Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

Issue 299: 02 November 2016

GFO is an independent newsletter about the Global Fund.

GFO Live >> | Aidspan Website >> | Contact GFO >>

CONTENTS OF THIS ISSUE:

1. COMMENTARY: Three ways the Global Fund could do more for TB

BY GEMMA OBERTH

The most recent statistics from the World Health Organization suggest that progress to end TB might be reversing. To achieve the Sustainable Development Goal of ending the disease by 2030, the Global Fund must do more to achieve results in TB. CCM representation, civil society engagement and reaching key populations are critical focus areas.

2. FEATURE: Implementation Through Partnership project addresses problem grants in 20 countries

BY DAVID GARMAISE

The Global Fund and several of its partners are collaborating on an Implementation Through Partnership Project to address issues like grants starting late, grants falling behind schedule, and grants having difficulty absorbing all of the financing they have been awarded.

3. NEWS: Activists urge continuation of special investments in community, rights and gender

BY MARK DAKU

As the 2014-2016 grant cycle comes to a close, the Global Fund's six Special Initiatives are also winding down. The impact of the Community, Rights and Gender Special Initiative (CRG SI) is of particular importance, given the Fund's elevated focus on rights and gender in its new 2017-2022 strategy. Activists urge its continuation in the 2017-2019 period, given its impact to date. The Global Fund Board will take a decision on renewing the initiative at its next meeting in November.

4. NEWS: For its next funding request, Zimbabwean civil society calling for test-and-treat, PrEP

BY GEMMA OBERTH

As the 2017-2019 funding cycle approaches, civil society in Zimbabwe are being proactive. Having kicked off consultations already, emerging themes include rolling out universal test-and-treat for HIV, expanding access to pre-exposure prophylaxis and other new prevention technologies, and elevating key populations and community responses. The country is likely to submit its next funding request to the Global Fund in the 23 May 2017 window.

5. NEWS: Donors and the Government of DRC have struggled to resolve the issue of salary incentives

BY MARY LLOYD

Trying to resolve the issue of salary incentives in the Democratic Republic of Congo has been a long and drawn-out struggle. A transitional plan is currently in place.

6. NEWS: Uganda continues to grapple with the challenge of expired medicines and health supplies

BY NATHAN MAGUME

The problem of expired drugs and medical supplies prevails in Uganda. Following the release of the Uganda OIG report which made specific mention of the problem, media in the country have conducted surveys to investigate the issue further. This article presents the findings of journalists that visited different health facilities and reported on the prevailing issue of expired drugs.

7. NEWS: Global Fund approves funding for six grants from four countries

BY LARSON MOTH

The Global Fund has approved $56.6 million for six country grants. This article provides a breakdown.

8. NEWS: Seven Countries in the EECA Region Projected to Transition by 2025

BY TINATIN ZARDISHVILI

This article provides Eastern Europe and Central Asia (EECA) region-related information from recently published documents namely, the Global Fund's Eligibility List 2017 and Projected Transitions from Global Fund Support by 2025.

9. NEWS: The ITP initiative improves the performance of Global Fund grants in Niger.

BY BERTRAND KAMPOER

By taking part in the Global Fund's ITP - Implementation Through Partnership initiative, Niger has seen a significant increase in the absorption rate of some Global Fund grants. In fact, absorption rates of HIV and malaria are 80% and 76% respectively, as of 30 August, 2016.

ARTICLES:

1. COMMENTARY: Three ways the Global Fund could do more for TB

The World Health Organization says global TB cases are on the rise

Gemma Oberth 20 October 2016

In October 2015, the World Health Organization reported that the Millennium Development Goal (MDG) to halt and reverse TB incidence (MDG 6c) was achieved on a worldwide basis, in each of WHO's six regions and in 16 of the WHO's 22 high-burden countries. While this progress is commendable, recent evidence suggests the trend may be reversing. The most recent Global TB Report highlights that 10.4 million people fell ill with TB in 2015—800,000 more than reported in 2014. Given that the new Sustainable Development Goals (SDGs) commit the world to *ending* the TB epidemic by 2030, these statistics are worrying.

The Global Fund is the largest external funder of TB programs worldwide, accounting for more than 75% of donor assistance for TB disease programs. This equates to investments of more than $4.7 billion in TB programs in more than 100 countries since 2002. In Uzbekistan, the Global Fund supports training of staff as well the medicine to treat TB so that it can be offered for free to patients who need it across the country. In Bangladesh, Global Fund investments in TB have averted more than 577,000 infections and saved more than 308,000 lives.

Despite this considerable effort, the Fund's 2015 Results Report noted that its TB treatment targets are perhaps overly ambitious. A total of 8.5 million TB patients received treatment between 2012 and 2014, below the benchmark to reach the Fund's target of treating 15 million TB patients over the 2012-2016 period. The Global Fund's new strategy for 2017-2022 contains further targets, aiming to reduce TB incidence by 20% and TB deaths by 35% by 2020 (compared with 2015 rates).

Although the Global Fund had a successful replenishment in September, raising nearly $13 billion for the 2017-2019 period, this is just 80% of what is actually required. With limited funds, investments must be made more strategically to reach targets. The Global Fund's new allocation methodology for 2017-2019 keeps the funding split for TB roughly the same as it has been in the past – 18% of total investment (with 51% for HIV and 31% for malaria). However, small changes to the allocation methodology means there will be a *25%* increase to the top *28* countries with the highest burden of multi-drug resistant TB (MDR-TB).

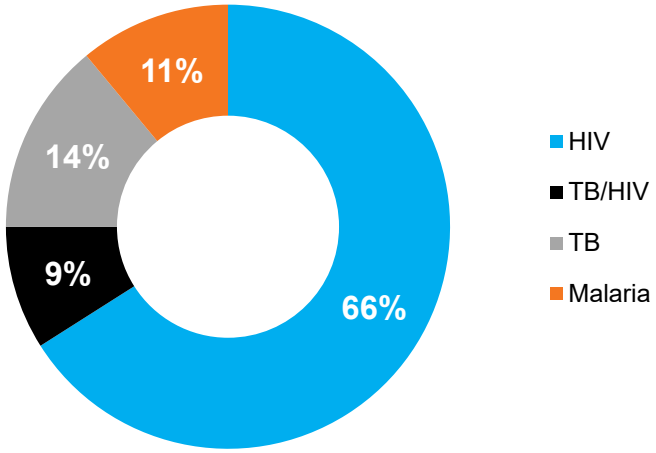
Slow (or even reversing) progress alongside ambitious targets and limited funding means rethinking how the Global Fund and its partners can do more to achieve impact towards ending TB. This article outlines three key areas where the response could be improved: TB

representation on country coordination mechanisms (CCM), civil society engagement and getting services to key populations.

Improve TB representation on CCMs

Strong and engaged TB representation on CCMs is critical for ensuring the right priorities go into funding requests and that grants are effectively implemented to achieve targets and save lives. However, a recent study published by the Stop TB Partnership highlights the inadequate representation of TB experts on CCMs. According to the study, just 14% of CCM members have TB-specific expertise, a clear under-representation compared to HIV specialists (Figure). Further, this expertise was concentrated among a small number of CCMs. Only 65 out of the 114 CCMs examined had at least one member with TB capacity. Where TB expertise does exist, the study found it was concentrated among representatives from government and non-governmental organizations. TB representatives for people living with diseases and key affected populations were disproportionately lacking.

Figure: Distribution of disease expertise among 1201 representatives from 114 CCMs (Stop TB Partnership, 2015)



Ntombekhaya Matsha-Carpentier, Global Fund and Communities Team Leader at the Stop TB Partnership, says that the voice of TB programs has historically been built on very weak foundations. “The advocacy and activism around the Global Fund has been mainly led by the HIV/AIDS community”, she said. “At country level, National AIDS Councils were already familiar with multi-stakeholder functioning that a body like the CCM requires, so naturally the AIDS community was more able to participate actively in CCMs.” It is critical that CCM representation for TB be improved to ensure more effective programming and to accelerate results.

Engage civil society

With the advent of the Global Fund’s New Funding Model (NFM) in 2014, emphasis on civil society and community participation throughout the grant cycle was significantly elevated. The importance of an engaged civil society continues to be institutionalized with the Fund’s

new 2017-2022 strategy. In India – the country with the largest number of incident TB cases - Global Fund investment supports civil society's role in the National TB Program, engaging communities and community-based care providers in 374 districts where there is low TB case detection or there is limited access to health services.

The Global Fund's Community, Rights and Gender Special Initiative has been a key commitment towards improving civil society engagement in Global Fund processes. The Initiative has fielded more than 100 requests for technical assistance, established six regional communication and coordination platforms, and supported eight networks of key populations through a partnership with the Robert Carr civil society Networks Fund (RCNF). While the CRG Special Initiative review is still ongoing, stakeholders have voiced concerns that it has been weak(er) on TB. For example, the RCNF grantees are all networks of HIV organizations, drawing criticism that the Special Initiative is not well balanced towards supporting TB and malaria communities to engage. In April 2015, the Global Fund issued a call for proposals for strengthening community engagement in Global Fund malaria grants, subsequently appointing several civil society organizations to lead this work. Similar investments in TB communities are limited, though they would make TB grants more efficient and effective.

In addition, the Stop TB Partnership CCM study referenced above found that civil society TB CCM membership was particularly lacking. In fact, half of all high-burden countries that are eligible for Global Fund grants have no civil society CCM members who represent TB communities. "The value of community engagement in CCMs is about the lived experience of what it's like to be affected by TB," Matsha-Carpentier told Aidspan. "It's about having people who know what barriers exist to access TB services, and getting guidance from them for solutions."

Prioritize key populations

The Global Fund's commitment to key populations is commendable. Preliminary results from an ongoing resource tracking initiative led by the Fund's CRG Department indicates that approximately 10% of all funds allocated to HIV and joint HIV/TB programs has been directed towards programs for key populations. The Fund also has a Special Initiative with the Stop TB Partnership to improve access to technical assistance to improve gender and human rights components in TB grants. However, a recent Global Fund analysis found that out of 49 TB concept notes, only 6 had human rights programs with a traceable budget (see GFO article). In addition, GFO has previously reported that the Fund's new initiative to intensify human rights efforts will be designed around the seven key interventions to reduce stigma and discrimination and increase access to justice identified by UNAIDS, suggesting they will be largely HIV-focused. According to the Fund, more work will be done in the second half of 2016 to clarify how human rights for TB can be elevated as part of the initiative.

Further, investing in multi-country programs is a vital way to reach TB key populations with services. Miners, migrants and refugees are all TB key populations who are often highly mobile and frequently face barriers to accessing TB services as a result. Multi-country programs like the TB in the Mining Sector grant in Southern Africa, or the grant managed by the Intergovernmental Authority on Development to address TB in East African refugee camps, are incredibly important. In the next grant cycle, the Global Fund will no longer be issuing open calls for multi-country grants, instead specifying the regions and priority programs they will be funding. To accelerate impact, the Global Fund's multi-country priorities should scale up cross-border initiatives that address TB vulnerabilities faced by key populations.

Conclusion

None of these areas is new for the Global Fund. Efforts in all three areas have been commendable, particularly in the last three years of the NFM. But the WHO's latest statistics clearly indicate that not enough is being done. As we anticipate the Board's decisions on multi-country grants and Strategic Initiatives in November, and country allocation letters in December, the Global Fund's focus on TB must be elevated. If not, the SDG to eliminate the disease by 2030 may prove out of reach.

TOP

---

2. FEATURE: Implementation Through Partnership project addresses problem grants in 20 countries

Goal is to alleviate bottlenecks, increase efficiency and impact

David Garmaise 1 November 2016

Over the past year, the Global Fund and many of its partner organizations have been actively collaborating on an Implementation Through Partnership (ITP) project to support countries that are encountering problems implementing grants. The problems include grants starting late; grants falling behind schedule; and grants having difficulty absorbing all of the financing they have been awarded.

(This article provides an overview of the ITP project. To read about how the project works in one of the countries, Niger, see article #9 in this issue.)

The ITP project aims to alleviate bottlenecks, increase operational efficiency and effectiveness, and ultimately to maximize impact via shared ownership and mutual accountability.

The project is being implemented in 20 countries in collaboration with the following partners: government entities from the U.S., France, and Germany; and multinational entities including

the World Health Organization (WHO), UNAIDS, the Stop TB Partnership, UNICEF, the Bill and Melinda Gates Foundation, and Gavi.

The ITP is focusing on 20 countries that received allocations greater than $150 million, and met one or more of the following criteria:

- historic fund absorption rates (expenditure vs. budget 2010-2014) of less than 70%; and
- scale-up of greater than 50% in annual expenditure required; and
- forecasted grant disbursements for the period 2015 (second quarter) to 2017 suggesting that greater than 20% of the country's allocation will remain undisbursed at the end of 2017.

The 20 countries are Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, India, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Pakistan, South Africa, South Sudan, Tanzania, and Uganda. For each of the countries, the ITP engaged the country, partners and the Global Fund in a dialogue that jointly assessed the situation in-country and prioritized and coordinated required additional technical assistance.

The project, which started in October 2015 and is scheduled to run through to December 2016, has five phases, which the Global Fund refers to as "milestones." See the table for a description of the milestones and corresponding timelines.

Table: ITP milestones and timelines

Milestone 1	Milestone 2	Milestone 3	Milestone 4	Milestone 5
In-depth country analyses completed	Actions identified and prioritized	Mobilization and coordination of technical support finalized	Actions implemented in-country, results monitored	Results captured, learning streamlined
Oct-Dec 2015		Jan-Feb 2016	Mar-Dec 2016	

Milestones 1-3 have been completed. Milestones 4 and 5 are in progress.

Description of the process

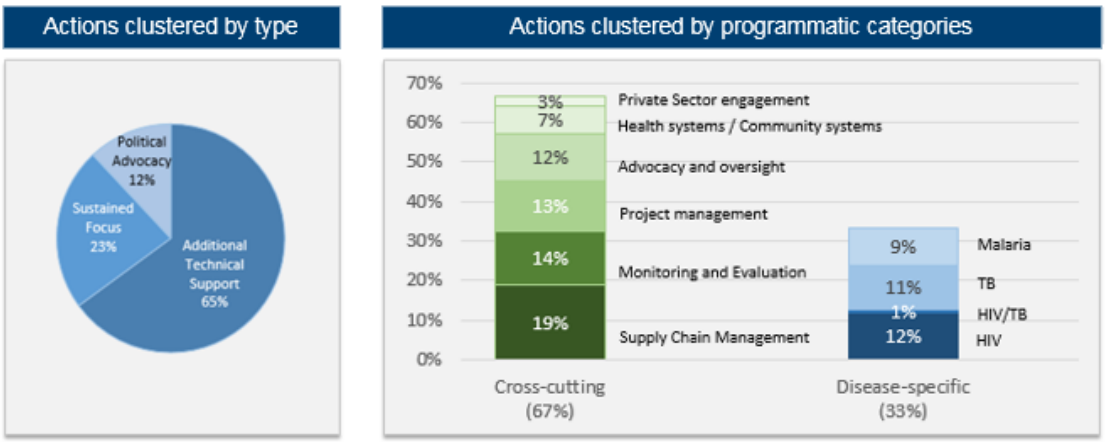
The ITP process started with an inclusive, broad engagement of partners and countries in a joint analysis and dialogue. The issues identified were further refined and prioritized through feedback from partners, countries and the Global Fund country teams into specific, time-limited, measurable actions where additional partnership support was needed.

The actions include **political leadership and advocacy**, where the bottlenecks might best be alleviated through high-level messaging from and to leadership in country; **sustained support**, where the action is underway, but is critical and requires ongoing and close engagement of partners in country; and **additional technical support**, where supplemental

technical advice and programmatic assistance is necessary. Follow-up and monitoring of the actions and results are coordinated with partners, country stakeholders, and the country teams and are reported through the ITP.

In terms of programmatic categories, 67% of all ITP actions focus on cross-cutting systemic challenges, while 33% are disease-specific (see figure).

Figure: Breakdown of ITP actions



Source: The Global Fund

For example, one the ITP actions involved partners conducting a joint high-level mission in one country to engage ambassadors and government officials regarding the release of a national co-financing commitment of 30% for health products relating to antiretroviral treatment (ART) and biological monitoring. According to the Global Fund Secretariat, this cross-cutting action, catering to political advocacy, was successfully carried out with the involvement of national authorities and high-level executives from Expertise France (the French international technical expertise agency), UNAIDS, the WHO, and the Global Fund. The timing of the procurement order which resulted from this action is crucial to achieving the 2017 national targets for ART scale-up.

Another example pertains to disease-specific efforts where, in another country, the ITP served as a catalytic factor in the launch of a time-sensitive mass distribution campaign of long-lasting insecticide-treated bednets. With sponsorship from partners from the Alliance for Malaria Prevention, in association with the (U.S.) President's Malaria Initiative, expert consultants were dispatched to the field within 10 days of this action being prioritized, and the necessary support was provided to grantees to commence efforts and launch the mass campaign without delay. The Secretariat told Aidspan that this action resulted in a noteworthy reduction in programmatic risk, as well as a significant increase in absorption for the period ending in July 2016. The partners' quick and coordinated response, facilitated through the ITP, was instrumental in ultimately limiting the population's exposure to malaria for the upcoming year.

The ITP partners developed a mutual accountability framework for the project. The framework defines the overall scope, timelines and reporting frequency, as well as the governance and leadership structure, and country selection criteria.

The project has a monitoring element which includes the following "core metrics": progress of actions; completion rates of actions; and levels of coordination and active collaboration with respect to the provision of technical assistance for stakeholders. Other metrics include monitoring impact on financial and programmatic indicators where the ITP is a contributor and complements the work of the partner's country teams. Progress on core indicators is collected and communicated on a monthly basis, whereas progress on other metrics is reported on a quarterly and semi-annual schedule.

Today, the focus of the partners continues to be on the prioritized actions, 50% of which have already been completed, and on incorporating the results and learnings from the ITP into an enhanced partnership focused on program quality, outcomes, and impact.

Building upon the current momentum created during the project phase of ITP, partners and country stakeholders are collectively exploring ways to evolve from "implementation" to "impact." The shared objective of maximizing impact at the country level will be key in ensuring evidence-informed (a) country-level dialogue and (b) central-level support in addressing technical assistance needs and building mutual accountability.

Post ITP, the Fund aims to learn from and maintain what worked well, while evolving elements that reflected more of a "project approach" into a sustainable model. Initial stakeholder's feedback identified the following themes to assess: Coordination, Transparency Technical Support and Accountability, under this theme, the Fund would seek to maintain coordination, transparency and mutual accountability orientation of technical support, moving beyond a focus only on implementation to longer term capacity development. In regards to the second theme of Technical Support Framework, stakeholders indentified the need to sustain a comprehensive framework for technical support, including demand identification, supply matching, and the monitoring of results. For the last theme of Country Ownership, stakeholders felt there ought to be an increased country level of engagement in technical support demand identification and implementation oversight.

Information for this article was provided by staff in the Global Fund Secretariat.

TOP

---

3. NEWS: Activists urge continuation of special investments in community, rights and gender

A decision will be made at the 36th Board Meeting in November

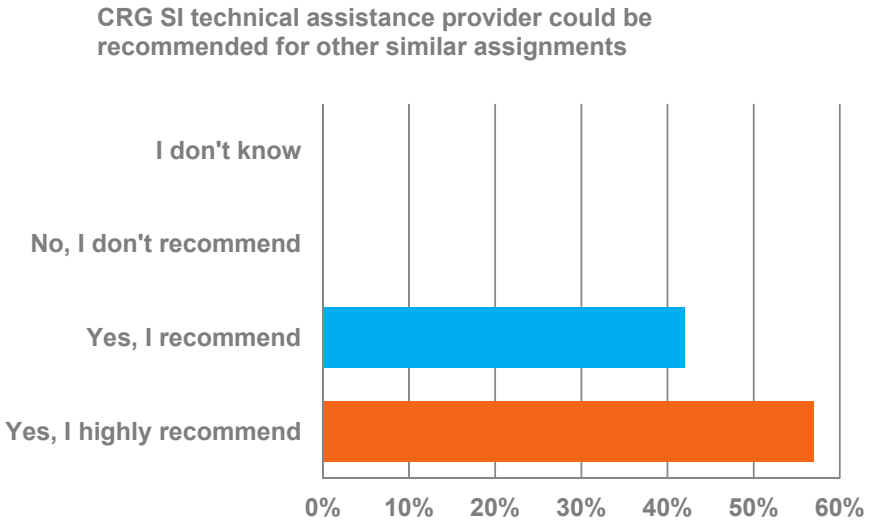
Mark Daku 31 October 2016

As the 2014-2016 grant cycle comes to a close, the Global Fund's six Special Initiatives are also winding down. The impact of the Community, Rights and Gender Special Initiative (CRG SI) is of particular importance, given the Fund's elevated focus on rights and gender in its new 2017-2022 strategy. The CRG SI has invested $15 million in the provision of technical assistance, capacity building of key populations and the establishment of six regional communication and coordination platforms. GFO has been monitoring progress on the CRG SI throughout implementation (see GFO stories here and here).

CRG SI partners representing the Robert Carr civil society Network Fund (RCNF) Grantees and the Regional Communication and Coordination Platforms gathered in early October in Marrakech, Morocco to network and learn from each other. However, with the CRG SI slated to end in December 2016, whether or not the CRG SI would continue, and what it might look like, was a prominent subtext on a lot of people's minds. "I hope they don't cancel the CRG. It's needed now more than ever," said Olive Mumba, Executive Director of the Eastern Africa National Networks of AIDS Service Organizations (EANNASO). "We have just begun the process," Mumba noted, "it would be very unfortunate if the CRG SI didn't continue." EANNASO is the host of the regional platform for Anglophone Africa.

There is a broad consensus that the initiative was successful in achieving its objectives, and that there is a lot of additional important work that needs be done. Some notable successes include Angola, where the African Men for Sexual Health and Rights (AMSHeR) provided short-term technical assistance to support to further the engagement of key populations affected by HIV in Global Fund processes. Quality assurance on the technical assistance provided through the CRG SI shows that the vast majority of assignments results in favourable reviews (Figure).

Figure: Quality assurance of CRG SI technical assistance provision



Other important results include the success of the RCNF grantees in increasing scale and quality of sex worker participation in country dialogues and concept notes of 27 countries. The Regional Platform for Asia Pacific, hosted by Apcaso, undertook a nine-country needs assessment to determine the degree of community and civil society access to Global Fund-related process information – to later be linked to potential resources.

Regardless of the successes, participants at the meeting in Morocco lamented that they were just getting started.

Indeed, many participants were learning about the work of the other partners for the first time at this meeting, noted Anuar Luna Cadena, Technical Coordinator for the Regional Platform for Latin America and the Caribbean, hosted by Via Libre. He said that the short amount of time remaining in the CRG SI makes implementing changes in their organization difficult, and that there was a strong need for the initiative to continue. This sentiment was echoed by Sergey Votyagov, Director of the Robert Carr civil society Network Fund. "The reality is that now there is something concrete in place," Votyagov said. "An investment has been made, and it should be continued."

For the RCNF grantees and the Regional Platforms, work only began in earnest in June 2015, while two of the Regional Platforms did not sign their contracts until early 2016. The meeting in Morocco was the first time that many representatives were given the opportunity to learn about the other organizations and how they might work together. For example, it is outside of the mandate of the Regional Platforms to engage in advocacy – however, this is well within the mandate of RCNF grantees. Opportunities for more effective advocacy through partnerships between the Platforms and RCNF grantees may have gone unseized in some cases.

CRG stakeholders note that the initiative has not only performed the function it set out to, but has also filled an important gap in communication, coordination, and networking needs that was previously ignored. While the CRG SI had originally been put in place to assist civil society and community groups to adapt to the new funding model, CRG partners told Aidspan that the initiative is proving to have value beyond its intended purpose. For example, in advance of the third Global Fund Partnership Forum to develop the Fund's new strategy for 2017-2022, which took place in the Eastern Europe and Central Asia (EECA) region, all regional key populations networks prepared and signed a joint position statement, unprecedentedly emphasizing the need to prioritize transgender communities in EECA's regional AIDS response.

The good news is that the CRG SI has made it onto the Global Fund Agenda for their next Board Meeting in November. If the Board approves the continuation of the program, it will no longer be considered a "Special Initiative" but would be rebranded a "Strategic Initiative", to be funded out of catalytic funding.

There's no question that in the minds of partners and beneficiaries that the CRG SI is providing an important service which should be continued. However, there are questions around how it should continue, who should be involved, and how much money should be allocated. The formal review of the CRG SI that is currently underway will shed light on whether the CRG SI partners have the technical capacity to effectively operate, or if they could they benefit from additional human resources. In advance of the review and the November Board meeting, many CRG SI partners must wait in anticipation about the future of the initiative.

GFO will continue to follow this story, publishing a follow up article on the results of the formal evaluation as well as the Board's decision regarding the CRG SI after the board meeting in November.

TOP

---

4. NEWS: For its next funding request, Zimbabwean civil society calling for test-and-treat, PrEP

The country is yet to adopt the latest WHO treatment guidelines

Gemma Oberth 21 October 2016

Since entering the New Funding Model (NFM) as an early applicant in 2013, Zimbabwe has been a unique case for Global Fund investments. The country submitted a single HIV concept note in April 2013 (before integrated HIV/TB concept notes were encouraged), was granted $311.2 million, and began implementation in January 2014. Then, the country was granted an additional $126.1 million in HIV funding in 2015, based on tweaks to the Fund's allocation methodology. In another unusual move, Zimbabwe was invited to submit an extra HIV concept note in May 2015, this time for incentive funding only. Subsequently, another $25.3 million was awarded. Zimbabwe has one of the world's highest HIV prevalence rates at 14.7% and is home to 1.4 million people living with HIV.

After a one-year costed grant extension, Zimbabwe's current HIV grant is set to run until the end of 2017. It is now aligned with the regular grant cycle (instead of being a year early), and aligned with the country's TB grant (making an integrated funding request possible). Now, the country is gearing up to prepare its HIV/TB funding request for the 2017-2019 grant cycle, likely to be submitted in the 23 May 2017 window. Building on the momentum from the NFM, civil society and communities are proactively engaging, analysing program gaps and setting priorities for the next three years. Aidspan spoke to several of these stakeholders to get a sense of the emerging themes for the country's upcoming funding request.

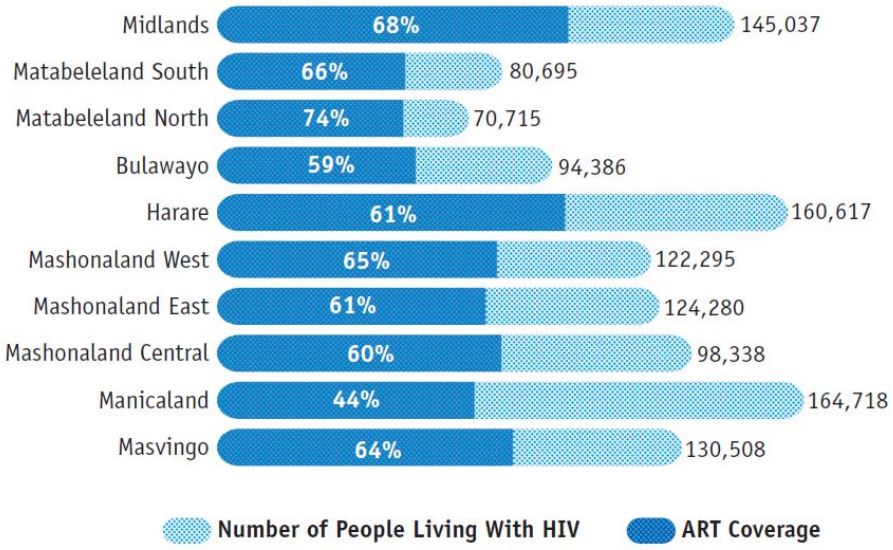
"Zimbabwean civil society from all perspectives – key populations, criminalized populations, networks of people living with HIV and their allies – are all acutely cognizant that the new

grant cycle presents a crucial opportunity for them to push forward a comprehensive agenda for higher quality service delivery," says Asia Russell, the Executive Director of Health GAP. Russel has been working with partners in Zimbabwe to prepare for the next Global Fund grant cycle. Zimbabwe's previous experience with concept note development underscores the need for an actively engaged civil society. In a report which reflects on Zimbabwe's NFM experience as an early applicant, a key lesson learned is that specific community needs often risk being sidelined. The report recommends a minimum funding set-aside for community responses, so this is not overshadowed by health systems strengthening and other biomedical priorities.

One of the top priorities that civil society is pushing for in the next Global Fund request is universal access to immediate HIV treatment for all people living with HIV, regardless of CD4 count. Commonly referred to as "test-and-treat", the World Health Organization began recommending this approach back in September 2015. More than a year later, Zimbabwe has yet to adopt these guidelines as national policy. Many other countries in the region have already done so: Malawi (as of April 2016), Lesotho (as of June 2016), Botswana (as of June 2016), Kenya (as of July 2016), Rwanda (as of July 2016) South Africa (as of September 2016), among others.

Stakeholders told Aidspan that the Zimbabwe government is apprehensive about the cost implications of offering HIV treatment to all. As a compromise, seven (out of 59) districts have rolled out test-and-treat on a pilot basis, supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Zimbabwe Ministry of Health and Child Care. However, activists charge that this is not good enough. "Why on earth is a person living with HIV in one geographic area more deserving of the latest science?" asks Russell. Treatment access is human rights issue in the country, with some provinces achieving much higher coverage levels than others (Figure). For instance, 74% of people living with HIV in Matabeleland North have access to antiretroviral therapy (ART), compared to just 44% in Manicaland. Part of the reason for this are sub-optimal HIV testing strategies, which often miss those who are most at risk. The next Global Fund funding request is an opportunity to close these gaps and move closer towards treating all.

Figure: HIV treatment coverage in Zimbabwe (Zimbabwe's HIV Investment Case, 2015)



Another civil society priority that is emerging is the need to roll out pre-exposure prophylaxis (PrEP) for HIV prevention. Unlike many others, the country has published PrEP guidelines. However, there is no additional funding in the prevention budget to invest in PrEP, beyond some important demonstration projects with female sex workers. HIV prevalence among female sex workers in Zimbabwe is 57.1% and has been increasing over the last three years.

Alongside PrEP, other new prevention technologies are being discussed for inclusion in the upcoming funding request. Civil society is also pressing upon the need to invigorate other areas of sexual prevention, such as building up the resiliency of communities. They say this is particularly important for adolescent girls, young women, and men who have sex with men (MSM). In Zimbabwe's recent People Living with HIV Stigma Index, 77.8% of MSM living with HIV reported experiencing stigma and discrimination, which can act as a human rights barrier to accessing vital services.

A third and critical priority being tabled by civil society for Zimbabwe's next funding request is a strong focus on key populations and community responses. Civil society is demanding that the long overdue size estimation studies of key populations to be made available in time to inform the funding request. In addition, while the country has embraced the 90-90-90 targets, activist in the country urge that reaching these goals will not be possible without improving quality service delivery and improving the environment in which services are provided – especially for MSM, sex workers and transgender people.

Differentiated delivery and bringing services to communities are also key priorities, including providing formal support for a cadre of lay workers. Civil society say this should be guided by Zimbabwe's task shifting policy, but that there is a need to cost out what it would take to train these people.

Stakeholders in-country began consolidating these priorities in mid-October, with consultation meetings ongoing among key populations, civil society and government, and with technical and development partners. So far, AVAC and EANNASO have been supporting civil society leadership on the Zimbabwe country coordinating mechanism (CCM) to spearhead these processes.

"It went beyond my imagination," says Donald Tobaiwa, a CCM member representing civil society and Chair of the TB Committee. "The key populations, they all came in their numbers. You know the Zimbabwean situation – we never thought that all the groups would come."

According to Talent Jumo, a new CCM member representing the women's sector, the challenge moving forward will be to secure resources and technical assistance so that key populations groups and women's organizations can continue to coordinate and monitor progress. "We need to ensure that key recommendations are mainstreamed into the National Strategic Plan, and the implementation framework in general." Zimbabwe's mid-term review of its 2015-2018 National HIV and AIDS Strategic Plan is currently underway. This process will be critical for informing the country's 2017 funding request to the Global Fund.

TOP

---

5. NEWS: Donors and the Government of DRC have struggled to resolve the issue of salary incentives

A transitional plan is currently in place

Mary Lloyd 30 October 2016

The Global Fund has been aware for at least the past six years that salary incentives paid to workers in the Democratic Republic of Congo (DRC) were problematic, but has struggled to find a way to move forward without them.

In GFO #295, we published an article on the issue of salary incentives and we used the DRC as an example. In this article, we provide more details on the efforts made in the DRC to resolve the issue.

The Global Fund has been paying salary incentives, or top-ups, to people helping to implement its projects since at least 2003, to compensate them for extra work they were doing on top of their regular duties. The intention of these payments was to acknowledge and reward the extra work, and to encourage the retention of quality staff, but it soon became evident that the practice created the kind of dependency the Fund was trying to move away from.

Efforts made in the DRC to wind back these payments show how hard it has been for the Global Fund to keep programs running in low income countries without workers receiving these added incentives.

One of the significant issues with incentives in the DRC is that a number of donors were providing them. The donors included the (U.K.) Department for International Development, GIZ, and Gavi. The practice of paying incentives led to a situation where some people were receiving multiple top-ups and were earning significantly more than their colleagues.

Global Fund documents from the DRC show that as far back as 2010, the Fund has been working with other development partners and the Ministry of Health to achieve a consistent approach to salary top-ups. In a Consolidated Program Grant Agreement for a tuberculosis project to be completed in 2012, for example, one of the conditions was for a "Harmonized Salary Top-up Plan for Global Fund Grants" to be developed before grant funds were disbursed for the payment of incentives.

Implementing this plan proved difficult. Further documents show that the Fund struggled to get the information needed. In the scorecard for a malaria grant it was noted that "It has taken a long time to get a full overview of what has been paid to whom and when."

In some cases, work on programs was disrupted by efforts to better control incentives. One scorecard from 2012 shows that salary top-ups were not paid because the plan for harmonizing them was submitted late, and that this non-payment led to delays in implementing a number of key project activities. The document also noted that ensuring data quality became a problem because data validation did not take place after salary top-ups were withheld.

By 2013, salary incentives were still an issue. In an implementation letter extending a 2011 funding agreement for a health systems strengthening grant, the Global Fund Secretariat reiterated the original conditions to be met before incentives could be paid, including the delivery of a detailed map of the sources of funding for the payments to health sector workers, and a plan to continue financing them.

Aidspan understands that the agreement for this grant took more than 18 months to be signed due to the complexity of the negotiations involved in designing a new national policy for performance-based financing. Unfortunately, despite this long and costly process, the grant failed and was closed.

According to Nicholas Farcy, the Global Fund's fund portfolio manager for the DRC, in 2014 the government was again asked to help establish a harmonized and sustainable system among donors for paying incentives. He said the MOH did not meet the conditions set out, so the Secretariat decided to freeze all incentive payments from the beginning of 2015. The freeze was lifted a couple of months later because the Fund decided it was too risky to stop payments altogether.

The donors decided it was not possible to reach agreement with the government, so they worked among themselves to find a harmonized way of transitioning away from salary incentives. The government was kept informed of developments.

One issue they had to overcome was that the government was not always able to provide correct information about what everyone within the Ministry of Health was being paid. Mr Farcy said some people were being promised government salary incentives, but weren't receiving them. Others said they weren't receiving salaries, but in fact were getting them.

"The processes are very chaotic," he said. "How can we rely on what the people are saying if those people themselves do not know exactly?"

With the help of PricewaterhouseCoopers, the donors were able to agree on a salary ceiling for each level. The agreement was that the top-ups would not represent more than 60% of the salary. The plan is being seen as a transitory approach, and the donors have agreed they will decrease the ceiling over time. Currently, the plan is to decrease it to 50% at the beginning of 2017.

The government is expected to take responsibility for paying these salary incentives over time.

Dr Bruno Miteyo Nyenge, the Executive Director of Caritas, one of the civil society principal recipients (PRs) for the DRC grants, told Aidspan that the salary incentives paid to the staff of the government PRs were necessary because of the very modest salaries they receive from the state. "These incentives motivate the workers to implement the grants effectively and to guard against possible fraud," he said.

Dr Miteyo said that the salaries of the staff of the civil society PRs are determined by the Global Fund. However, he noted that there are discrepancies in the way staff in the different PRs who are doing the same work are being remunerated. "There is a need, therefore, to harmonize the salaries for each position. We believe that the responsibility for doing this lies with the CCM, the Global Fund and the donors."

Carola Jacobi-Sambou, Resident Director the GIZ bureau in the DRC, told Aidspan that in the last few years GIZ has stopped the practice of paying incentives in development projects financed by the German Government in DRC. "While we see this practice very critically in terms of sustainability, we are aware of the difficulties encountered especially in remote areas inside the country to engage qualified local personnel of public institutions in the execution of development programs."

Ms Jacobi Sambou added that GIZ welcomes the efforts by Global Fund to coordinate and harmonize any payment practices among donors "as a first step towards a more focalized use of this instrument."

David Garmaise contributed reporting for this article.

TOP

---

6. NEWS: Uganda continues to grapple with the challenge of expired medicines and health supplies

Nathan Mugume 21 October 2016

Findings conducted by The Observer, a Kampala based newspaper, indicate that instances of expired medicines and health supplies in Uganda is still rampant, and that expired drugs were still on the shelves at various health facilities during a recent survey conducted by the newspaper.

In 2012 the Uganda Ministry of Health put in place the national guidelines on the redistribution and prevention of expiry and handling of medicines and health supplies in order to provide a harmonized framework for the redistribution and prevention of the expiry of medicines in Uganda. Nonetheless, Uganda continues to face challenges regarding expired medicines and health supplies.

In the recent past, evaluations of drug wastage conducted by the Uganda Ministry of Health indicated that 10 million doses of antimalarial and US$550,000 worth of antiretroviral (ARV) had expired. According to health experts, expired products are not only ineffective but can result in the emergence of resistance to antimicrobial agents, toxicity in humans and other animals.

The Observer stated that at Kasangati health center in Uganda, expired drugs were still on shelves ready to be served to patients, and expired aluvia syrup for HIV/AIDS-infected children below five years was found at Kiswa Health center III. At Kyabazaala health center III in Mukono district, there was expired niverapine syrup for babies exposed to HIV/AIDS, aluvia syrup for HIV-positive babies and lumartem for malaria- the news report can be accessed here.

The findings of The Observer newspaper confirm the findings of the OIG audit report entitled: “Global Fund Grants to the Republic of Uganda”, released on February 26, 2016. According to the report, 12% of the 50 facilities visited were testing for HIV using expired test kits, and 14% of facilities visited did not perform confirmatory tests on clients diagnosed as HIV positive. This increases the risk of patients getting false HIV results.

The Assistant Commissioner for Integrated Curative Services at the Uganda Ministry of Health, Dr. Jackson Amone, told the Observer that the findings by the Global Fund report pointed to a worrying trend. The article can be read here.

In an article by the Daily Monitor- another Ugandan based newspaper, the Country Coordinating Mechanism (CCM) expressed concerns over wastage of drugs by health facilities in Kalangala district islands. Ms Syson Namaganda, the Secretariat Coordinator told the Daily Monitor that “It is painful to see drugs go to waste here yet there are people who are suffering without drugs in some other parts of the country." This was during a fact finding mission by her team on how health facilities are benefiting from the Global Fund, adding that the management at the National Medical Stores should come out to explain the circumstances under which these drugs expire.

In Uganda, the National Medical Stores is mandated with supplying health commodities. The OIG report indicates that the Joint Medical Stores supplied and delivered test kits to some facilities with just two months-worth of shelf life. During the audit, among the 50 (40 public and 10 private facilities) visited country-wide, there was widespread use of expired drugs. The increase availability of expired medicines and test kits at health facilities is attributed to supplying commodities with short shelf-lives and supplying commodities that have not been requested by the health facilities.

In an interview with the Daily Monitor, Moses Kamabare, the National Medical Stores (NMS) general manager said when drugs are delivered, their responsibility, proper use and management lies in the hands of the hospital or health facility managers. "All medicines received by a facility are expected to be used before they expire," he says. Adding that upon expiry, the district is supposed to arrange for the destruction of expiry drugs by paying the National Drug Authority (NDA) or NMS to destroy them on their behalf. The problem of expiring drugs includes not only public providers, but also extends to private wholesalers, hospitals, clinics and pharmacies.

However, the most recent value-for money audit on NMS by the Office of the Auditor General showed the tug of war within the organization to maintain the legally-mandated buffer stock levels of four months while at the same time ensuring that they don’t overstock medicines.

“NMS stocks drugs without regard to buffer stock levels; as such, certain drugs are in excess of the one year’s requirement while others are under- stocked. There were huge stocks of expired drugs within the stores of NMS,” said the report, which was released in March 2010.
In an article by The Observer newspaper more than six years later, workers at the health facilities which were visited during the two months of this investigation, indicated that NMS has not yet found a lasting solution to the problem. Different sources at these health facilities said that NMS uses a “push system” of dumping unrequested medicines in a bid to avoid audit queries over expiries in their stores.

“Health centres can’t also redistribute these drugs to other centres since they don’t have the mandate. As a result, medicines end up accumulating and expire,” explained a medical officer at Kasangati health centre IV, who declined to be named for fear of retribution.

According to the assistant commissioner in charge of the Pharmacy Department at the ministry of health, Morris Seru, in the case of ARVs, the periodic changes of HIV/AIDS treatment to match new scientific findings affect the government's ability to utilize all the medicines it stocks. "When policies change, some regimens of ARVs drop from use, yet they had stocked many and then expire," he stated in The Observer article.

A World Health Organization bulletin identified causes that lead to drug expiry in Uganda and suggested solutions:

- Procurement of medicines with short shelf lives
- Expiry due do treatment and policy change
- Slow turnover of expensive medications
- Slow turnover of medicines with unpleasant tastes
- Slow turnover of medicines that treat rare diseases

The Global Fund has disbursed US$623 million to the Republic of Uganda since 2002. The OIG noted that only 46% of funds disbursed to the Ministry of Finance between January 2013 and June 2015 had been spent at the time of the audit. The country has made significant headway in the treatment of the three diseases, for example, new HIV infections have decreased from 140,000 in 2010 to less than 100,000 in 2014, the number of people receiving anti-retroviral treatment for HIV has gone up from 21% in 2010 to 50% in 2014, and malaria prevalence in young children has decreased from 42% in 2009 to 19% in 2015.

Aidspan's previous article on the OIG report on Uganda can be read here.

TOP

---

7. NEWS: Global Fund approves funding for six grants from four countries

Larson Moth 27 October 2016

In October 2016, the Global Fund Board approved $56.6 million for six grants emanating from concept notes submitted by four countries. Of the $56.6 million, $37.2 million represented new money; the balance was existing funding that has been approved prior to the new funding model (NFM) but was nevertheless included in the NFM allocations to countries. and one regional grant. The Board was acting on recommendations from the Grant Approvals Committee (GAC) and the Technical Review Panel (TRP).

The Board awarded $3.9 million in incentive funding and added initiatives worth $2.9 million to the registry of unfunded quality demand. See the table for details.

Table: Funding for country grants approved by the Global Fund, August 2016 ($ million)

Country (component)	Grant name	Principal recipient	Approved funding		
			Existing	New	Total
Angola [1] (TB/RSSH)	AGO-T-MOH	Ministry of Health	6.6 m	13.5 m	20.1 m[1]
Ecuador (HIV)	ECU-H-KIMI	Corporación Kimirina	2.3 m	3.4 m	5.7 m
	ECU-H-MCDS	MCDS	1.6 m	0.0 m	1.6 m
Guineau-Bissau (HIV)	GNB-H-SNLS	SNLS	8.9 m	5.3 m	14.2 m
Kenya (malaria) [2]	KEN-M-AMREF	AMREF	0.0 m	2.8 m	2.8 m
	KEN-M-TNT	National Treasury	0.0 m	12.2 m	12.2 m
TOTALS			**19.4 m**	**37.2 m**	**56.6 m**

The award to the Guinea-Bissau was in euros, which we have converted to U.S. dollars at a rate of 1.0984.

[1] The amount awarded to Angola includes $3.9 million in incentive funding. Also, An $2.9 million was added to the unfunded quality demand register.
[2] This was a shortened grant that has previously received funding.

The largest award went to Angola ($20.1 million for HIV/RSSH).

The balance of this article provides a summary of the comments of the GAC on the funding awards.

Angola (TB/RSSH)

The TB burden in Angola is high, with an incidence rate of 370 per 100,000 and a prevalence rate of 490 per 100,000 in 2014. The trend in case notifications for all forms of TB shows a progressive increase from 2007 to 2013 but TB case detection rates remain low. The objectives of the Global Fund-financed programs in Angola are:

- to support the expansion of case notifications for all forms of TB to 72,685 cases in 2017 and 77,774 in 2018;
- to provide treatment and diagnostic equipment needs for multidrug resistant TB in coordination with the Government of Angola;
- to strengthen the epidemiological routine surveillance system, the health information system and program monitoring and evaluation;
- to strengthen the national procurement, storage and supply chain systems;
- to increase the treatment success rate of bacteriologically confirmed TB cases from 66.2% in 2014 to 85% in 2018;
- to decrease the percentage cases with drug-resistant TB started on treatment for multidrug resistant TB that were lost to follow up after six months, from 12.8% in 2014 to 4% in 2018; and

- to increase the proportion of health management information systems or other routine reporting units submitting timely reports according to national guidelines from 45.1% in 2015 to 100% in 2018.

In its report, the GAC Secretariat identified several major risks for the Angola programs and have put in place the following mitigation measures to counter weak program management capacity and poor absorption and Risk of treatment disruptions due to a weakness in the national storage system and supply chain. For the former, a technical support unit is being established to provide technical assistance, build capacity and drive implementation of the new grants implemented by the Ministry of Health, to replace the existing program management unit with the help of a transition team. For the latter, Global Fund-financed commodities will be distributed using a private sector service provider who also stores and distributes Global Fund-financed HIV health commodities, in order to assure their delivery to end users at beneficiary facilities.

Furthermore, it was found that poor TB data quality was an issue and what was needed was for long-term technical assistance to be provided to the national TB program throughout the duration of the grant, particularly for community-based DOTS, diagnostics strengthening, MDR-TB, and TB/HIV integrated services. The grant budget includes funds to train TB focal point officers at provincial level in all 18 provinces monitoring on evaluation and statistical analysis. The report stated that this would be periodically reinforced by routine supervision to ensure strengthening of capacity, and improve decision-making processes.

It was noted by the GAC that the Angolan TB program does not presently have a reporting system at the community level and the integration of community-level data collected by community health workers is still under discussion. To rectify this, the Ministry of Health will integrate community-based DOTs indicators into the new national TB monitoring and evaluation framework and the national TB program will validate the reporting tools at all levels.

Of particular interest, is that the report makes mention of an investigation conducted by the Office of the Investigator General (OIG), in which it identified US$4 million of ineligible expenditures by the Ministry of Health in 2013 under the malaria program as recoverable through procurement fraud. To date, US$2.8 million has been recovered and in order to prevent such fraud occurring in the future, new measures for the use of program funds are being enforced including engaging a fiscal agent financed by the Ministry of Health, and provisioning for a fiscal agent to oversee the financial management and procurement of non-health goods and services.

In the meantime, Angolan authorities have arrested and indicted the officials involved and criminal proceedings are ongoing. The repayment of the outstanding US$1.2 million has been included as a condition in the new malaria grant and the Secretariat will continue to engage the Government of Angola on this subject.

Total domestic financial commitments from Angola for TB amount to US$14.4 million,

which represents 59% of total resources available for the next implementation period. The 2016 budget reflects a 24% increase for health. TB-specific budget lines have been created to track expenditures. The government has provided a written commitment to procure all first-line TB drugs and their share of other TB health commodities as well as absorbing the costs associated with second-line TB drugs by December 2018. The report states that all procurements will be closely monitored by the Secretariat.

The GAC had numerous recommendations as a result of its findings. In short, the GAC called on partners to invest in high-level dialogue to ensure sustained increase and delivery of domestic financial commitments for health, with specific reference to the TB program and building resilient and sustainable systems for health, and highlighted the need for partners' collaboration to ensure long-term technical support to the country.

Ecuador

Ecuador's HIV epidemic is concentrated in men who have sex with men and transgender women, with respective prevalence rates of 11% and a 31.9% in urban areas. The goal of the Global Fund-supported program is to contribute to achieving the 90-90-90 goals by intensifying HIV prevention and reducing access barriers to services for key populations in Ecuador.

The proposed program includes goals such as an increased percentage of men who have sex with men who can obtain a defined package of HIV prevention services, up to 95% in 2019 in the 8 priority regions through the interventions managed by the civil society principal recipient and increasing the percentage of transgender people who are reached with a defined package of HIV prevention services up to 92% in 2019 in the 8 priority regions through the interventions managed by the civil society principal recipient.

Guinea-Bissau

The Global Fund-supported program's goal is to help the country start its transition towards a prosperous, mutually supportive society that guarantees universal access to HIV prevention and AIDS treatment services. Context-specific strategies and activities to support this goal include ensuring essential prevention services for key populations at higher risk of HIV exposure and infection; providing a continuity of essential services for adults and children living with HIV according to their specific needs; and providing complete and reliable strategic information on epidemic trends for decision-making and resource allocation.

With regard to the objectives of the proposed programming, the report stated the program intends to "increase the percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART from 73.6 in 2014 to 81% in 2017, increase the percentage of men who have sex with men who are reached with a defined package of HIV prevention services from 35.7% in 2015 to 78% in 2017; and increase the proportion of expected facility reports received during the reporting period to 100% by 2017."

The report stated that the Global Fund finances 100% of all human resource costs of the

principal recipient, the National AIDS Secretariat. “In order to pursue the objective of increased country ownership and sustainability,” the GAC said, “a condition has been included in the grant agreement that a human resources and sustainability plan level must be submitted by December 2016, with the minimum contribution from the government to cover the salary of the executive secretary of the National AIDS Secretariat by December 2017.”

According to the GAC, prior to the signature of the grants in the 2014 to 2016 allocation period, performance incentives for a selected number of staff at sub-recipient and implementation level had been misaligned across the active Global Fund grants in Guinea-Bissau. In order to harmonize top-up levels across the grants, with an eventual aim to phase them out, the CCM submitted a proposal for standardized top-ups to be applied to all grants . The GAC said that the Global Fund has approved this plan and it will be in effect through December 2017, after which point incentives will no longer be paid. The GAC pointed out that the new incentive scheme being implemented is performance-based.

The TRP initially reviewed the Guinea-Bissau HIV grant in Window 8 in November 2015 and found that it was not fully strategically focused and lacked a comprehensive analysis of the HIV epidemic. However, due to the challenging operating environment in Guinea Bissau and weak health system capacities, the TRP applied flexibilities and a differentiated approach to managing the Guinea Bissau concept note and decided to recommend it proceed to grant-making rather than go back to the CCM to be re-submitted. The TRP requested the applicant to revisit the strategic priorities to focus on key priority and high impact interventions including key populations in line with the HIV epidemic and country context and to develop a plan to conduct a biological and behavioral study among key populations and validate size estimates of key populations and hot spot or geographical mapping of the epidemic to help inform future targeting of the national response and lastly, to develop a time-bound plan with associated budget to strengthen the procurement and supply chain management system, to be implemented during grant implementation.

Kenya

Grants for the Kenya malaria program were authorized to have a shortened grant duration until 30 June 2017 for KEN-M-AMREF and KEN-M-TNT. In order to continue implementation through 31 December 2017, and to sustain the scope and scale of essential malaria services in 2017, the GAC has recommended the extension of Kenya’s malaria shortened grants.

In its review of the Kenya malaria program, the TRP, GAC and Board raised several concerns that were addressed by the applicant. The Principal Recipient developed a risk mitigation plan to address the challenges arising from devolution, including guidelines to enhance accountability and efficient use of resources at the national- and county-level. The implementation of this plan is currently underway.

To address concerns over incentive payments to community health workers, the community health strategy department of the Ministry of Health will lead the process of developing a

sustainability plan in which the malaria program and counties will participate. The Ministry of Health, together with key stakeholders, will work towards ensuring that counties take over. To this end, the county of Siaya has already taken over these payments and the Secretariat anticipates that the other counties will gradually take over this function as well.

Additionally, a US$500,000 special initiative through the Bill and Melinda Gates Foundation will finance advocacy workshops and sensitization activities with parliamentarians, county executives and active engagement of the Secretariat, to encourage increased domestic financing and putting more funding into the county and national health budgets.

The Kenyan government has contributed counterpart financing and wiliness-to-pay over the last two consecutive financial years of 2015 to 2016 and 2016 to 2017 has been US$26 million and US$28 million, respectively, out of which approximately US$6 million was committed to fund the malaria component for procurement of health commodities. The government seems committed to increasing the share of health in total government expenditure and is in the process of implementing a number of initiatives to improve domestic financing and address financing gaps for health programs.

The other disease components with Shortened Grant implementation periods for which funding has not yet been approved by the Board are Kenya malaria, Mozambique Malaria, Mozambique HIV, Sudan Malaria, Tanzania HIV, Uganda Malaria, Uganda HIV, Zimbabwe Malaria, Congo (Democratic Republic) Malaria, Nigeria Malaria, and Ghana Malaria.

Information for this article comes from the report of the Secretariat's Grant Approvals Committee to the Board (GF-B35-ER12). This document is not available on the Fund's website.

TOP

---

8. NEWS: seven countries in the EECA region projected to transition by 2025

Overview on the GF's 2017 Eligibility List and Transition Projection Tool

Tinatin Zardiashvili 01 November 2016

Following the Global Fund's recent replenishment in September, the country eligibility list for the 2017-2019 grant cycle has been published. This list identifies the countries and disease components that are eligible to receive funding from the Global Fund for the next three years.

Eligibility List

The list is reflective of the Global Fund's new Eligibility Policy, where countries with higher disease burdens and lower income levels continue to be prioritized for investment (see

previous GFO article on eligibility). However, just because a country is listed as eligible for Global Fund grants does not guarantee an allocation. The Fund is expected to notify countries of their allocation amounts by mid-December 2016.

Countries in the EECA region have been bracing for limited eligibility and reduced allocations. Aidspan has previously reported that this region's allocation for the 2017-2019 period will be about half the size it was in 2014-2016 (see GFO story).

For this region, the countries and disease components which are eligible for Global Fund grants in 2017-2019 are presented in Table 1.

Table 1: EECA countries listed alphabetically in the income group: eligible disease components and burden

EECA Countries by Income Category	Disease Component	Disease Burden	Eligibility
UMI			
Albania	HIV	Low	Transition 2015
Albania	TB	Low	Transition 2015
Albania	Malaria	Low	Not eligible
Azerbaijan	HIV	High	Yes
Azerbaijan	TB	Severe	Yes
Azerbaijan	Malaria	Moderate	Not eligible
Belarus	HIV	High	Yes
Belarus	TB	High	Yes
Belarus	Malaria	Low	Not eligible
Bulgaria	HIV	High	Not eligible
Bulgaria	TB	Moderate	Transition 2016
Bulgaria	Malaria	Low	Not eligible
Georgia	HIV	High	Yes
Georgia	TB	High	Yes
Georgia	Malaria	Moderate	Not eligible
Kazakhstan	HIV	High	Yes
Kazakhstan	TB	Severe	Yes
Kazakhstan	Malaria	Low	Not eligible
Romania	HIV	High	Not eligible

Romania	TB	High	Yes
Romania	Malaria	Low	Not eligible
Turkmenistan	HIV	Low	Not eligible
Turkmenistan	TB	Low	Transition 2016
Turkmenistan	Malaria	Low	Not eligible
Upper-LMI			
Armenia	HIV	Moderate	Yes
Armenia	TB	Moderate	Yes
Armenia	Malaria	Low	Not eligible
Kosovo	HIV	Low	Yes
Kosovo	TB	Low	Yes
Kosovo	Malaria	Low	Not eligible
Ukraine	HIV	High	Yes
Ukraine	TB	Severe	Yes
Ukraine	Malaria	Low	Not eligible
Lower-LMI			
Kyrgyzstan	HIV	High	Yes
Kyrgyzstan	TB	Severe	Yes
Kyrgyzstan	Malaria	Moderate	Yes
Moldova	HIV	High	Yes
Moldova	TB	Severe	Yes
Moldova	Malaria	Low	Not eligible

UMI= Upper Middle Income, LMI= Lower Middle Income

The eligibility list also includes countries which are currently transitioning to domestic funding: Albania's HIV and TB components as well as Bulgaria and Turkmenistan's TB components will transition out of Global Fund support over the 2017-2019 period. These countries will receive one final transition grant during this time, aimed at facilitating smooth handover by the end of 2019. In accordance with the Global Fund's Sustainability, Transition and Co-Financing Policy, the amount and length of transition funding will be decided by the Secretariat, based both upon the context and upon portfolio considerations. This funding will not exceed a period of three years. In addition, high income countries are not eligible for transition funding.

Bulgaria meets the NGO rule criteria (see Box) of the Global Fund's Eligibility Policy, meaning that country can take the opportunity to revive certain programs which already ended in 2016. Bulgaria's Global Fund HIV grant was meant to end on 31 December 2015, but a no-cost extension carried it into 2016.

Box: NGO Rule in Global Fund's New Eligibility Policy (2016)

Upper-middle income countries not listed on the Organization for Economic Co-operation and Development's (OECD) Development Assistance Committee list of official development assistance recipients are eligible to receive an allocation for HIV and AIDS funding only if they have a reported disease burden of 'High', 'Severe' or 'Extreme' and are eligible to apply for such funds only if the following conditions are met:

a. Confirmation that the allocation will be used to fund interventions that are not being provided due to political barriers and are supported by the country's epidemiology;

b. Confirmation that: (i) the application will be submitted by a non-CCM or other multi-stakeholder coordinating body; and (ii) the program will be managed by a nongovernmental organization (NGO) within the country in which activities would be implemented;

c. The government of such country shall not directly receive any funding; and d. Applicants meet all other applicable requirements as set forth in the Sustainability, Transition and Co-financing Policy, as amended from time to time.

Countries without any eligible components are not included into the list. In the EECA region, the ineligible countries are the Russian Federation (RF), Bosnia and Herzegovina, Serbia, Croatia and Macedonia. This news was expected, as these countries were already aware with regard to their current or impending ineligibility. GFO has reviewed some opinions about program sustainability in RF and Balkan countries (See GFO articles here, here and here).
There is a degree of opportunity for excluded countries to be included in regional or multi-country applications; but even in such cases, a minimum of 51% of participating countries must still be eligible for receiving funding for the disease addressed in the group application.
The Global Fund strongly encourages all upper-middle income countries, regardless of disease burden, and all lower-middle income countries with low or moderate disease burden should be doing sustainability and transition planning over the 2017-2019 period. The STC policy urges these plans to be integrated into national strategic plans.

The EECA region has already made significant steps in transition planning. From 2014, the requirement of the Global Fund was that all programs submitted under the new funding mechanism should contain the transition planning component. Currently, all countries in the EECA are at certain stage of the planning. The priority of all regional programs funded under the new funding mechanism is the empowering of communities to advocate for increased domestic funding and for risk-free and responsible transitioning. However, maintaining the services for key affected populations in most countries remains uncertain.

Anna Dovbakh, Executive Director of Strategy, Development and Governance Team at Eurasian Harm Reduction Network (EHRN), stated that "using only World Bank economic growth indications are not fair for countries, especially in the case of massive cuts to donor funding for HIV. The Global Fund knows better than anyone that in some countries in the region, the transition to domestic funding will cause the disappearance of all developed services for key affected populations."

Transition Projections

The Global Fund has also published a list of countries which are projected to become ineligible over the next ten years (up to 2025), and will therefore be faced with transition. This list is intended to support adequate planning ahead of transition, encourage timely submissions for transition grants, and help countries identify technical support needs in order to facilitate a smooth and sustainable transition for each country.

The transition projection for the period leading up to 2025 in the EECA region covers seven countries out of the fifteen listed in Table 1. The details are provided in the Table 2 below.

Table 2. Transition Projections 2016-2025 for the EECA Region

These transition projections are based on forecasted gross national income per capita and current disease burden data. Current disease data is used instead of projected burden following the recommendations of the technical partners (WHO, UNAIDS, Stop TB partnership and Roll Back Malaria). For the most part, the reason given is because the projected disease burden is not very relevant to transition readiness. TB case notification rates and historic malaria morbidity and mortality – the Global Funds eligibility indicators – do not lend particularly well to future projections, either. Further, there are unlikely to be significant changes in HIV prevalence over the next 10 years.

The Global Fund has emphasized that the projection list is to be considered as an additional resource, designed to support long-term transition planning. These transition projections are not intended to be binding determinations or statements of Global Fund policy. It is important to remember that transition projections are based only on current data, and therefore are subject to change or revision at a later point.

Pavlo Skala, Associate Director of Policy and Partnership at the Alliance for Public Health-APH in Ukraine said “The changes developed by the Global Fund will help countries to protect key affected populations and will support financial and programmatic sustainability of HIV and TB programs.” The APH is a Principal Recipient (PR) of Global Fund Grants in Ukraine. “I am glad,” he continues, noting that “the lessons are learned and now the donor will help us to avoid the painful experiences of some EECA countries that just closed programs and missed the transition phase.”

TOP

---

9. NEWS: The ITP initiative expects to improve the performance of Global Fund grants in Niger

Bertrand Kampoer 24 October 2106

As a result of Niger's participation in the ITP, the country is now expect increased absorption rates of some grants. The country is one of those participating in the Global Fund’s Implementation Through Partnership (ITP) initiative on which a separate article in this issue here, provides a further description.

A 7% absorption rate for January 2016

Absorption rates concerning TB is 7% for the first half of the year 2016. Absorption rates for the HIV and Malaria grants were 76% and 80% respectively as of 30th of September. Although those rates are higher than the one of TB, they are less than optimal as well. The reasons for the low absorption rates include the fact the principal recipient (PR) was not fully staffed and is progressively recruiting, a delay in signing subsidies under agreements with the sub-recipient (SR), a delay in by the PR in the acquisition of health products and equipment.

Other bottlenecks remain despite the Country Coordinating Mechanism (CCM) provision for the proper implementation of the grant, the administrative burden for purchasing and contracting sub recipients, the low operational capacity of actors in the implementation, and the "Zero Cash policy" which is a centralized spending policy at the level of the Principal Recipient (PR). These cumbersome procedures contributed to the low rate of abortion of grants (TB/HSS). The Fund is aware of this situation hence Niger’s participation in the ITP initiative.

“Zero Cash Policy’’ slows the absorption rate.

From 22 to 30 June 2016, the Global Fund Secretariat invited Niger to participate with 10 other countries in the Francophone Africa region to a workshop on performance

improvement (GFO 293). Beyond the overall recommendations for the region, Niger has adopted specific recommendations related to its own context. A national workshop was organized from 17 to 18 August 2016 with the aim of "Improving the implementation of Global Fund grants through the operational structures of the Ministry of Public Health". The workshop brought together central and regional officials from the Ministry of Public Health, members of the CCM, Technical and Financial Partners (TFP), PRs and representatives of Sub Recipients (SR).

For two days, the participants worked on the priority issues that hinder grants such as: coordination of activities; premiums and benefits; preparation, processing and approval of applications; timely transmissions of valid vouchers; quantification, expression of requirements, distribution and stock management.

A member of the CCM told Aidspan that: "low financial consumption is due to the non-functionality of consultation framework, the lack of coordination procedures of the PR; the long duration for the validation of terms of reference and the "Zero Cash Policy". With regard to the "zero cash" policy, it is the PR that runs all expenses. No transaction passes through health facilities. The health facilities seem frustrated and we noted a certain degree of disinterest in activities financed by the Global Fund. In fact, this policy was adopted by Global Fund to overcome the Sub Recipient's incapacity in financial management."
Concerning supply management, he stated that: "insecurity causes delay in the preparation and transmission of bidding documents, there is also product losses due to lack of quality control of inputs; and the lack of insurance system for securing inputs (storage and transport)."

"Zero Cash Policy" relief

Now, the CCM and the Strategic Monitoring Committee organize the follow-up of grant implementation with the Secretariat General of the Ministry of Health and give top leadership to local authorities. The Global Fund conducts weekly phone calls with the Secretariat of the CCM to follow up of recommendations. Partners such as UNAIDS, W.H.O, UNICEF and the French Development Agency were mobilized for technical assistance.

The Strategic Monitoring Committee has now strengthened quarterly planning and reprogramming meetings with the SR. These meetings enable the stock-taking of quarterly achievements. The main achievement is "Zero Cash Policy" relief with the adaptation of it to the country context. Community activities are paid for through money transfers via the post-office, including activities of the PR, and SRs. Field activities from the central to regional level have been better defined, and management tools (justification of expenditure) for the three programs have been standardized.

The Chief Administrative and Financial Services at the Ministry of Health now use GF tools to track spending and relevant receipts. The expectation is that these efforts will contribute to increased grant consumption rates for the three diseases.

This is issue #299 of the GLOBAL FUND OBSERVER (GFO) Newsletter. Please send all suggestions for news items, commentaries or any other feedback to the GFO Editor at mailto:larson.moth@aidspan.org. To subscribe to GFO, go to www.aidspan.org.

GFO Newsletter is a free and independent source of news, analysis and commentary about the Global Fund to Fight AIDS, TB and Malaria (www.theglobalfund.org).

Aidspan (www.aidspan.org) is a Kenya-based international NGO that serves as an independent watchdog of the Global Fund, aiming to benefit all countries wishing to obtain and make effective use of Global Fund resources. Aidspan finances its work through grants from foundations and bilateral donors. Aidspan does not accept Global Fund money, perform paid consulting work, or charge for any of its products. The Board and staff of the Fund have no influence on, and bear no responsibility for, the content of GFO or of any other Aidspan publication.

GFO Newsletter is now available in English and French. Some articles are also available in Russian.

GFO Editor: Larson Moth (larson.moth@aidspan.org)

Are you a newcomer to Global Fund issues? See Aidspan's "A Beginner's Guide to the Global Fund – 3rd Edition" at www.aidspan.org/node/934.

GFO archives are available at www.aidspan.org/page/back-issues.