, it is not clear yet whether, under the Fund's eligibility criteria, Serbia's HIV component will be eligible for funding for the next allocation period (2017-2019).

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8. NEWS: NFM poses a threat to harm reduction, researcher say

Middle-income countries are particularly at risk

Tinatin Zardiashvili *22 September 2015*

Although the Global Fund is committed to promoting harm reduction, serious concerns have been raised that the new funding model poses a threat to investments in harm reduction. This is one of the main findings of an article published in the International Journal of Drug Policy on 15 August.

The article was based on a study conducted by a group of experts representing different universities and international organizations.

The study analyzed Global Fund investments in harm reduction from 2002 until the start of the new funding model in 2014. The study found that 151 grants for 58 countries, plus one regional proposal, contained activities targeting people who inject drugs, and that this constituted a total investment of $620 million. The authors said that this was far short of what was need. They said that an estimated $2.3 billion was needed for harm reduction in 2015 alone. More than 90% of the Global Fund investments in harm reduction in 2002-2013 were for Eastern Europe and Central Asia.

But the article focused primarily on concerns about the future. "There are widespread concerns regarding the withdrawal from middle-income countries where harm reduction remains essential and unfunded through other sources: for example, 15% of the identified investments were for countries which are now ineligible for Global Fund support," the authors said.

Of the 58 countries previously funded for harm reduction by the Global Fund, 11 countries had become ineligible by the time the NFM allocations were determined; three countries were eligible only under the "NGO rule" (which has certain restrictions); more than half of

the eligible countries were included Band 4 under the allocation methodology, which restricts the amounts they can receive; and 26 countries were labeled as "over-allocated" or "significantly over-allocated," meaning that they will receive less funding over in 2014-2017 than they had been receiving.

Of the 11 countries that became ineligible, six are in the EECA. All three countries eligible under the NGO rule are in the EECA.

According to the article, in recent years harm reduction programs in the EECA that had been funded by the Global Fund have already closed in Romania and Serbia, where there is no sustainable alternative funding available.

The article said that the criteria used to calculate allocations under the NFM are too blunt. "Using only national disease burden data may not adequately reflect concentrated HIV epidemics among people who inject drugs, or in specific regions or cities within a country," the authors said. "Using country income categorisations from the World Bank overlooks vast wealth inequalities within countries."

Furthermore, the article said, the vast majority of poor people now live in middle income countries, "as do the majority of people living with HIV and the majority of people who inject drugs." According to the Global Fund's own analysis, the authors said, "upper-middle-income countries account for 18% of the disease burden, yet receive just 8% of the new funding model allocations."

The authors applauded the fact that under the new funding model, some funding has been set aside for regional proposals, that the Eurasian Harm Reduction Network was invited to apply as an early applicant, and that harm reduction proposals have been developed for East Africa and Asia. "This is a welcome avenue for greater funding for the critical enablers such as advocacy and community systems strengthening," the article said.

The authors recommended that "as a matter of urgency," the Global Fund should further measure and analyze the impact of the NFM on harm reduction programs and that this analysis should inform the development of the Fund's new strategy for 2017-2021.

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9. NEWS: Summaries of eight regional concept notes that have been approved for grant-making

Audrey Cheptoo, Tinatin Zardiashvili, Gemma Oberth, Anna Maalsen, Tunde Akpeji

22 September 2015

This article provides short summaries of eight of the 13 regional concept notes that were submitted in 2015, that have cleared the reviews by the Technical Review Panel and by the Grant Approvals Committee (first of two) and that were approved for grant-making. We obtained the information from the applicants themselves. When we listed the applicants in a

recent article of GFO, we were not able to obtain summaries of the concept notes from the Global Fund Secretariat.

Three of the 13 concept notes have already been approved for funding: the Centre for Health Studies (PAS), the South African Development Community (SADC), and the Kenya NGO AIDS Consortium. We provided summaries of these concept notes in a separate GFO article.

We were not able to obtain summaries of the two regional projects in the Latin America and Caribbean region (in time for this article), for which the applicants were (1) ICW Latina and (2) the Latin America and Caribbean Network of Transgender People (REDLSACTRANS).

Summaries

East Europe and Central Asia Union of People Living with HIV (ECUO). The project envisaged for three years aims to enhance the effectiveness, accessibility, sustainability and scale-up of HIV treatment programs in Eastern Europe and Central Asia, with a special emphasis on key populations. The project has two objectives: (1) Create enabling conditions at national and regional levels for facilitating access to HIV care by improving linkages between the main elements of the continuum of HIV care for key populations; and (2) Advocate for transition to the strategic and sustainable state funding of the continuum of HIV care, based on evidence and on the needs of key populations. To support the attainment of these objectives, the project will strengthen the capacity of people living with HIV and key populations, using "learning by doing" approach. [Summary provided by the applicant]

Centre for Health Policies and Studies (PAS). This is a three- year project which aims to decrease the TB burden and impede the drug resistance in 11 EECA countries through increasing political commitment and translating evidence into implementation of patient-centered TB models of care. The project is structured around two main objectives: (1) increase political commitment, regional cooperation and evidence sharing for sustainable transformation of the heath systems supporting effective TB response; and (2) support countries in developing effective and efficient TB service systems backed up by sustainable financing. The World Health Organization regional office and several British and local academic institutions have been included as project partners to ensure a highly professional and evidence-based approach to project initiatives.

Humanist Institute for Cooperation with Developing Countries, Southern Africa (Hivos). The name of the program submitted by Hivos is "Key Population Representation, Evidence and Advocacy for Change in Health" (KP REACH). It is an eight-country program (Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe) aimed at strengthening regional networks of five key populations: men who have sex with men, women who have sex with women, sex workers, drug users, and transgender people. It also strives to improve the evidence base for key populations in the region in order to influence programs and policies at national level, as well as develop a unified voice to shift harmful norms and attitudes. The structure for the implementation of the KP REACH program is based on an existing collaborative consortium of partners. Hivos is the principal recipient, with African Men Sexual Health and Rights (AMSHeR), African Sex Worker Alliance (ASWA), the Coalition of African Lesbians (CAL), Human Sciences Research

Council (HSRC), Positive Vibes, SAfAIDS, and TB/HIV Care Association as sub-recipients. Gender Dyanmix and the International HIV/AIDS Alliance are also part of the consortium, with expert advice provided by M&C Saatchi World Services as a communications partner.

Southern Africa Regional Coordinating Mechanism (SARCM). The SARCM project, called "TB in Mines," targets the same eight countries as KP REACH plus Mozambique and Tanzania. TB in Mines strives to harmonize a regional response to TB across the ten countries, streamlining patient referrals and contact tracing across borders, promoting service delivery consistency between private mine clinics and public facilities, and enhancing the integration of gender and human rights into TB interventions in peri-mining communities. The program largely responds to health challenges associated with the region's large migrant labor system, fueled by the large gold, diamond and platinum mines in South Africa. The Wits Health Consortium has been identified as the principal recipient.

AIDS and Rights Alliance for Southern Africa (ARASA) and ENDA Sante. The overall goal of ARASA's proposed project, "Removing Legal Barriers," is to work with parliamentarians, policy makers, law enforcement officials, cultural leaders, lawyers, and the judiciary to strengthen access to services for key populations (men who have sex with men, sex workers, and people who use drugs) in 10 countries – Botswana, Cote d'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda, and Zambia. UNDP has been nominated as the PR, along with four SRs: AIDS and Rights Alliance for Southern Africa (ARASA), ENDA Sante, KELIN, and Southern African Litigation Centre (SALC) – all organizations with recognized expertise in human rights and HIV in the region.

Asia Pacific Network of People Living with HIV/AIDS (APN+). The goal of this project is to increase the evidence base to support more effective advocacy at the regional and country level across nine countries in South Asia and Southeast Asia (Bangladesh, Cambodia, Indonesia, Myanmar, Nepal, Pakistan, Philippines, Thailand, and Vietnam). Specifically, the activities are focused on improving the quality, relevance, and accessibility of HIV prevention, testing, care, and treatment services for persons living with HIV and key population groups through community-based service quality monitoring. The regional approach was proposed in order to address key population-specific issues that transcend national borders and to give a stronger voice at country level and more opportunities to advocate for policy change at both the regional and national level. APN+ will be the PR for this project and will work with three other key population networks – Asian Network of People Who Use Drugs (ANPUD), Asia Pacific Network of Sex Works (APNSW), and Asia Pacific Transgender Network (APTN).

The African Network for the Care of Children Affected by HIV/AIDS (ANECCA). This project aims to improve the coverage and quality of HIV care, treatment and support for children and adolescents living with HIV in seven countries (Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania, and Uganda). Specific objectives include the following: (a) promote the adoption and implementation of policies that increase coverage and quality of paediatric and adolescent HIV care, treatment and support; (b) improve the capacity of HIV service providers in the provision of HIV care, treatment and psychosocial support to children and adolescents living with HIV; and (c) identify, document and promote innovative

approaches and best practices. ANECCA will be the PR but will not implement in-country activities directly. Instead, ANECCA will strengthen the framework already in place in the seven countries.

Abijan-Lagos Corridor Organization (OCAL). The goal of this project is to reduce new HIV infections among the key and vulnerable populations in the West African sub-region that includes Cote d'Ivoire, Ghana, Togo, Benin, and Nigeria. The project will focus on key and vulnerable populations such as MSM, sex workers (including transgender sex workers) and their clients, women and girls, and migrants (including truckers). Project activities will create awareness, improve access to testing and care, and strengthen governance across major economic hubs in the five countries.

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