Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

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5. NEWS and ANALYSIS: New co-financing requirements do away with the old counterpart financing thresholds

> The new co-financing requirements are quite different from the counterpart financing requirements which they replace. Rather than using a formula that applies to all countries, the new requirements will be determined on a country-by-country basis.

6. NEWS: Global Fund HIV grant to Russian Federation supports TB/HIV project in the Tomsk oblast

> The Russian Federation's HIV grant, which is that country's only active grant, includes a TB/HIV project in the Tomsk oblast. The project may be expanded to other oblasts.

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1. NEWS: Resources for the community response must increase if we are to meet our targets: UNAIDS

Report reviews experiences of six countries where governments have allocated funding to CSOs

Civil society representative says that funding for key populations is still difficult to obtain

David Garmaise 5 July 2016

Resources for the community response will have to grow markedly over the coming years if ambitious treatment, prevention and human rights targets for HIV are to be achieved, according to a report published by UNAIDS. The report said that community-based HIV service delivery will have to go from representing 5% of all service delivery in 2013 to representing at least 30% in 2030.

"Although international and private funders have typically provided the majority of funding for community HIV responses," the report said, "several low- and middle-income country governments have recognized the critical contribution of community and succeeded in allocating funding to community-based organizations through national policies that recognize and fund civil society."

UNAIDS reviewed the experiences of six countries that have supported community-based HIV programs through government mechanisms. In four of the countries – Argentina, Brazil, India, and Malaysia – national resources available for the AIDS response have been allocated to civil society organizations. In the other two countries – Malawi and Moldova – Global Fund resources allocated to the government flowed through to CSOs.

Both governments and CSOs have benefited. For example, governments have been able to expand the reach of services by transferring some tasks to community health workers and

volunteers; and community organizations have been able to maintain a continuum of care and to facilitate access to services for hard-to-reach groups.

Although there have been challenges – such as bureaucratic barriers that impeded or slowed the movement of funds from central treasuries to local programs – UNAIDS said that in the six countries it documented, health officials found innovative ways to ensure that funds reached the CSOs. The report identified factors that were key to success, including the following:

- including community representatives in the selection of grant recipients;
- creating quasi-governmental organizations to receive government funding and redirect it to CSOs;
- maintaining rigorous standards for grant recipients while investing in capacity building; and
- facilitating collaboration among CSOs working in the HIV response.

Reaction

GFO asked James Robertson, Chief Executive of Alliance India, to comment on the UNAIDS study. Robertson said that while the model of government funding for communities is appropriate and appealing, UNAIDS' new report highlights an approach that is overly optimistic for key populations. "Unfortunately," Robertson said, "experience has shown again and again that these groups face substantial difficulties in securing domestic government funding as it would, of course, come from the same governments that criminalize them."

Robertson said that nearly 15 years since the advent of The Global Fund and PEPFAR, "we've seen how hard it's been for donor governments themselves to support programming for key populations." In most places, he said, donor-funded interventions for key populations do not even approximate the scale needed, "and now donors appear to be looking for an exit. If donor countries have been so reluctant to fund programming that is politically and socially unpopular even while strongly indicated epidemiologically, why should we expect others to behave any differently?"

James Robertson, Chief Executive, Alliance India

Robertson believes that more than attractive models are needed to fund the HIV response for key populations. "We need practical strategies that acknowledge the vital role of communities and key populations have in responding to the epidemic but that also recognize limitations and gaps and provide targeted support to build capacity, sustain programming, and protect rights," he said.

Just paying lip service to communities is not enough, Robertson said, and it is altogether too early to believe that somehow domestic funding will flow without further priming the pump. "Truth be told, too many national governments have failed to leverage communities and key

populations as strengths in their epidemic responses, and donor investments have also been inadequate towards supporting this goal. At this point, rather than edging toward the door, donors and national governments should be working together to identify long-term co-investment strategies to support communities and key populations."

While the case for domestic support for treatment and other clinical services is considerably more clear, Robertson said, other parts of the HIV response – such as prevention – that often rely on the engagement of communities and key populations for success will undoubtedly suffer without external donor investment. "Many governments simply don't trust civil society organizations as they are regarded as government critics not collaborators, and key populations are more often treated as criminals than as deserving beneficiaries or implementation partners," he said. "Attitudes and laws change much slower than election or budget cycles, and if we are seriously committed to leveraging communities and key populations as partners in ending AIDS, the investment horizon that guides donors needs to be informed more by the cool clarity of experience than the warm optimism of aspiration."

Findings by country

Below, we summarize what the report said about five of the six countries included in the study: Argentina, Brazil, India, Malawi, and Malaysia. (See separate GFO article in this issue for a summary of what the report said about Moldova, and reaction from civil society representatives.)

Argentina

Before Argentina transitioned from Global Fund financing, the Ministry of Health began funding community organizations and networks directly. In 2011, $103,384 was granted to 15 organizations: six networks of people living with HIV; two organizations addressing stigma and discrimination; two networks of transgender people; two organizations focusing on children living with HIV and other vulnerable children; and three organizations of people who use drugs. Since 2011, the funding has grown each year, reaching $223,591 in 2015. The MOH has indicated "an interest" in increasing the finding to $532,359 in 2016.

Although the grants are small (the maximum award is about $21,000), UNAIDS said that they are nevertheless important because the money can be used to for grass-roots community work for which other sources of funding are limited.

UNAIDS said that community groups have asked for greater transparency and predictability of the government funding for the community response. "Although the Ministry of Health acknowledges the essential role of community organizations, stronger political commitment at the highest level and an ongoing dialogue with community organizations are needed."

Brazil

Funding community-based HIV programs began in Brazil in 1994 when the country signed the first of a series of four World Bank loan agreements. Grants were small, at around $50,000, and were aimed at encouraging the growth of grass-roots organizations. About 15 years ago, Brazil began direct fund transfers to states and municipalities. A portion of this

money was to be allocated to NGO-led projects. This continues to this day, although there were some challenges along the way.

One example of successful partnership between government and civil society to deliver community-based services is the project Viva Melhor Sabendo ("Live Better Knowing"), being piloted to scale up self-testing among key populations. In the first year of the program, almost 30,000 people were tested through 53 NGOs in 20 of the 27 states in Brazil. A new round of the project has been just launched.

In addition, the Fundo PositHiVo (the National Sustainability Fund for Civil Society Organizations) was established in December 2014, supported by the Brazilian Government. This program aims to raise funds from the private sector to finance civil society organization projects related to sexually transmitted infections, HIV, and viral hepatitis.

India

UNAIDS said that India's prevention programs have helped to reduce new infections by 66% since 2000. (The reductions are not across the board. While HIV prevalence among sex workers and men who have sex with men has fallen, prevalence among people who inject drugs is increasing.) According to UNAIDS, India has achieved these reductions in new infections in part "through a unique system of decentralized direct funding to, and capacity-building of, community-based and community-led organizations that have the trust and experience to reach key populations."

Early on, funds sent from the Indian Government to the state treasuries were slow to reach state-level civil society organizations. Tamil Nadu was one of the first states to establish an independent funding mechanism to address this problem. Tamil Nadu set up an independent state AIDS control society, chaired by a senior Indian Government official, with an executive committee that included other Indian Government officials, civil society representatives, representatives of key populations, and people living with HIV. The central Indian Government was able to disburse AIDS funding directly to the state AIDS control society, bypassing the bottlenecks in the state treasury. Other states soon established similar state AIDS control societies.

An innovation in the Indian model of governmental financing of civil society organizations was the costing of packages of focused programs among different subpopulations. For example, the cost to deliver a package of services to 1,000 sex workers would be calculated, and civil society could then be contracted to deliver a certain number of packages.

The National AIDS Control Organization (NACO) has released standardized guidelines for issuing calls for applications from NGOs, for screening applications, for selecting which applications to fund, for assessing the capacities of the selected NGOs, and for conducting training.

Malawi

UNAIDS said that funding for community engagement in the HIV response has been central to Malawi's national AIDS strategy since the national AIDS control program was established in 1989.

The government has shifted a number of the non-clinical tasks related to patient follow-up and adherence support to community-based lay health workers and volunteers, thus relieving the burden on the health-care system.

Local councils are mandated to identify and support community organizations to implement activities, such as home-based care, and support for orphans and other vulnerable children.

According to the report, this flexibility to fund small local community groups is one of the strengths of Malawi's community engagement approach. "The approach has demonstrated the potential impact and cost-effectiveness of supporting motivated local groups. Recent examples include a community-run campaign costing around $200 that resulted in recruitment of over 100 men to take part in voluntary medical male circumcision."

The National AIDS Commission was able to direct funds to community programs from 2008 to 2015 using funding from the Global Fund and from a pooled funding mechanism that consolidates resources from several funders.

In 2014 several community organizations came together to develop the Malawi Civil Society Priorities Charter, an advocacy road map for programs that civil society believed were crucial to address the epidemic (see GFO article). This civil society gathering and the Charter have been critical in informing the Global Fund concept note that Malawi subsequently submitted (as well as a proposal to PEPFAR).

According to the UNAIDS report, Malawian NGOs have raised concerns that although they have built substantial capacity and demonstrated that they play an essential role in the HIV response, overall funding available to support their work is decreasing. "Although the Global Fund's new grant with Malawi has not yet been signed, it is anticipated that it will allocate increased funding to the community response, but to a fewer number of organizations to ease principal and secondary recipient management."

The idea of a civil society organization sustainability strategy is being considered (to be developed in 2016 with the participation of civil society). As an initial step, the Government of Malawi, together with the HIV/AIDS Donor Group and civil society, have requested UNAIDS to chair a multi-stakeholder taskforce to identify short- and long-term solutions to the funding crisis faced by the community response, particularly regarding critical community-based critical services at risk of disruption.

Malaysia

In 1992, the Ministry of Health established the Malaysian AIDS Council (MAC) as an umbrella project focusing on preventing among key populations. Since then, 49 CSOs have been funded.

UNAIDS said that the MAC maps HIV prevalence among key populations in order to identify specific program needs. Based on this mapping, the MAC issues an annual call for proposals. Partner organizations submit proposals for programs that can include harm reduction, HIV prevention among specific key populations, and HIV-related shelter homes for women and children. The MAC has an internal technical review panel which evaluates proposals.

Malaysia now confronts the challenge of addressing the rapidly increasing burden of HIV among MSM, sex workers, and transgender people. According to UNAIDS, the Malaysian AIDS Council argues that there are few organizations with the capacity to reach MSM, and that few organizations are able to legally register. Funding for programs for MSM and transgender people comes predominantly from international sources. "Incorporating representatives of key populations on the technical review panel and allocating additional resources to funding and capacity strengthening for organizations serving marginalized and criminalized groups could help to address these concerns," UNAIDS said.

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2. NEWS: UNAIDS study cites Moldova as an example of Global Fund money flowing through governments to CSOs

Governments and CSOs discuss mechanisms to sub-contract services to CSOs

David Garmaise 5 July 2016

Currently there are several national CSOs in Moldova providing services to vulnerable and key populations and people living with HIV. These services include psychosocial support, prevention programming, and harm reduction. Funding for this work has come predominately from The Global Fund and has been administered by an NGO principal recipient, the Center for Health Policies and Studies. According to UNAIDS, civil society organizations benefit from some modest in-kind support from the Moldovan Government, such as provision of rapid tests and local authority office space.

In addition, Moldova is recognized as an example of good practices in the HIV response due to its successful implementation of harm reduction programs in communities and prisons.

Moldova was one of the six countries included in a UNAIDS study of governments that have allocated funding to civil society organizations. (See separate article in this issue for a summary of the study.)

In anticipation of the reduction of Global Fund funding, the Moldovan Government has indicated it will assume the cost of all antiretroviral therapy, including second- and third-line therapies, treatment monitoring and patient follow-up, through the Ministry of Health budget

and the national health insurance program. (See GFO article on transition planning in Moldova.)

UNAIDS said that in 2014, the MOH set aside money in its budget to support one prevention project focusing on people who use drugs, to be implemented by a national NGO. The MOH plans to increase its commitment to fund two harm reduction projects per year starting in 2016. "The national AIDS program acknowledges that community organizations should implement these programs, because they are better equipped and better trusted by key populations than state agencies."

According to UNAIDS, to be able to allocate funding to NGOs, the Moldovan Government needs to approve a new normative framework that defines a mechanism for financing health NGOs. A technical working group under the MOH has developed the framework, but due to changes in the government, as of September 2015 the framework had not yet been approved. "The funding set aside in 2014 and 2014 for NGO programming has lapsed," UNAIDS said.

In August 2015, the National Health Insurance Fund also announced a mechanism to finance NGO prevention programs, the details of which are still to be worked out, UNAIDS said.

Even when these new mechanisms are in place, UNAIDS said, it is unclear whether funding will be sufficient to meet the needs of the community component of the HIV response. "NGOs anticipate that unless additional funding is made available, they will be unable to continue offering the current levels of services."

Regulatory hurdles have turned out to be more time-consuming than was anticipated, UNAIDS said, which may delay the smooth transition to country-financed support for community responses. "NGOs from Moldova and elsewhere in the region have argued it is crucial to monitor levels of funding available to support the community component of the response. If funding decreases and community services are discontinued, the gains achieved so far in addressing the epidemic could be in jeopardy."

Reaction

When contacted by GFO, Viorel Soltan, Director of Center for Health Policies and Studies, said that while Moldova continues to implement harm reduction programs recommended by the World Health Organization in communities and prisons, the costs of these programs are still allocated from external funding, primarily from The Global Fund. Since 2014, he said, the Government of Moldova has partially covered antiretroviral therapy, and has supported treatment monitoring and patient follow-up through domestic funding.

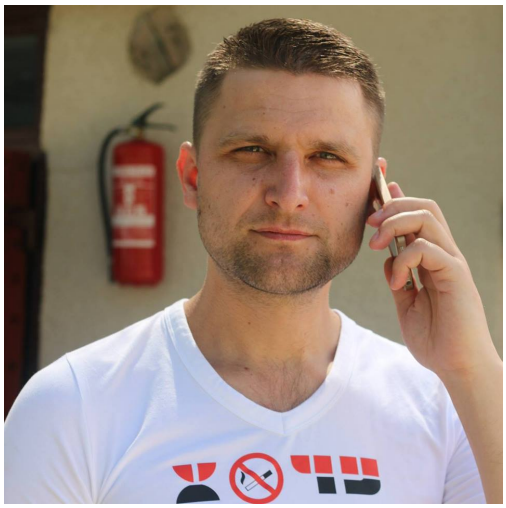
Viorel Soltan, Director, Centre for Health Policies and Studies

Soltan said that the CCM is currently developing a sustainability plan and is documenting existing experience on investments and cost-

effectiveness of harm reduction interventions, as well as existing mechanisms of government funding of NGOs in the region. The country is assessing the funding situation of the national HIV program in the context of transitioning from international to domestic support.

Soltan told GFO that recently, as part of the *Harm Reduction Works – Fund It!* initiative, a high level national dialogue was held in Chisinau on successful transition to national funding of harm reduction in the context of HIV response in Moldova. He said that the event was attended by high level officials of the government, The Global Fund, UNAIDS, the U.N. Office on Drugs and Crime (UNODC), as well as representatives of local partners, NGOs, and communities.

According to Soltan, during the event participants reiterated their commitment to the government taking over the costs of the national program, and agreed on concrete actions to be taken by the government, experts, NGOs, community organizations, multilaterals, and donors in order to ensure a smooth transition from international to national funding of the HIV response and to sustain harm reduction programs. Among other important outcomes of this dialogue, Soltan said, the government officials agreed to put in place relevant mechanisms to sub-contract NGO services through National Health Insurance Fund and Ministry of Health budgets in 2016.



Alexandr Curasov, Executive Director, Positive Initiative Association

Alexandr Curasov, Executive Director of the Positive Initiative Association, told GFO that the government, The Global Fund, development partners, and donors have already reached the point where they realize one simple thing: Communities living with or affected by infections are equal partners and should be involved meaningfully if Moldova really wants to stop an epidemics and save lives. “It is time to move from declared partnership to the genuine partnership,” he said.

We are not only patients,” Curasov explained. “We possess the unique expertise and capabilities for contributing to each stage of the response to the epidemics, from planning the strategy and action, budget development, implementation and monitoring, to searching for the resources.”

Curasov said that what is needed is an atmosphere of transparency and accountability from both the state and the civil society. “Transparency, accountability and equal partnership will allow us to achieve efficient results, achieve optimal use of resources, and have consistent, flexible, and creative approaches in resolving problems,” he said. “We invested a lot in the communities for quite long time, so now it is time to give them an opportunity to apply their potential.”

Tinatin Zardiashvili, our correspondent in Eastern Europe and Central Asia, contributed reporting for this article.

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3. NEWS: France pledges € 1.08 billion for 2017-2019, matching its pledge for the previous replenishment period

Friends of The Global Fund Europe expresses disappointment that the pledge was not increased

Anna Maalsen 4 July 2016

On 26 June, France announced that it is pledging € 1.08 billion for The Global Fund's Fifth Replenishment, covering the period 2017-2019. The amount is equivalent to what France pledged for the Fourth Replenishment (2014-2016). France is The Global Fund's second biggest donor (after the U.S.), having contributed € 3.8 billion since the Fund was established in 2002.

France has also introduced an airline ticket levy which funds France's contribution to UNITAID. Global Fund Executive Director Mark Dybul said that "France's leadership is indispensable, in many ways."

The Friends of the Global Fund Europe were less exuberant about France's pledge. The organization said that France's commitment "didn't tally with the investment level needed to end the epidemics." The Friends of the Global Fund Europe said it signaled a potential decline of French leadership with respect to this fight against the three diseases. The organization added that "France had missed an opportunity to save millions of lives and to do more towards the end of the epidemics as the international community has committed to in September 2015 with the adoption of the Sustainable Development Goals."

Laurent Vigier, Chair of Friends of the Global Fund Europe further commented that "even a minimal and symbolical increase of the French contribution would have been a sign of the constant political will of France to end these epidemics, to support the most vulnerable populations, and to promote global health as a factor of development."

Italy pledges € 130 million

The day after France's announcement, Italy pledged € 130 million for the Fifth Replenishment. In a news release, The Global Fund said that this represented an increase of 30% over Italy's last contribution to the Fund. Canadian Prime Minister Justin Trudeau, who earlier announced that Canada will host the Fifth Replenishment conference, was quick to congratulate Italy on its increased contribution pledge on twitter.

Bill Gates, Co-Chair of the Bill & Melinda Gates Foundation, praised Italy's renewed commitment to The Global Fund. The Fund's news release quotes Bill Gates as saying that "As a country at the forefront of the migration crisis, Italy understands that we live in an interconnected world and that we have a responsibility to help the most disadvantaged people…. I hope that we will see Italy once again become a leading supporter of the fight against these three deadly diseases which still kill three million people every year."

U.S. Senate approves 2017 budget

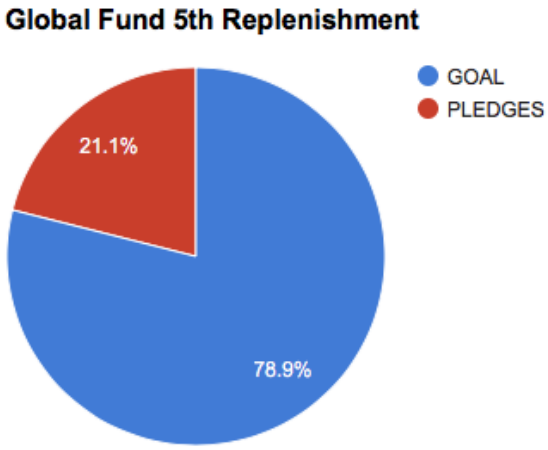
Whilst the United States has not officially made a fifth replenishment pledge, the Senate Appropriations Committee has approved $ 1.35 billion for The Global Fund in fiscal 2017 Budget. This should keep the U.S. on track to contribute at least $4.0 billion for 2017-2019 providing enough other countries come through. In 2013, President Obama's pledged to provide $1 for every $2 pledged by other donors. By (U.S.) law, the U.S. can only contribute 30% of the total.

GFAN Fifth Replenishment tracker

The Global Fund Advocates Network (GFAN) has developed a live pledge tracker which can be accessed here. So far the announced pledges total 21% of the $13 billion replenishment goal (see figure).

Official pledges so far have come from the European Commission, and the governments of Canada, France, Italy, Japan, Luxembourg, and New Zealand.

There is just over two months to go until the Fifth Replenishment Conference scheduled for 16 September in Montreal, Canada. Traditionally, the majority of countries wait until the conference to make their pledges.



Source: http://www.globalfundadvocatesnetwork.org/campaign/global-fund-5th-replenishment/

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4. ANALYSIS: There are more civil society representatives on CCMs now, but do they have the skills they need?

The "learning by doing" approach of many regional programs is part of the solution

Tinatin Zardiashvili 5 July 2016

In the past few years, representation of the civil sector – NGOs and communities – on CCMs has increased, particularly in response to recommendations that key populations be included. However, the initial excitement that accompanied this change has been replaced by growing frustration and complaints from different stakeholders.

What happened is that there was a realization that the technical capacity of the civil society representatives matters as much as their physical presence, and that this capacity was often lacking.

It is desirable, in particular, for civil society representatives to be familiar with the Global Fund procedures and polices; to have experience in budget planning, proposal development, and conducting advocacy; to be able negotiate with the state officials; and to be accountable when representing big group of populations. Thus, effective participation requires multiple skills.

Some community representatives are unhappy with their own performance, and some are criticized by the communities and organizations that nominated them. This discussion occurs frequently at regional gatherings and in closed community pages on Facebook.

A member of the Kyrgyz NGO "Tais Plus," Kristina Makhnicheva, believes that part of the problem is that organizations that were doing advocacy work a decade ago are now delivering services because The Global Fund focused on service provision for so many years – and, so, these organizations have lost their advocacy skills.

There is a general consensus among CSO and community representatives that, in the absence of standards and text books on community involvement, one of the most effective ways to resolve this problem is to "learn by doing" – i.e. to roll up your sleeves, get involved, make mistakes, and then learn from these mistakes. GFO talked with a number of these representatives. They said that the growing number of regional initiatives were particularly useful in this regard.

The joint advocacy initiatives organized by the regional programs and the program monitoring widely practiced by community representatives in the Russian Federation and Kyrgyzstan were mentioned as relevant opportunities to learn. Online webinars were also considered effective for getting information and building skills. If such webinars are recorded, they can cover a wide audience.

"Community empowerment starts by formal participation," Vitali Rabinciuc, the leader of PULS, an advocacy group for people who inject drugs, told GFO. "When a community representative is given opportunity to participate, he or she sees the gap in competences, and so starts thinking about self-development and learning."

The Eurasian Harm Reduction Network (EHRN) leads and participates in a number of regional programs implementing cross-country advocacy and community empowerment activities. EHRN's program director, Anna Dovbakh, told GFO that "understanding of Global Fund language is important for community representatives, but it is not a key obstacle to their meaningful involvement and to their ability to influence decisions."

Dovbakh said that based on EHRN's experience, one of the factors that could make CCMs and its working groups more productive is regular participation in all CCM gatherings (not just the official meetings). This is not always possible, she said, as usually there is no funding available to cover the costs of transport and accommodation for community representatives who are not working for grant-funded projects or NGOs.

Another factor, Dovbakh said, is having basic knowledge of budget processes, economic planning principles, national programs, and state procedures.

A third factor is being able to nominate to the CCM community representatives who are influential and who would be accepted and listened to. However, Dovbakh said, there is a significant lack of experienced community leaders. "Unfortunately, community mobilization components of national grants from The Global Fund and other donors in our region vanished at least three years ago. This mean that only a few leaders from communities who are funded to provide services could remain in the area. National networks that are not providing services are disappearing, which mean that there is no system of watch dogging."

One of the regional initiatives supported by The Global Fund that target community empowerment is *Harm Reduction Works – Fund It!* The initiative, which covers six countries, trains communities on budget processes (including how to advocate on budget issues), and on NGO skills.

Another regional program dealing with the technical capacity of the communities is *Partnership for Equitable Access to the HIV Care Continuum in the EECA Region.* A partnership between EHRN and the East Europe and Central Asia Union of People Living with HIV (ECUO), this initiative aims at enhancing the effectiveness, accessibility, and sustainability of HIV treatment programs in the EECA region with special emphasis on KAPs.

EHRN often organizes various workshops, trainings and meetings to enable community leaders and representatives to enhance their policy advocacy, budgeting, and representation skills. One example is a workshop conducted in Kiev on 21-23 June for CSO and community representatives from Estonia, Kyrgyzstan, and Armenia on "the budget, advocacy, and evaluation of investments and priorities of HIV prevention, diagnostics, treatment, and care services."

Many of the training activities that are part of the regional programs are really workshops where participants discuss problems, share experiences, and come up with ideas for how to get things done. This is a form of learning by doing.

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5. NEWS and ANALYSIS: New co-financing requirements do away with the old counterpart financing thresholds

Secretariat will determine the requirements after discussions with each country

David Garmaise 4 July 2016

Under the new co-financing requirements (previously called "counterpart financing requirements") adopted by The Global Fund, countries no longer have to meet a minimum threshold expressed as a percentage of the cost of the national programs for HIV, TB, and malaria.

Under the old counterpart financing requirements, the thresholds were 5% for low-income countries (LICs), 20% for lower lower-middle-income countries (lower LMICS), 40% for upper lower-middle-income countries (upper LMICs), and 60% for upper-middle-income countries (UMICs).

In addition to the counterpart financing requirements, there was also a separate willingness-to-pay provision. This provision has now been folded into the new co-financing requirements.

The new requirements are part of the new policy on sustainability, transition, and co-financing which the Global Fund Board adopted at its 35th meeting in April 2016. Under the new co-financing requirements, countries have to demonstrate two achievements:

1. progressive government expenditure on health to meet national universal health coverage (UHC) goals; and
2. increasing co-financing of Global Fund–supported programs over each allocation period, focused on progressively taking up key costs of national disease plans.

That much is clear in the new policy. But exactly how it will work is a little cloudy. For example, with respect to progressive public expenditure on health, the requirements include general statements such as the following:

- The Global Fund expects and encourages national governments to fulfill their financial commitments to the health sector in line with recognized international declarations and national strategies;
- in all countries, public policies for mobilization and effective use of domestic resources for health, underscored by the principle of national ownership, will be central to the Global Fund's approach to co-financing; and
- with partners and through global platforms, the Global Fund will actively engage countries with a high, severe, or extreme disease burden for two or more disease components who have a low prioritization of government spending on health or low capacity for domestic revenue capture, to develop a robust health financing strategy and incorporate its provisions in national development frameworks before the end of 2020.

And with respect to increasing co-financing of Global Fund–supported programs, the requirements state that:

- as countries grow economically and have increased fiscal capacity, they are expected to increase their contributions to the disease programs and health systems in line with the requirements of their national plans and fiscal capacity, over each allocation period; and
- applicants should be able to demonstrate that domestic funding is progressively absorbing the costs of key program components such as human resources and procurement of essential drugs and commodities, programs that address human rights and gender related barriers and programs for key and vulnerable populations.

The Global Fund says that the new requirements allow it to tailor co-financing requirements along the development continuum to ensure that they support the health sector and incentivize investments in line with national priorities. At the lower end of the continuum, the emphasis is on domestic investments to build resilient and sustainable systems for health and move towards universal health coverage; along with minimal requirements to co-finance Global Fund–supported programs. As countries move along the development continuum, expectations call for progressively higher co-financing of disease programs and key program

components, such as interventions for key and vulnerable populations and systems strengthening interventions aimed at critical barriers to sustainability.

The Global Fund says that, in general, the following parameters will apply when assessing co-financing contributions:

- For LICs, regardless of disease burden, co-financing contributions are not restricted to the disease program or related health systems costs, and the countries may dedicate 100% of their investment to health systems.
- For lower LMICs, co-financing contributions should be in line with identified priority areas within the disease program or health systems, with a minimum of 50% in disease programs.
- For upper LMICs with a high, severe, or extreme disease burden, co-financing contributions should be in line with identified priority areas within the disease program and health systems, with a minimum 75% in disease programs. In LMICs with a low or moderate disease burden, applicants are encouraged to show a greater share of domestic contributions that will address systemic bottlenecks for transition and sustainability.
- For UMICs, regardless of disease burden, co-financing contributions should be focused on disease components and health systems activities to address roadblocks to transition, with a minimum 50% invested in specific disease components targeting key and vulnerable populations.

It appears that the precise amounts of co-financing for each component will be determined by the Secretariat in consultation with each country.

Under the new requirements, in order to encourage additional domestic investment, a "co-financing incentive" amounting to not less than 15% percent of the Global Fund allocation for each component will be made available upon increases in co-financing of the disease program or health systems that are (a) at least 50% of the co-financing incentive for LICs, and at least 100% of the co-financing incentive for LMICs and UMICs; (b) invested in priority areas of national strategic plans, in line with the investment guidance developed with partners; and (c) evidenced through allocations to specific budget lines, or other agreed assurance mechanisms.

Each country component's access to the co-financing incentive will be determined by the Secretariat on a case-by-case basis taking into account country context, including fiscal space considerations. The amount of the co-financing incentive will be proportional to the level of additional co-financing provided by the country, unless a strong justification is provided.

All country components eligible to receive an allocation from the Global Fund must comply with co-financing requirements to access their allocation. Regional, multi-country, and Non-CCM applicants are not required to meet the co-financing requirements.

Monitoring compliance

Under the co-financing requirements, countries must provide evidence that the Ministry of Finance or other relevant bodies have confirmed the co-financing commitments. The Secretariat will verify this as required.

Co-financing requirements will be measured separately for the overall health sector and for each disease program.

If a country believes that it is not in a position to fulfil its co-financing requirements, it may request a full or partial waiver of requirements at the application stage or during grant implementation. Any waiver of co-financing requirements will require strong justification, as well as a plan for addressing funding shortfalls.

Unless requirements are waived by the Secretariat, failure to demonstrate progressive government expenditure on health or comply with other co-financing commitments will be factored into subsequent allocations. The Secretariat may also, at its discretion, withhold a proportional share of Global Fund disbursements or reduce annual grant amounts during the grant implementation period, if confirmed commitments do not materialize.

The Secretariat will establish mechanisms for annual monitoring of specific co-financing commitments, aligned to national reporting systems.

In order to ensure a reliable basis for tracking government commitments and spending, applicants may request interventions to strengthen public financial management systems through their applications to The Global Fund. In addition, the Global Fund will also invest through its grants and partners to support institutionalization of standardized methods for tracking health and disease expenditures.

In the context of The Global Fund, co-financing refers to pooled domestic public resources and domestic private contributions that finance the health sector and national strategic plans. Domestic public resources include: government revenues, government borrowings, social health insurance, and debt relief proceeds, including Debt2Health arrangements. With the exception of loans and debt relief, all other forms of international assistance, even when channeled through government budgets, are not considered as co-financing.

The Global Fund Sustainability, Transition, and Co-Financing Policy, Board Document GF-B35-04, is available at www.theglobalfund.org/en/board/meetings/35.

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6. NEWS: Global Fund HIV grant to Russian Federation supports TB/HIV project in the Tomsk oblast

Project may be expanded to other oblasts

Tinatin Zardiashvili 5 July 2016

The Russian Federation has not been eligible to apply for funding for TB several years. That does not mean that there is no TB problem in the Russian Federation. In fact, the TB risk is ranked as "severe" according to the Global Fund's own index. The Federation was not eligible to apply for TB because of its income level. The Russian Federation is currently categorized as high-income. A couple of years ago it was classified as upper-middle-income. The Global Fund believes that the Russian Federation has sufficient resources to offer comprehensive TB services to its population without requiring outside assistance.

However, the reality has been that TB services were not being provided to some key affected populations (KAPs) because of the negative attitudes towards these populations in official circles.

So, The Global Fund took advantage of the fact that under the NGO rule, Russia was still receiving funding to provide HIV services. The Fund included a small TB/HIV component in the HIV grant aimed at early detection of TB among people who inject drugs (PWID) in the Tomsk oblast (i.e. region). This component of the grant also supports a training centre, which is providing educational seminars and training for KAPs in HIV, TB, and hepatitis C prevention; reproductive health; drug overdosing prevention; and other topics related to harm reduction and infection control. The component has two core objectives: (1) to prevent TB/HIV co-infection; and (2) to strengthen the TB-control capacity of NGOs providing HIV services.

The component is run by local NGO, Tomsk-AntiAIDS, founded in 2000 to support people living with HIV and PWID, and to prevent a rapidly growing HIV epidemic in the Tomsk oblast. Tomsk-AntiAIDS has been partnering with two PRs from The Global Fund rounds-based programs: Partners in Health, and the Open Health Institute (OHI). The latter is current PR for the HIV grant.

Tomsk Anti-AIDS has accumulated extensive experience and knowledge in providing low-threshold services, psycho-social support, peer education, outreach, training, and counselling. One of the achievements of the round-based programs is a replicable TB control and prevention model among KAPs.

The model, the capacity of the training centre, the existence of a counselling facility, and the technical knowledge and experience of the project staff and volunteers – all of these things argued in favour of the expansion of the TB/HIV component of the HIV grant.

According to Elena Zaitseva, The Global Fund Program Director at OHI, “Tomsk has a long and positive history working on HIV/TB co-infection among PWID. They were pioneers in providing TB treatment and social support at low-threshold settings and their experience is well known in Russia and beyond.”

Because the funding for the current grant was limited, initially only Tomsk was included in the project. However, the current budget of the HIV program may be large enough and flexible enough to accommodate expansion of the TB/HIV component to other oblasts. At the beginning of June, representatives of six cities in the Russian Federation, HIV project staff, volunteers, peer educators, and coordinators attended a training and learned about the basics of TB and TB-control, early diagnostics of TB among KAPs, methods of the treatment, and barriers to including PWID into the treatment services.

Some of the reasons why the TB/HIV project has been successful are that everything (including the budget) is built around a single strategy; all results are documented; and the results are presented to local government to obtain their buy-in. The initiative has been around a long time (since the early 2000s) and has been consistently producing results. As Elena Borzunova, program director of Tomsk Anti-AIDS explained, “We are not physicians, we see ourselves as mediators between the KAPs communities and medical services. Our mission is to identify, refer, accompany, and protect rights.”

Transforming the Tomsk project into a replicable model for TB/HIV prevention among KAPs and supporting the training centre’s capacity in module development would be a step towards sustainability of these services in the Russian Federation. However, the reality is that there are still legislative restrictions in the Federation to providing any prevention programs to certain KAPs. The road ahead is not without its challenges.

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GFO Editor: David Garmaise (david.garmaise@aidspan.org).

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