Independent observer of the Global Fund

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NEWSLETTER

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BY DAVID GARMAISE

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BY CHARLIE BARAN AND ADÈLE SULCAS

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3. NEWS: Global Fund Board approves another $28 million in grants from the 2017–2019 allocations

BY DAVID GARMAISE

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BY ADÈLE SULCAS

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BY DAVID GARMAISE

The Global Fund Board has provided funding for some interventions from the Unfunded Quality Demand Register. The funding has been added to an existing malaria grant in Burundi and an existing TB grant in Philippines. This is the first set of interventions from a portfolio optimization exercise conducted by the Secretariat for the 2017–2019 allocation cycle. The additional resources come from funding designated by the Audit and Finance Committee as being available for portfolio optimization.

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BY FRIENDS OF THE GLOBAL FIGHT

Aidspan Board member Dr. Jesse Boardman Bump reflects on allocation processes for funding and other resources, on the eve of the Global Fund's 40th Board meeting, to be held in Geneva on 14–15 November 2018. Allocations is one of the topics expected to be discussed at the meeting, before the Global Fund institutes changes to its allocations policy in 2019.

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1. NEWS: Board Leadership welcomes the OIG review on Global Fund governance

Several measures have been taken since the Governance Action Plan was developed in response to the review

David Garmaise **6 November 2018**

In an article in GFO 344 published on 17 October 2018, we reported on the contents of the advisory review on governance conducted by the Office of the Inspector General (OIG). We also reported on measures in the Global Fund's Governance Action Plan which was developed in response to the advisory review.

In a post on the Global Fund website published concurrently with the OIG report on 28 September 2018, Board Chair Aida Kurtovic and Vice-Chair Ambassador John Simon said that, "The review highlights significant progress in governance structures and processes that has been implemented since the previous review in 2014 ensuring more effective and robust Board governance. [And] Further progress has been made."

Kurtovic and Simon described some essential actions of the Governance Action Plan that have already been implemented — specifically:

- A new non-voting seat to give a voice at the Board to additional public donors who are not part of an existing constituency;
- Training on ethics and on mitigating actual or perceived conflicts of interest;
- An enhanced selection process for both Board and committee leadership proactively addressing competency, institutional memory, and conflict of interest; and
- A sharper focus by the Board and committees on decision-making and strategic issues most relevant to achieve the goals of the Global Fund Strategy 2017–2022.

(Some of these actions were mentioned in the GFO article.)

Kurtovic and Simon also said that among other actions taken since the review, the Board approved a Risk Appetite Framework — which included target risk levels — thus addressing a major OIG recommendation. In addition, they said, the documentation for Board meetings has become progressively more focused and reduced in amount.

"The Global Fund is constantly evolving to improve its impact for the people affected by the diseases and its progress toward ending the epidemics," Kurtovic and Simon said. "The OIG is a central and important part of these efforts. As the OIG advisory review and our actions in response clearly demonstrate, collectively we continue to improve the effectiveness of our governance structures, processes and practices."

Sources:

- Global Fund releases report on the 2017 OIG Advisory Review on governance, Global Fund Observer Issue 344, 16 October 2018
- Message from the Board Leadership — Governance Review, Global Fund website, 28 September 2018

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2. FEATURE: Rwanda's pioneering National Strategy Financing model improved Global Fund grant performance, says external report

Independent evaluation shows improved flexibility, country ownership, and target achievement

Charlie Baran and Adèle Sulcas **6 November 2018**

In 2014 the Global Fund and Government of Rwanda entered into an agreement to pilot a result-based financing model for the Fund's three grants in the country (See GFO Live, 11 February 2014), a first for the Fund. The model, which has been named "National Strategy Financing" (NSF), leveraged Rwanda's track record of strong performance and clean management of Global Fund grants to establish a more flexible approach to the country's grants, namely through transferred grant management responsibility – from the Fund to the Government – and increased reliance on national financial systems and controls, with greater reprogramming flexibility for the Rwanda CCM and principal recipients.

As Rwanda Fund Portfolio Manager Mr. Osian Jones described it, the NSF model "laid down the foundation for a very different type of partner relationship between the country and the Global Fund."

The NSF model evaluation covered the years 2013 to 2017, and was conducted by Euro Health Group, a Danish health consulting firm. The evaluation report was released internally in July 2018. No official public statements about the evaluation have – until now – been made by the Global Fund, the Government of Rwanda, or other stakeholders.

Commenting on the report, Rwanda's Minister of Health, Dr. Diane Gashumba, told Aidspan that she considered the most important outcomes of the National Strategy Financing for Rwanda to be the use of country systems, the related ability to continue achieving target results – by using national systems – despite a 30% reduction in the Global Fund's allocation to Rwanda, and ownership of the NSF model by in-country policies, strategies, processes and institutions at all levels.

In addition, the Minister said, the flexibility of the model allowed for accelerate decision-making, which help the CCM and the Principal Recipient to take rapid decisions during grant implementation. One example of this was the decision to allocate some cost savings to indoor residual spraying and anti-malaria medicines when an increase in malaria incidence became apparent.

"Using country systems, with the Global Fund no longer separate to others, is inclusive – and this provides more visibility, accountability and sustainability for the country," the Minister said. "However, it is a learning process, and we still have areas for improvement, specifically from communities to overall health-systems' building blocks, to ensure we keep the gains but also cope with emerging challenges."

Principles of 'national strategy financing'

'National strategy financing' embodies the same principles as 'result-based financing'. Chief among these is improved efficiency of donor financing. In a press release announcing the signing of the Rwanda agreement in February 2014, the Global Fund described the mechanism. "Rwanda and the Global Fund designed this new approach that is aligned with existing national systems

and strategy, ties future disbursements directly to outcome and impact indicators, and lessens administrative burden and cost, in a framework of harmonization and mutual accountability."

The core tenets of the Rwanda NSF model are:

- Joint Assessment of National Strategies (JANS) – reviewed, costed national strategic plans for all three diseases, which serve as the key reference documents for all programmatic decisions
- Annual funding decisions are based on performance against defined indicators and targets
- National systems (rather than Global Fund systems) are used for grant management, monitoring and assurance purposes
- Traceability of Global Fund resources in national accounts is maintained ("ring-fenced" funding), which mitigates risk for the Fund
- The Government of Rwanda must meet its counterpart financing requirements.

Rwanda was the first country to implement this approach with the Global Fund. The country was selected, "because of its track record of success in health program and financial management," according to the Global Fund's 2014 press release. It is this combination of sustained strong health system performance and strong financial controls and oversight that opened the door to a less Fund-controlled approach to disbursing funds in Rwanda. The pilot process in Rwanda has generally showed promise, and is being continued into Rwanda's current grant cycle, which began in January 2018.

The Permanent Secretary of the Ministry of Health, Dr. Jean Pierre Nyemazi, described his role (as CCM Chair) in the NSF process as ensuring a participatory process, ensuring the inclusion of Civil Society (who receive Global Fund funding through the Ministry of Finance and Economic Planning), and ensuring that the CCM exercises its oversight functions of all grant implementation, including reallocation approvals, review and reporting of results, and review of audit-relation actions implementation.

Mr. Jones, the FPM, suggested that while national strategy financing is not appropriate for all countries at this time, it may ultimately show itself to be an essential building block for program sustainability in many countries, before, during, and after transition from Global Fund support.

Key findings of the evaluation

According to a presentation made by Euro Health Group consultants, the NSF evaluation had four core objectives:

1. Determine the effect of the NSF model on country ownership and use of national systems.
2. Assess the effect of the model on program focus and prioritization to achieve better programmatic results and impact.

3. Determine the influence of the NSF model on investment decisions, value for money and transaction costs.
4. Document strengths and weaknesses of the results-based financing/national strategy financing model, lessons learnt and recommend areas of further improvement.

Country ownership

According to the evaluation report, the NSF model did well at promoting country-ownership of the Global Fund grants, primarily because it was, "fully owned and driven by in-country policies, strategies, processes and institutions at all levels."

In addition to local oversight, the predictability and flexibility of grant funds was cited as key to a sense of country-ownership, as well as to better grant performance. Predictability comes from disbursements being linked to the achievement of targets and national plan, rather than from the absorption of financial budgets. And flexibility refers mainly to the ability of the CCM and Principal Recipient to reprogram and reprioritize the use of funds without the Global Fund's prior approval, as long as the reprioritization aligns with the relevant national strategy and its operational plan.

The integration of the grants into prevailing national financial and program management systems has reduced or streamlined the administrative burden of Rwanda's $210 million in Global Fund grants. Some see this as playing a major role in improving the efficiency of Rwanda's grants. The FPM noted the example that the country continues to make considerable progress on HIV despite overall reductions in available resources from donors to Rwanda for HIV.

Refocusing for better results

Of the 23 indicators, or targets, set for HIV (6), TB (10), and malaria (7), 17 were fully or almost fully achieved, while all 23 were considered to have been satisfactorily met. The report elaborated: "Although Rwanda is generally a high performer, the model contributed to sustaining the high achievements and to pushing the country towards universal coverage of testing and treatment with decline in funding."

The evaluators attributed Rwanda's high performance within the NSF, at least partially, to the flexibilities afforded by the model, whereby the country was able to use savings for rapid reinvestments in other high-impact interventions, as well as rapidly respond to changing circumstances. Examples of successful savings reinvestments included the procurement of hepatitis vaccines country-wide, renovation of maternity and radiotherapy centers, and the halting of an upsurge in malaria cases due to climate change and changes in mosquito behaviors.

Value for money

The evaluators concluded that the NSF model contributed to greater value for money by promoting greater efficiency in grant management and implementation. Two instruments are

credited with having significant impact on the greater efficiencies: early planning, and joint planning and budgeting processes.

Early planning was enabled by the predictability of funding. For example, based on the reliability of funding forecasts, budget control managers were able to begin annual procurement planning up to two months prior to the start of new budget years. According to the report, "This created the opportunity to prepare bids early, to negotiate the process well, and to ensure the delivery of the right goods at the right time, which also allowed procurement savings."

'Joint planning and budgeting processes' refers to the improved ability of managers across the three grants to better coordinate their activities, and to share costs where appropriate. The evaluators reported several examples of this coordination, leading to savings which were then reinvested into other programs.

Health Minister Dr. Gashumba told Aidspan that the model was designed to facilitate the country's using efficiencies to advance progress in the elimination of the diseases, including prevention of mother-to-child transmission of HIV, and to broaden the scope of the fight against other co-morbidities, such as HIV and hepatitis comorbidities management.

In addition, evaluators noted that there was evidence that the model saved time for the PR, which led to reduced transaction costs, as well as reduced management costs on the part of the Global Fund.

Risks and challenges

The evaluators cited five key risks associated with the NSF model, which mostly concern the potential for bad-faith behavior at country level, such as using cost savings to offset domestic financing commitments or inaccurate program reporting. Nonetheless, the evaluators reported that, "These risks…have not been observed in Rwanda due to the existence of strong results focus and systems, governance and oversight mechanisms."

The implementation challenges reported in the evaluation are typical of pilots, such as start-up issues, calendar and procedural inconsistencies between Global Fund and national systems, and some communication issues, among others. None of the challenges were insurmountable.

"The biggest challenge was that we were all learning by doing," said Rwanda FPM Mr. Jones. He said the challenges that came up were mostly of a sort that could not be predicted, but had to surface organically through implementation. This was, in fact, the first attempt at such a model ever in a Global Fund context. "By implementing the model, we have learned, and we have fine-tuned."

Minister Gashumba specified that challenges still included how to reinforce data collection and reporting mechanisms from community to central levels during a crisis situation (she cited the example of the recent spike in malaria incidence, declared in December 2015 by the Rwandan government and which led to the development of the Malaria Contingency Plan, a multisectoral approach in the fight against malaria including all involved Ministries,) as well as the dissemination and utilization of data results at all levels.

Notwithstanding the challenges, the evaluators concluded that "the model is functioning well." They describe the model as "relevant," "effective," and providing good value for money. Rwanda appears to have been an excellent NSF pilot environment, as the Fund had hoped. "The success of the model in Rwanda is due not only to the strength of the design of the grant mechanism, but also to the existence of the necessary conditions for successful result-based disbursements," said the report.

Lessons learned

The evaluators concluded that the NSF model is replicable, but not to all countries. Among a series of lessons learned for other countries, the evaluators laid out four essential criteria for countries to be considered for an NSF model. Countries must have:

- Sound and not over-costed national strategic plans
- Credible leadership and governance
- Functional and integrated health systems, including at the decentralized levels
- Credible monitoring-and evaluation and oversight mechanisms

Each of these criteria is open to interpretation. As such, the report recommends the Global Fund develop clear readiness-assessment criteria, and apply that to candidate countries.

In order to scale up the NSF model, say the evaluators, the Fund needs to develop and carry out the readiness assessments. In addition, the model should be revised so as to balance flexibility with independent verification opportunities, merge all grants for each component into a single grant (where multiple grants exist), ensure adaptability of the model to different country contexts, and fine-tune the guidelines on budgeting, legal, and compliance mechanisms.

Minister Gashumba emphasized that the success of a national strategy financing model needs multisectoral and multi-level collaboration, including, she said, "high-level political will; commitment and ownership of interventions by all actors/implementers; sector-wide consultations and involvement of other non-health sectors; close monitoring of implementation bottlenecks and building the capacity to foresee, prevent and sort them out; timely disbursement of funds and reporting; ensuring well-performing national systems [within] finance, M&E, procurement, PSM, etc." Lastly, she said, it was critical to document best practices and challenges, and to publish these, to promote "learning by doing".

The evaluators concluded that the model is working well at delivering results, enhancing efficiency, strengthening country systems, and contributing toward Rwanda's effort to move to universal health coverage, while also saving time and money for the Global Fund. It has emerged as a true 'win-win.' Because of this success, it is recommended that the model be further piloted in other countries, but only in those that meet the necessary criteria.

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3. Global Fund Board approves another $28 million in grants from the 2017–2019 allocations

$16 million in matching funds also approved

Countries include Armenia, Bhutan, Chad, Comoros, Côte d'Ivoire, Djibouti, El Salvador, Guatemala, Lesotho, Madagascar, Mozambique, Romania, Suriname, Tunisia

David Garmaise **5 November 2018**

On 17 August 2018 and on 26 October 2018, the Global Fund Board approved two HIV grants and three TB grants worth $28.1 million. The Board also approved $15.9 million in matching funds requests for six components.

These were the 12th and 13th batches of approvals from the 2017–2019 allocations. The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC). Interventions totaling $7.5 million were added to the Unfunded Quality Demand (UQD) Register. Domestic commitments to the programs represented by the approved grants amounted to $520.1 million.

See Tables 1 and 2 for details.

This article provides information on this approved funding. In the last section of this article, we also provide limited information on funding that was awarded around May 2018 for Batches 10 and 11, which we did not cover at the time.

On 26 October, the Board also approved $14.9 million to fund interventions on the Register of Unfunded Quality Demand (see separate article on UQD in this issue).

Table 1: Grants approved from the 2017–2019 allocations (Batches 12 and 13)

Applicant	Com-ponent	Grant name	Principal recipient	Amount approved ($)	UQD ($)	Domestic commitment ($)
Comoros	TB	COM-T-PNLT	PNLT	885,659	N/A	423,624
El Salvador	TB	SLV-T-MOH	Ministry of Health	4,242,741	N/A	30,313,557
Guatemala	HIV	GTM-H-INCAP	INCAP	14,761,220	3,750,824	124,237,798
Romania	TB	ROU-T-MOH	Ministry of Health	4,125,714	2,063,478	343,725,720
Tunisia	HIV	TUN-H-ONFP	ONFP	4,058,019	1,724,786	22,126,996
			Totals	**28,073,353**	**7,539,088**	**520,827,695**

Notes:

1. *PNLT = "Programme National de Lutte Contre la Tuberculose et la Lepre." INCAP = "Instituto de Nutrición de Centro América y Panamá." ONFP = "Office National de la Famille et de la Population."*
2. *Amounts approved are upper ceilings.*
3. *The domestic commitments shown are for the disease programs and exclude RSSH.*
4. *For grants denominated in euros (El Salvador and Romania), a conversion rate of 1 euro = 1.1492 US dollars was used. (The grants to El Salvador and Romania were approved in October 2018).*
5. *Tunisia was also awarded $1,000,000 in matching funds (see Table 2).*

As is customary, the approved funding is subject to availability of funding and will be committed in annual tranches.

Table 2: Matching funds awarded (Batches 12 and 13)

Applicant	Com-ponent	Grant name	Principal recipient	Amount approved ($)	Strategic priority areas
Ethiopia	RSSH	ETH-S-FMOH	Fed. Ministry of Health	3,000,000	RSSH: Human resources for health
Ghana	HIV	GHA-H-WAPCAS	WAPCAS	5,898,599	HIV: Human rights–related barriers to health services; Key populations
Philippines	HIV	PHL-H-SC	Save the Children Federation	1,000,000	HIV: Human rights–related barriers to health services
Tanzania	Malaria	TZA-M-MOFP	Ministry of Finance and Planning	2,962,058	RSSH: Data
Togo	Malaria	TGO-M-PMT	Primature de la République Togolaise	2,080,882	RSSH: Data
Tunisia	HIV	TUN-H-ONFP	ONFP	1,000,000	HIV: Human rights–related barriers to health services
			Total	**15,941,539**	

Notes:

1. *WAPCAS = West African Program to Combat AIDS and STI. ONFP = "Office National de la Famille et de la Population."*
2. *For the grant denominated in euros (Togo), a conversion rate of 1 euro = 1.1676 US dollars was used. (The matching funds for Togo were approved in August 2018.)*

A few more to come

To date, the Board has approved 239 country grants, representing $9.28 billion of the $10.30 billion allocation, for 2017–2019.

In 2018, there were three windows for the submission of funding requests, as follows:

Window 4: 7 February (TRP review took place 19–29 March)
Window 5: 30 April (TRP review took place 3–11 June)
Window 6: 6 August (TRP review took place 9–21 September)

There were 26 country funding requests in Window 4, 20 in Window 5 and 18 in Window 6. There were also 19 multi-country requests in Window 5 and another ten in Window 6.

No further formal windows are scheduled. The Secretariat informed Aidspan that funding requests from nine components remain outstanding — three iterations, two TB, two TB/HIV, one HIV and one malaria. Some of these will be reviewed remotely during the remainder of 2018 by the TRP. (The first remote "plenary" was scheduled for October 2018.) Two remote review submission dates are planned for 2019: 31 January and 30 April.

GAC comments on individual funding requests

In presenting its recommendations, the GAC also provided comments on the individual funding requests. Below, we provide a summary.

Comoros TB

The Comoros TB grant aims to contribute to reducing TB mortality by 75% and incidence by 50% by 2025 compared to 2015 levels. The main activities of the grant are as follows: geolocating TB cases; systematically and exhaustively investigating contacts; finalizing a national guide for diagnosis and pediatric TB; organizing transportation of sputum to the GeneXpert machines; increasing integration of the national TB and HIV programs; and effectively implementing the community-based strategy, which was revised in 2018 along the lines of the Engage-TB approach. (The WHO's Engage-TB approach involves integrating community-based TB activities into the work of civil society organizations.)

"Geolocation" refers to the process of identifying the geographical location of a person or device by means of digital information processed via the internet.

With support from the Global Fund grant, the National TB and Leprosy program aims to increase TB notification by 6% a year, reaching a 90% treatment success rate by 2021.

According to the GAC, the Government of Comoros has made a commitment to contribute an additional €453,724 to support the national disease programs, thus meeting the minimum co-financing requirement. (Table 2 above, which is based on a table from the same GAC report, shows a lower amount.) The GAC noted, however, that the country is vulnerable to

"macroeconomic volatilities" and health systems challenges. The Secretariat will continue to monitor the progress on co-financing.

The GAC said that the Secretariat will encourage the country to exceed the minimum commitment "especially in light of a reduced allocation across the three components." The reference to reduced allocations presumably means that the final 2017–2019 allocation to Comoros was below what the allocation formula called for. The formula-derived amounts were subject to a series of adjustments, one of which was a reduction for components that were deemed to have been "over-allocated" prior to the introduction of the new funding model.

The TB grant is the first of Comoros' three grants from the 2017–2019 allocation to be approved. The HIV and malaria grants are currently in grant-making. The TB grant is scheduled to run from 1 October 2018 to 30 September 2021. The other two grants will have different time frames.

The GAC report referred to the possibility of a unique TB, HIV and malaria grant for the 2020–2022 allocation period. The Senior Fund Portfolio Manager for the Southern and Eastern African Region in the Secretariat's Grants Management Division, Osian Jones, explained to Aidspan that the possibility of moving towards a unique grant covering the three disease components was discussed at a Comoros CCM General Assembly meeting on 14 July 2018, which coincided with grant negotiations.

"Having a unique grant could help reduce management and administrative costs across the portfolio, thereby maximizing the resources allocated to programmatic activities," Jones said.

Jones noted that all of the Comoros grants for the 2017–2019 allocation will now be managed by the national disease programs as principal recipients (PRs). "For the 2020–2022 allocation period," Jones said, "the CCM may decide to submit a joint application with a unique PR if adequate management structures are in place and if this is relevant to the country context at that time."

At its meeting in July 2018, the CCM said that it would work with the PRs, the Ministry of Health and the Global Fund country team to harmonize the grant cycles for the 2020–2022 allocation period, ideally synchronized to Comoros' fiscal cycle (1 January to 31 December).

The GAC welcomed what it termed "the harmonization of RSSH activities across the three grants," noting that this is designed to facilitate the transition towards a unique grant in the 2020–2022 allocation period. Jones explained that, currently, there is no stand-alone RSSH grant in the Comoros portfolio. However, he said, the current HIV grant (COM-H-DNLS), which ends on 30 June 2019, contains an RSSH component which represents more than half the grant's budget (€2.6 million out of €4.5 million). This RSSH component supports certain cross-cutting activities and investments that are common to all three national disease programs, such as the strengthening of M&E, and procurement and supply management systems.

Jones said that given there will be no RSSH component in the grants funded through the 2017–2019 allocations, in a decision taken on 25 November 2017 the CCM requested all PRs to reserve 10% of the grant budgets towards RSSH activities. This represents a total of € 604,966 over three years.

In addition, Jones said, during grant negotiations, it was agreed that the CCM, the Ministry of Health and the PRs would work with technical and financial partners to define a common RSSH work plan to ensure the efficient and effective use of the funds reserved for RSSH in each of the grant budgets.

El Salvador TB

The El Salvador TB grant will have an implementation period of 1 January 2019 (approximately) to 31 December 2021. The current TB grant, funded from El Salvador's 2014–2016 allocation, is a national strategy financing (NSF) pilot. NSF pilots involve using achievements against a small set of national strategic plan (NSP) outcomes or impact indicators as the basis for annual funding decisions and disbursements. (See article in this issue on NSF in Rwanda.) El Salvador has chosen to continue using the NSF approach for its new grant. Adjustments have been made based on lessons learned from the pilot.

The TB grant will support the strengthening of prevention and comprehensive care of new TB cases. El Salvador has adopted a strategic approach for priority populations and families facing catastrophic costs as a result of TB, in line with the global End TB Strategy. Key priorities of the country's NSP include the following:

- Increasing TB detection, mainly among people in detention and other key populations;
- Increasing MDR-TB detection by increasing access to drug sensitivity tests; and
- Maintaining achievements in treatment success rates.

Additionally, the NSP aims to strengthen the health information system and ensure data quality to monitor TB diagnostic and treatment outcomes.

The GAC noted that the Government of El Salvador has committed to contribute an additional $637,060 to the national TB program in the 2017–2019 allocation period, thus meeting the minimum co-financing requirement. These funds will be spent on additional treatment, on cartridges for the GeneXpert machines, on maintenance, and on monitoring and evaluation.

The GAC said that the NSF pilot had resulted in "increased country ownership of the national response and a focus on value for money and impact rather than input management." The GAC said that continuation of the pilot is key to the sustainability of the TB response in El Salvador.

According to Global Fund projections, El Salvador's TB and malaria components are expected to become ineligible for support from the Fund during the 2017–2019 allocation cycle as a result of

the country being reclassified by the World Bank as upper-middle income; the country may receive transition funding for TB and malaria in 2020–2022.

The country's updated NSP (2017–2021) calls for the development of a strategy for building a sustainable national TB response. It also calls for the risks of transitioning from Global Fund support to be addressed.

The fund portfolio manager for El Salvador, Carmen Gonzalez, provided Aidspan with a copy of the NSP. The plan identifies the main risks as the national economic crisis; low revenues from taxes; and changes in government around election time.

The NSP states that El Salvador will achieve a successful transition through the implementation of the following strategies: (a) **Governance and leadership**: Strengthen the regulatory framework for the response to TB; (b) **Financing**: Increase domestic financing for the response to TB; (c) **Efficiency**: Strengthen the efficient use of existing resources; and (d) **Participation**: Strengthen community participation in the response to tuberculosis.

Guatemala HIV

The HIV grant will focus on the following areas:

- Comprehensive prevention programs for men who have sex with men (MSM), transgender people, sex workers and people in prison in prioritized areas, based on disease burden;
- Treatment care and support, including improved access to viral load and CD4 counts, transition to dolutegravir in first-line regimens, and differentiated and decentralized HIV care; and
- Strengthening the health management information systems (HMIS) to allow monitoring of continuum of care and identification of key populations.

The aim of the prevention programs is to improve targeting, improve the quality of the prevention package and increase HIV case finding.

These investments are designed to reach 90% of the estimated population in targeted municipalities by 2020: 36,120 MSM, 1,610 transgender people, 13,095 sex workers and 4,500 people in prison. The goal is to have 20,609 people on antiretroviral treatment by the same date.

The GAC said that the Government of Guatemala has committed to contribute an additional $113.3 million, which is above the minimum co-financing requirement, and which represents an increase of $23.0 million compared to the 2014–2016 allocation period. The government has committed to increase the amount spent on human resources for the HIV response by almost $3.0 million. The GAC is encouraging the government to increase its HIV investments in medicines and diagnostic commodities.

The GAC welcomed the government's interest in developing a sustainability strategy. The Secretariat indicated that there have been discussions with country stakeholders, including other donors and partners, with respect to the scope of the sustainability strategy, technical assistance (TA) needs, and an overall roadmap for development of the strategy. The terms of reference for the TA, which will be funded from the strategic initiative on Sustainability, Transition and Efficiency, have been developed. The TA is currently ongoing.

The GAC observed that the recommendation of the TRP to strengthen interventions addressing gender-based violence against girls and women, including transgender women, is "still in the process of being resolved." The Secretariat suggested that the country develop a plan to frame the proposed interventions and identify activities that will be supported by the grant, as well as the activities that remain without funding and that may be considered for financing in future through a reprogramming exercise. A small amount of funding has been ring-fenced to finance any required TA and any additional needs that might arise from this plan.

Romania TB

Romania's TB grant is a transition grant. It was developed on the understanding that Romania is not expected to receive any more funding from the Global Fund after this allocation and that the necessary measures for a successful transition to domestic funding will be adopted during the implementation period of the grant.

The GAC said that the funding request was based on thorough in-country consultations which included the development of a transition work plan. The systemic changes in-country that will be required during the transition will be supported by strengthening the capacities of civil society organizations (CSOs) to work with local and central decision-making authorities to increase access to health care for vulnerable groups.

The Global Fund grant will focus on the following areas:

- Strengthening Romania's capacity to develop and implement national health strategies, and disease-specific strategic plans;
- Developing legislation to ensure universal health coverage for key populations;
- Reshaping the model of care from hospital-based to ambulatory and community services;
- Improving treatment outcomes in the most vulnerable, underserved and at-risk populations by developing a community-based integrated model of services; and
- Strengthening community responses, systems and commitment for disease control by widening the involvement of CSOs and other community stakeholders to better address the needs of key and vulnerable populations — including through the development and roll-out of a social contracting model for CSOs.

The fund portfolio manager for Romania, Sandra Irbe, told Aidspan that the transition grant includes a component on piloting an integrated care center for 2,000 persons from vulnerable groups, particularly people who inject drugs. The care center was created through a joint partnership agreement involving the Ministry of Health, the Bucharest Municipality Health Department, relevant healthcare centers and NGOs involved in harm reduction.

The center will provide an array of services, including (among others) needle exchange; opioid substitution therapy; condoms; medical and psychological support; and food and beverages.

Irbe said that because the last Global Fund HIV grant in Romania ended in 2011, and because no harm reduction services were picked up by domestic or external funding — except for small financing of these services in Bucharest through the Global Fund's TB grants — this partnership agreement can be seen as a major milestone in promoting domestic awareness about the importance of this intervention.

Irbe told Aidspan that the Bucharest Local Council has just recently approved the purchase of a building where the integrated care center will be located.

The Government of Romania has agreed to contribute an additional €810,594, thus meeting its co-financing requirement for 2017–2019.

The grant budget includes salary incentives for 20 specialists employed by the Ministry of Health (MOH). The GAC deemed that the incentives were justified because of the need to deliver significant systemic changes and progress on policy issues within a short period of time. The MOH will assume 100% of the costs of all staff no later than 1 January 2021. (The end date of the grant is 31 March 2021.)

Tunisia HIV

Tunisia's HIV grant will emphasize civil society strengthening. The GAC said that "the contributions of civil society will be crucial in terms of promoting the new services offered and supporting marginalized populations in accessing quality and sustainable care."

The main focus of the grant will be on the following:

- Harmonizing prevention interventions aimed at key populations;
- Improving care services by offering antiretroviral therapy (ART) through four new outpatient clinics at national people-living-with-HIV care centers; and
- Strengthening biological and viral load monitoring for 2,500 people on ART (nearly 70% of the estimated number of people living with HIV by 2021).

According to the GAC, more than 60% of sex workers and MSM will receive a package of services tailored to the needs of these populations; and 75% of injecting drug users will benefit

from harm reduction interventions such as sterile syringe distribution, prevention, condom use, testing and referral to health facilities.

The GAC said that the Government of Tunisia has committed to increasing funding for the national HIV program by 2% a year, which is sufficient to meet its co-financing requirement. However, the GAC added, Tunisia is facing significant macroeconomic and fiscal challenges. Consequently, the Secretariat will monitor the co-financing commitments, which include funding for government utilization of a proposed methodology for HIV expenditures for the 2018 fiscal year by 30 June 2019; and development of a work-plan for the implementation of a transition readiness assessment.

The GAC noted that although the minimum co-financing requirements were met, there were no current plans for domestic uptake or scaling up of key population activities. In this light, the proposed transition readiness assessment takes on added importance.

The GAC applauded Tunisia's commitment to address human rights–related issues identified through the country's baseline assessment as well as the upcoming national plan for a comprehensive program to remove human rights–related barriers to HIV services. (This was the focus of the $1million in matching funds that Tunisia was awarded.)

GAC comments on matching fund awards

For the matching funds awards related to the Ethiopia RSSH and Tanzania RSSH priority areas, and for one of the awards for Ghana HIV (human rights-related barriers priority area), the matching funds conditions were met. For the other awards, exceptions were requested.

For the Ghana HIV award related to the key populations impact priority area, the applicant did not meet the allocation condition, as the country was unable to demonstrate an increase in investment for this priority area vis-à-vis its 2014-2016 allocation.

For Philippines HIV, Togo RSSH and Tunisia HIV priority areas, the applicants were not able to meet the 1:1 match condition. The 1:1 condition requires that funding within the 2017–2019 allocation invested in the strategic priority area be equal to, or more than, the matching funds requested.

"Based on TRP recommendations," the GAC said, "and noting the operating environment as well as the potential catalytic effect / impact of the investments," waivers to the conditions were approved for Ghana, Philippines, Togo and Tunisia.

For previous matching funds requests, the GAC has frequently granted waivers to the conditions. Countries that have had their allocations reduced because the components in question were deemed to have been over-allocated prior to the introduction of the new funding model have had trouble finding the fiscal space to devote sufficient funding to the priority area for which

matching funds were requested. The Global Fund will likely revisit the matching funds conditions when it determines the allocation methodology for the 2020–2022 period.

Extensions approved

The GAC said that to prevent program disruptions during grant-making, six-month extensions were granted for four grants: Armenia HIV (two grants), Guatemala malaria and Elimination 8 (a multi-country initiative). In all cases except Guatemala malaria, some additional funding was awarded. This funding was taken from the 2017–2019 allocations for the applicants involved.

Additional approvals: Batches 10 and 11

Editor's Note: *Through GFO, Aidspan has endeavored to report on the funding approvals for all grants in the 2017–2019 allocation period. We missed two batches of grants (batches #10 and #11) when they were approved around May 2018. In the two tables below, we provide some information on these approvals.*

Table 3: Grants approved from the 2017–2019 allocations (Batches 10 and 11)

Applicant	Com-ponent	Grant name	Principal recipient	Amount approved ($)	UQD ($)	Domestic commitment ($)
Armenia	TB/HIV	ARM-C-MOH	Ministry of Health	3,138,925	N/A	13,900,000
Bhutan	HIV	BTN-H-MOH	Ministry of Health	1,081,903	233,423	1,688,506
	Malaria	BTN-M-MOH	Ministry of Health	1,432,470	348,384	4,661,147
	TB	BTN-T-MOH	Ministry of Health	1,074,146	249,506	2,545,133
Chad	Malaria	TCD-M-UNDP	UNDP	39,183,392	5,974,360	15,429,676
Djibouti	Malaria	DJI-M-UNDP	UNDP	2,322,022	716,828	4,093,787
	TB/HIV	DJI-C-UNDP	UNDP	4,916,424	1,115,325	5,755,961
Lesotho	TB/HIV	LSO-C-MOF	Ministry of Finance	55,499,451	448,641	147,378,805
		LSO-C-PACT	Pact Lesotho	12,347,559		
Madagascar	Malaria	MDG-M-MOH	Ministry of Health	12,308,822	13,724,403	7,958,486
		MDG-M-PSI	PSI	41,518,651		
Suriname	TB/HIV	SUR-C-MOH	Ministry of Health	1,800,395	55,500	10,304,510
			Totals	**176,624,160**	**22,866,370**	**213,716,011**

Notes:

1. *PSI = Population Services International.*
2. *Amounts approved are upper ceilings.*
3. *The domestic commitments shown are for the disease programs and exclude RSSH.*
4. *For the grant denominated in euros (Chad), a conversion rate of 1 euro = 1.168 US dollars was used.*
5. *The grant for Armenia TB/HIV includes funding for the TB portion only. Funding for the HIV portion is expected to be awarded at a later date.*
6. *Lesotho was also awarded $1,500,000 in matching funds (see Table 4).*

Table 4: Matching funds awarded (Batches 10 and 11)

Applicant	Com-ponent	Grant name	Principal recipient	Amount approved ($)	Strategic priority areas
Côte d'Ivoire	HIV	CIV-H-ACI	ACI	5,548,884	HIV: Key populations; and Human rights–related barriers to health services
Lesotho	TB/HIV	LSO-C-MOF & LSO-C-PACT	Ministry of Finance and Pact Lesotho	1,500,000	HIV: AGYW
Mozambique	HIV	MOZ-H-FDC	FDC	547,758	HIV: Human rights–related barriers to health services; and RSSH: Data
		MOZ-H-MOH	Ministry of Health	4,708,044	
	TB/HIV	MOZ-C-CCS	CCS	2,444,197	
			Total	**14,748,883**	

Notes:

1. *ACI = Alliance Nationale Contre le Sida. FDC = Fundacao para o Desenvolvimento da Comunidade.*
2. *For the grant denominated in euros (Côte d'Ivoire), a conversion rate of 1 euro = 1.168 US dollars was used.*

Aidspan reported on the ninth batch of grant approvals here. That article contains links to the GFO articles on the first eight batches.

Most of the information for this article was taken from four Board Documents: GF-B39-ER03, GF-B39-ER06, GF-B39-ER08 and GF-B39-ER12, each titled "Electronic Report to the Board: Report of the Secretariat's Grant Approvals Committee" and each undated. These documents are not available on the Global Fund website.

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TOP

4. INTERVIEW: Former Director of External Relations reflects on 15 years of resource mobilization at the Global Fund

"Much has depended on very strong advocacy from civil society around the world"

Adèle Sulcas **5 November 2018**

Dr. Christoph Benn was the Director of External Relations for the Global Fund to Fight AIDS, Tuberculosis and Malaria from 2003 to 2018, and was a member of the founding Board of the Global Fund in 2002. In his role as Director of External Relations, he was responsible for mobilizing financial resources for the Fund from public, private, and philanthropic donors, including establishing the Fund's Replenishment mechanism, and pioneering approaches to

global health and development resource mobilization through private sector and innovative financing initiatives. Under Dr. Benn's leadership, the Global Fund has mobilized pledges and contributions of more than $50 billion.

GFO: Your completion of 15 years at the Global Fund marks the end of an era – for you in that role, and for the Fund. How do you feel about your term as Director of External Relations?

Christoph Benn: First, I've always felt extremely privileged that I have had this opportunity in my life, to be engaged with the Global Fund from its creation, and that I was given this task as Director of External Relations from the beginning – because for me the Global Fund was always more than an organization you happened to work for. The Global Fund was, for me, the fulfilment of some dreams that for many years we thought would be absolutely impossible.

I had worked in Africa during the early days of the devastating AIDS epidemic in the late 80s and early 90s when so many people were dying while we had so little to offer to prevent this tragedy. When then the first [antiretroviral] treatment became available after 1996, my first question – and that of my colleagues, of the whole NGO community – was: could we possibly make that available – comprehensive treatment, prevention and care – to all people in need but particularly in Africa? The answer could only be an instrument like the Global Fund.

That's why the Global Fund was the answer to these dreams. Finally there was global solidarity, there was this strong sense of equity, the sharing of people who can afford with those who, without that solidarity, would simply die. Throughout those 15 years there was hardly a day that I wasn't aware that it was a privilege to work for this organization.
Furthermore. I was fortunate enough to work with an amazing team in External Relations over all the years. Whatever we achieved together was due to their incredible commitment, professionalism, creativity and strong sense of community at work.

Of course nobody could have predicted how it went – because the Global Fund at the beginning was just an experiment, it was a disruption of the system. And we were supposed to raise billions of dollars. Nobody knew exactly how much but it was clear that it had to be billions. But there was no blueprint, there was no model – the only model out there was maybe the World Bank. But it was completely different, we knew we couldn't copy the World Bank. But apart from that it was like a blank sheet. How would we address that? That was both a challenge and an opportunity, to create something from scratch – including the Resource Mobilization function.

Obviously we started first with a more conventional approach, called 'ad hoc' resource mobilization. It was not very systematic, and much more opportunistic. Then, over time, we created the Replenishment mechanism for the Global Fund, to make [the] approach more systematic and predictable – we needed not only a lot of money, but also predictability so that the Global Fund was able to support people and programs for years to come.

GFO: What do you consider have been your and your team's greatest achievements at the Global Fund?

Christoph Benn: I think the greatest achievement is not so much the amount of money we raised but the fact that as the Global Fund partnership we've been able to maintain the confidence of our donors and partners over a long period of time. Resource mobilization is basically all about confidence and trust. Unless your donors trust the organization and feel this is a good investment of their money, they will not provide you with their money. That's the capital we had to have; the challenge was to maintain that over a long period – by and large one can say the trust hasn't changed much. Donors have almost without exception continued to support the Global Fund and usually have increased their support. The trajectory has been going up from the beginning. It's relatively easy to score a short-term goal but to maintain that over a long period is much more difficult.

I always described resource mobilization at the Global Fund as a marathon and not a sprint. Not only [in terms of] the support of donors but to maintain a very high level of support from our advocates and the civil society community. So much has depended on very strong advocacy from CS around the world. That it has been possible to keep this level of support and trust of the civil society community would count as one of the major achievements of [our] work.

It evolved also from a few NGOs that helped us in the early years to the creation of GFAN [the Global Fund Advocates Network] – with dedicated advocates in more than 80 countries around the world. It's a major benefit to have lots of civil society leaders on all continents making the case for the Fund.

The governance model, with 3 NGO delegations having full voting rights, always meant that there was a high degree of ownership within the NGO community – it wasn't just temporary support. It was their instrument, they could shape decisions – not that there's been a lack of criticism from civil society! Regardless of any of their positions and often frustrations – they would never question that this was their instrument. This unwavering support has never changed, exactly because of the model of inclusiveness and transparency at global and at country level.

GFO: Can you describe the evolution in the Fund's approach to resource mobilization since the very early days, before there even was a 'Replenishment'?

Christoph Benn: In the very early days we had an opportunistic approach – to try to convince major donors to give generously to the Global Fund – in the first two years mainly through G7 processes, ever since [the G7 meeting in] Genoa in 2001. The G7 provided the essential support to the Global Fund – but it was clearly not enough. That's why as early as November 2003, which was my first Board meeting as Director of External Relations, the Board instructed me to develop a Replenishment mechanism for the Global Fund.

It was a really big challenge because we were a young organization, I had a very small team at that time, and I had basically no experience with organizing replenishments. Other institutions had a machinery, they knew how that worked. I was asked specifically by the Board not to copy the model of development banks – they said 'develop a specific replenishment for the Global Fund, Replenishment 'lite,' with less meetings, less documentation. and a different style.

So we started to develop a model that would be specific to the Global Fund. In the end, it turned out to be a model that was indeed heavily driven by effective advocacy – built on the strong support of advocates from civil society but also of advocates in donor capitals at the political level: business leaders, UN leaders.

Kofi Annan became the first Chair of the Replenishment; as then-Secretary General of the UN with his stature and reputation. To have him as our first chair was huge for us. He chaired the first two Replenishments very successfully – and we got a very senior person, Sven Sandstrom, one of the Managing Directors of the World Bank, who became the vice chair of our first Replenishment. We worked on a daily basis with him, benefitting from his huge experience of what other organizations had been doing while we were about to do it in a different way. These were outstanding leaders who offered their support to the Global Fund, and that enabled us to launch the first rounds of Replenishment.

GFO: Do the five Replenishments so far serve as 'defining moments' in how you think about the Global Fund's changes in its approach to resource mobilization, and have there been other major influences?

Christoph Benn: I could easily go through the history of [the Global Fund's] resource mobilization quoting the Replenishments because they were all unique. The Replenishment became the key mechanism. At the beginning of each Replenishment we asked ourselves who might be the most influential leader who could help us drive that process. The first Replenishment, scheduled for 2005, was the year of broad political support for development with the slogan of "make poverty history" at the G8 Summit in Gleneagles, and we presented the Global Fund as one of the instruments in this very important development. So the UK government, under Tony Blair, hosted our first Replenishment in 2005, and that was basis for the following Replenishments.

The first [Replenishment period] was only scheduled for two years as it was still an experiment. Already two years later we had to organise another one. In 2005, Angela Merkela was elected as Chancellor of Germany, and we knew she'd be president of the G8 in 2007, so it was natural that we approached her and her minister for development Heidemarie Wieczorek-Zeul, and asked them if they were ready to be our champions. It was not a given at all as Chancellor Merkel was new. She had never really been involved in global development and health. But she did host the Second Replenishment meeting, which became a huge success – in 2007 we saw the biggest

jump in our resources we'd ever had. [From $3.7 billion in pledges for two years in the first Replenishment, to $9.7 billion in pledges for three years for the second.]

The Third Replenishment was in 2010, when we had changed to a 3-year cycle, and this was probably the most difficult of all. It was the first Replenishment after the major financial and economic crisis of 2008. There were many who predicted at that time that we should give up on our Replenishments. Countries were struggling, budgets everywhere were under huge pressure, major donor countries like Italy and Spain dropped out because they simply didn't have a development budget anymore, all countries were looking at their own deficits and prioritizing that over global solidarity. Preparing for this was the most challenging of all. Nevertheless, as Kofi Annan had stepped down as UN Secretary General, we convinced [the next Secretary General] Ban Ki-Moon to host the next Replenishment. We didn't get the same type of increase as we'd achieved before but still, we managed to get more resources than in 2007 – and I consider that, in a different way, to be a huge success. To achieve an increase in that situation was quite significant.

Next was in 2013, hosted by President Obama and his team in the US. At that time, the economic situation had improved somewhat so that we could get to the next step in funding levels, and we achieved yet another increase in this Replenishment, with $12 billion.
For the Fifth Replenishment we approached [Canadian Prime Minister] Trudeau. We were fortunate to have this dynamic young leader who with his team, helped us enormously to drive that process – and the Fifth Replenishment raised $12.9 billion for the Fund.

Now, looking into the future at the Sixth Replenishment – we did succeed again to get the G7 President of next year (2019), [French President] Emmanuel Macron, fully in line with that kind of tradition: Whenever possible, get the G7/G8 President of that year to host and be the champion. That was one of key elements of our strategy from the beginning: to always identify the best possible champion for the Global Fund.

It's quite amazing that this still seems to work – even after 15 years of Global Fund, that there is still sufficient enthusiasm and interest at a political level so that the model still works. In many cases, including Canada [as host] and coming up in France, it never would have been possible without the support of national NGOs. It's a key success factor – strong support of NGOs in that country. It reduces their [governments'] risk, if you like. They don't have to be concerned that [their decision to fund the Global Fund] would not be supported, that they would be criticised. They can be pretty sure they would be praised. You have to create a 'win-win' because [you generate] positive publicity by doing that, and it's positive for the Global Fund because you have the most influential leaders on your side.

GFO: After the 'boom' years of the early- to mid-2000s came the 2008 crash, and a change in the donor environment – how would you describe this and what effect did it have on your approach to resource mobilization (both with public and private sector)?

Christoph Benn: Apart from the economic crisis in 2008, the Global Fund faced a crisis of confidence after negative media reports in early 2011. It became clearer at that time that we had to improve risk and financial management but also to adjust our messages. The Secretariat and Board established a High-level Panel (HLP) in 2011 to review our process and they came up with a report called 'From emergency to sustainability'. This was a welcome move. We had driven resource mobilization on the basis of an emergency response – it was all about speed. There was a clear choice, whether we emphasized speed or accountability, and in the first years we went for speed. But you cannot maintain that indefinitely, you need to adapt the message. The crisis taught us that our emphasis on 'lives saved' had to be complemented by a strong focus on impact and the longer-term perspective of how to make our investments more sustainable. The Global Fund deserves credit for having always remained agile enough to respond to these kinds of challenges.

Being a public-private partnership, the private sector has always played a very important role in the Global Fund. Some people assumed that the main role of the private sector is to compensate for shortfalls in public-sector financing – but we knew from the beginning that this would not work. The private sector was very important in its own right. The private sector cannot contribute to the Global Fund on the same scale as the public sector, but this does not mean that [private sector contributions are] are not important. Having strong private sector partners has helped us also to remain a nimble, 21st-century model, influenced by principles of effectiveness, accountability and quick decision making.

The private sector has also contributed significantly in financial terms particularly through our unique partnership with Product (RED). Building on the original ideas of Bono and Bobby Shriver, Product (RED) has pioneered consumer-based fundraising. Until now, (RED) has contributed cumulatively more than $500 million to the Fund. This is completely unprecedented in development finance, and Product (RED) is still going from strength to strength.

The Gates Foundation has obviously been an amazing partner as well, providing a very significant level of resources, and supporting very strongly our advocacy campaigns.

[Editor's note: see the Global Fund's Private & NGO Partners page for a full list of private sector partners.]

GFO: How do you (or do you?) see the role of the private sector and innovative financing changing, ie. do you think a 'step-change' is possible in order to substantially shift the proportions of funding that come from public and private/philanthropic sources, towards more of the latter?

Christoph Benn: I don't think that the shares of public and private funding are set to change significantly in development finance over the next few years. It is my impression that many

people have unrealistic expectations when it comes to Innovative Finance. It's very important to have a clear understanding of what innovative financing is and what it is not. Many people treat it as if that was the solution to any potential shortfalls in development finance.

Without any doubt the world needs to make a huge investment to achieve the Sustainable Development Goals, not only in health. But this investment can only come from three sources: the most important is obviously domestic funding. Particularly in high and middle-income countries, almost all the investment is already coming from domestic sources and this has to increase further. However, there are many countries where domestic funding needs to be complemented by international solidarity. This applies particularly to the low-income countries but also to interventions in middle-income countries that for a variety of reasons are not sufficiently supported by national governments. International support can basically come from two sources: governments, largely through Official Development Assistance (ODA) and private sources.

Innovative finance is not a different source of funding but can be a creative combination of these three. It can provide incentives, and can sometimes leverage further funding. However, its most important role is to create new models that make implementation of programs more efficient and effective.

In health, we have to challenge the assumption that Development Assistance for Health will necessarily remain flat in the future. The need is still huge and health remains an excellent investment for national governments, international public donors, and the private sector.

GFO: What do you see as the most challenging issue(s) ahead for the Global Fund's resource mobilization?

Christoph Benn: The greatest challenge for the Global Fund will be to maintain the high level of confidence and support from the political level to civil servants, from civil society to the private sector. But I am fairly optimistic that the Global Fund will continue to maintain this level of support. I am also optimistic because Peter Sands has appointed, in Francoise Vanni, a wonderful colleague to lead the great team in External Relations, and I am asking all our partners and friends to extend the same kind of support and friendship to her as they have done to me over so many years.

All indications are that the Global Fund is well prepared for the Sixth Replenishment. Having India and France as respective hosts for the preparatory and pledging conferences is a wonderful expression of support from two major G20 and G7 countries.

But we are all aware that one of the inherent challenges, not just for the Global Fund, is that AIDS, TB and malaria will not necessarily remain as high on the political agenda as they used to be. The mission of the Global Fund is part of the broader SDG 2030 agenda, moving to achieve

healthy lives for all, at all ages. We have just seen the launch of the SDG 3 Action Plan which the Global Fund has strongly supported. The Global Fund will be and has to be part of this agenda. We do experience also a broadening civil-society global movement towards Universal Health Coverage (UHC) and the Global Fund should welcome this development. We still need political leaders who our inspired by the progress we have seen in global health and by the prospect of achieving even more amazing goals in the future.

As long as global health will remain high on the political agenda I am not worried about the role of the Global Fund. It is and will be an important part of the global health architecture and will inspire political and civil society leaders to support its mission.

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Editor's Note: Dr. Christoph Benn has been appointed as the Director for Global Health Diplomacy at the Joep Lange Institute. The Global Fund's new Head of External Relations, Francoise Vanni, joined the Fund in September 2018.

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TOP

5. FEATURE: Global Fund African Constituencies meeting in Ethiopia focuses on absorptive capacity

"Probably one of the most debated topics in the Global Fund environment"

Ida Hakizinka **6 November 2018**

Low absorption of funds within Global Fund grants has been a persistent and pervasive challenge in grant implementation, especially in sub-Saharan Africa, which receives about two third of Global Fund investment. This question was again debated in the African Constituencies (Eastern and Southern Africa and West and Central Africa) annual consultative meeting of the Global Fund that was held from 18-19 October 2018, in Addis Ababa, Ethiopia.

Participants of the meeting came from the 46 countries within the constituencies, and also present were six participants from the Global Fund Secretariat, three from UNAIDS, and Global Fund Board Chair Aida Kurtovic. Representing the countries were the two board representatives for each constituency, their respective alternates from the African Constituency, representatives of the Country Coordinating Mechanism (CCM), and State Principal Recipients.

Absorptive capacity measures how effectively allocated grants are utilized to achieve desired impact. Absorption can be measured on different levels/dimensions including:

- Allocation utilization: *a ratio of disbursement forecast to allocation*;
- In-country absorption: *a ratio of in-country expenditure to budget*;

- Budget utilization: *a ratio of disbursement to budget*; and
- Disbursement utilization: *a ratio of expenditure to disbursement*.

Low absorptive capacity denies potential beneficiaries timely access to interventions; leads to reduced value for money due to limited efficiencies in grant implementation, and more importantly, raises concerns among donors as to why they need to stake more resources when those already available cannot be put to full use.

Identifying problems that lead to low absorptive capacity

While low absorptive capacity was recognized much earlier as a challenge, the problem seemed to have increased with the introduction and rolling out of the New Funding Model (NFM). Implementers' own assessment of the causes of low absorptive capacity point to a number of issues.

Participants in the ACB meeting agreed that absorbing grant funds is a shared responsibility between the countries' stakeholders and the Secretariat.

Important issues identified during the workshop that affect absorptive capacity include:

- Delays in contracting procedures and disbursement of funds that resulted in delayed implemented especially at the beginning of the NFM;
- Low capacity in country, including within the Country Coordinating Mechanism (CCM), Principal Recipients (PR) (see OIG audits on Zambia and Malawi), and poor health systems;
- High levels of government bureaucracy, for example in procurement procedures;
- Reprogramming (changes to programming activities whose choice was initially based on poor planning or data, or because of delays in implementation);
- Poor relations between implementers and Global Fund country teams;
- Stringent Global Fund fiduciary policies and guidelines, which are well-intentioned but in some ways impede work, for example the "Zero cash policy".

(Additional information was obtained from prior GFO publications on country-level impediments to absorption of funds, low absorptive capacity, Secretariat-level impediments to absorptive capacity, and a publication by the African Constituencies Bureau (ACB))

Participants expressed the view that the Secretariat already possesses the necessary resources to fix their issues quickly; for example, they said, country teams could be more pro-active in identifying the need for reprogramming, minimize the delays in replying to countries' enquiries or in responding to requests for reprogramming, and in sending management letters when Local Fund Agents (LFA) identify key issues during their assessment.

Another issue that countries discussed at length is the high number of Global Fund 'country team' visits country or/and the lack of structure of some of those visits. The issue is that repeated and sometimes untimely visits by country teams disrupt program implementation as staff do not have the time to concentrate on the work as they have to hold meetings and take visitors around.

Recognition of the absorption problem across PRs, CCMs and the Secretariat, as well as of the various contributing factors, has led to various responses being implemented, especially in the later part of the 4th Replenishment cycle, including:

a) Implementation Through Partnerships (ITP): A total of 20 countries with marked absorption challenges were identified and supported to conduct a country-level diagnosis of the bottlenecks and suggested actions including mobilization of partners' resources. For example, the Abidjan meeting of 2015 brought together Francophone countries that had significant absorption challenges and at the end of the meeting each country developed a roadmap for action that was reviewed a year later to assess progress;
b) Targeted capability development and flexibilities based on country categorization (Challenging Operating Environments [COE], Francophone countries);
c) Continuous monitoring of implementation progress at both operational and senior management level of the Global Fund Secretariat. There was a general feeling that implementers were increasingly receiving more support from the Secretariat over the last implementation period (2014-2017) and had better working relationships, which was a marked contrast to earlier years when country teams were viewed with apprehension instead of implementers seeing them as partners.
d) Enforcement of cut off (ie. no possibility to carry unused funds over to another grant) provided an incentive for implementers to improve planning and focus on reprogramming as early as possible. The Global Fund has made it clear that unspent money at the end of the grant cycle would be put back into the pool. This has motivated countries to act to improve their absorption.
e) Financial management strengthening and capacity-building initiatives: As the New Funding Model (NFM) was being rolled out, many concepts that affected utilization of funds were not clear to countries, including the fear of incurring ineligible expenses, among others.
f) The African Constituencies Bureau helped galvanize and bring together the ESA and WCA constituencies, and motivated member-country participation and engagement with the Global Fund, including several meetings with the Secretariat Leadership and OIG to unlock some of the challenges with which they had previously grappled in isolation.

All these actions seemed to have contributed to the progress recorded towards the end of 2017, participants said, when it was observed (as shown in a presentation made by the Secretariat) that absorption, particularly in-country spending, had dramatically improved in both East and Southern Africa (79%) and West and Central Africa WCA (75%) regions as well as by disease area (HIV-80%; Malaria-76% and TB-72%). This data was featured as part of a presentation at

the meeting by the Secretariat (Financial Controlling) that summarized the range of issues around absorption, and lessons learned from the 4th Replenishment implementation period.

Participants highlighted their concern with the manner in which those improved (and high) absorption rates were obtained. Towards the end of 2017, countries and the Secretariat, aiming to increase absorption, focused most reprogramming efforts on health commodities – on which money can be spent more quickly – rather than on health system strengthening. In countries with weak supply chains, such a push may result in wastage because of unnecessary expiries or poor storage. As one participant said, "A high absorption rate is sometimes good, sometimes bad: what is behind this figure should be carefully analyzed". Participants agreed that the absorption rate should not be an end in itself, and countries should not take this "easy way out" to absorb unused funds.

Participants from countries with challenging operating environments and additional safeguard policies also raised specific concerns. All have more stringent control mechanisms, and some do not choose their own PR. While these policies and checks contribute to reducing fraud and mismanagement, they also slow down implementation, thus reducing absorption.

Participants said that the Global Fund and countries should work together on strengthening countries internal processes so that those countries eventually graduate out of additional safeguard policies.

Conclusions

Workshop participants affirmed that absorption of funds in Global Fund grants markedly increased between round-based and NFM grants across the portfolio, through joint recipient-country and Secretariat efforts. They emphasized that country-team engagement and support are critical to alert them to issues in their absorptive performance with enough lead-time so that corrective actions can be taken. If unused funds are identified, they can be put to better use. All Participants all agreed that countries, partners and the Secretariat need to maintain efforts geared towards sustaining higher absorption of funds so that for the gains not to be lost.

Editor's note: *This article mainly reflects the views of participants at the African Constituencies annual consultative meeting. The Global Fund Observer will do a follow-up article in a forthcoming issue discussing Secretariat initiatives to support improved absorption of funds in Global Fund grants.*

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6. Global Fund Board approves funding for first set of interventions on UQD register for 2017–2019 identified through portfolio optimization

$15 million approved for grants in Burundi and Philippines; more to come

David Garmaise **5 November 2018**

On 26 October, the Global Fund Board approved additional funding of $14.9 million for the first set of interventions on the Register of Unfunded Quality Demand (UQD) to be funded as a result of portfolio optimization for the 2017–2019 allocation cycle. The approved funding will be added to two grants, one for Burundi malaria and the other for Philippines TB. See the table for details.

The Board was acting on the recommendations of the Grant Approvals Committee (GAC). As is the case with new grants, the awards are subject to the availability of funding and will be committed in annual tranches.

This article reports on the recommendations of the GAC and the decisions of the Board with respect to the portfolio optimization exercise. It also summarizes the GAC's comments on the awards to Burundi and Philippines.

In a report sent to the Board, the GAC recommended that a total of $127.7 million of UQD interventions be funded. Over the coming months, the Board will be asked to approve additional sets of interventions from this total. The precise timing "will be aligned to programmatic needs, on a case-by-case basis," the GAC said. The Secretariat informed Aidspan that the next set of interventions that will be recommended to the Board for funding will involve a grant to Rwanda.

Table: UQD interventions for 2017–2019 funded as a result of portfolio optimization

Applicant	Comp.	Grant name	Principal recipient	Amount approved ($)	Revised program budget ($)
Burundi	Malaria	BDI-M-UNDP	UNDP	4,870,607	41,526,625
Philippines	TB	PHL-T-PBSP	PBSP	10,000,000	98,543,887
			Totals	**14,870,607**	**140,070,512**

Note: PBSP stands for "Philippine Business for Social Progress."

Additional resources to fund interventions on the UQD Register are derived from available funding as validated by the Audit and Finance Committee (AFC) for portfolio optimization. This past July, the AFC identified $100.0 million as being available. This was in addition to $50.0 million which the AFC had previously identified. This brought the total available for portfolio optimization for 2017–2019 to $150.0 million.

About $10.0 million of the funds identified for portfolio optimization were diverted to other uses. (See the "Follow the Money" box below; and also the GFO articles on Venezuela, the CCM Code of Conduct and CCM Evolution.)

Interventions on the UQD Register come from applicants' prioritized above-allocation requests (PAAR). The interventions have been deemed by the Technical Review Panel (TRP) to be technically sound and strategically focused. When it reviewed each intervention, the TRP identified it as being of high, medium or low priority — within that country's funding requests.

The GAC recommendations followed operationalization by the Secretariat of the Global Fund's Prioritization Framework using what the GAC termed "a rigorous and comprehensive process" with inputs from partners.

As part of its portfolio optimization exercise, the Secretariat undertook a holistic analysis of the UQD Register; considered the filters outlined in Stage 1 of the Prioritization Framework; assessed whether the interventions on the register supported essential life-saving services and programs in line with the aims of the Fund's allocation methodology; and carried out a business analysis and prioritization of the register.

This process involved input from partners with respect to the following factors:

- The potential for increased measurable impact;
- The need for strategic investments to strengthen sustainability;
- The extent to which a given disease component is below its formula-allocated amount; and
- Additional considerations for investment in identified strategic or operational priorities.

The GAC is responsible for overseeing the operationalization of the Prioritization Framework. In July 2018, the GAC made recommendations concerning which interventions should be awarded funding. The recommendations were categorized into four subsets: "award now"; "award through in-country optimization"; "award later, should additional resources become available"; and "queued."

The interventions identified for "award now" reflected priority investment cases where the needs were time-sensitive and where funds made available by the AFC could be deployed for immediate investment (i.e. by the end of 2018 or early 2019).

"In-country optimization" refers to savings realized at country level that can be reinvested in the same country to finance relevant interventions on the UQD Register.

Finally, for those interventions where the need was clear but the intervention would take place later in 2019 or in 2020, or where additional information was required around portfolio absorption, interventions were identified, respectively, as "for award later" or "queued."

Follow the money

- In June 2017, the Audit and Finance Committee (AFC) identified $50 million as being available for portfolio optimization. In June 2018, the AFC identified a further $100 million as being available — for a total of $150 million.

- In May 2018, the Board authorized the use of $10,069,700 of funds designated for portfolio optimization for other priorities. Specifically:
  - $1,219,700 was approved for enforcement of the CCM Code of Conduct (GF-B39-DP09);
  - $3,850,000 was approved for the implementation of CCM Evolution (GF-B39-DP10); and
  - $5,000,000 was approved for a donation to address the health crisis in Venezuela (GF-B39-EDP11)

- This left $139,930,300 available for portfolio optimization.

- In October 2018, the Grant Approvals Committee (GAC) recommended $127.7 million in "immediate awards" from portfolio optimization. (Of this amount, awards totaling $14.9 million for Burundi and Philippines were approved by the Board; other approvals will be forthcoming.)

- This means that $12,230,300 in portfolio optimization funds are still available — i.e. awards using this funding have not yet been recommended by the GAC.

- In addition, in October 2018, the AFC made available another $100 million for portfolio optimization. A second portfolio optimization assessment is in the pipeline. GAC award recommendations from this assessment are expected before the end of 2018.

Following the GAC's recommendations in July 2018, the Secretariat and in-country stakeholders entered into a grant-revision process to incorporate the additional funds for the

interventions recommended by the GAC. Burundi malaria and Philippines TB are the first set of grants to have concluded grant revision negotiations. In September 2018, the GAC Executive reviewed final documents related to these two grants.

GAC comments on the interventions approved for funding

In its report to the Board, the GAC provided comments on the interventions recommended for funding now.

Burundi malaria

The interventions being funded for Burundi malaria, valued at $4.9 million, relate to vector control.

After its malaria epidemic had been brought under control a few years ago, Burundi experienced a resurgence in malaria from late 2015 through 2017, the cause of which was thought to be multifactorial, the GAC said. Insecticide resistance was believed to be one of the factors.

The epidemic was controlled through a combination of expanded case-management services (mobile and community-based service provision) as well as dual vector control (bed nets and indoor residual spraying, or IRS) in areas with highest increases in cases and evidence of insecticide resistance. The Global Fund grant supported four districts with IRS in 2016–2017, which the GAC said Burundi is no longer able to fund with current resources.

The GAC said that maintaining IRS in the previously supported districts is critical to sustain coverage. The additional $4.9 million financed through portfolio optimization will allow Burundi to undertake target spraying before the April–May 2019 peak mosquito season.

Philippines TB

The interventions being funded for Philippines TB, valued at $10.0 million, relate to MDR-TB and TB care and prevention.

A prevalence survey completed recently in the Philippines indicated that the TB burden is approximately 1.7 times higher than anticipated. The previous estimation was used for the purpose of calculating the 2017–2019 TB allocation and was the underlying basis for developing the funding request. The new information revealed that there are gaps in the response to the epidemic.

The GAC noted that the Government of Philippines is investing in drug-susceptible TB diagnostics and treatment, but said that there are gaps especially in case finding for both drug-susceptible and drug-resistant TB.

The GAC also noted that the low coverage and sub-optimal treatment outcomes of MDR-TB in the Philippines, measured in 2017 at 32% and 54%, respectively, remain a concern. The TB program and the Global Fund grant have been investing substantially in decentralizing MDR-TB services to minimize treatment interruptions and to address the sub-optimal

treatment outcomes. The GAC and partners noted the important need for diagnosis and treatment of additional people with drug-resistant TB, and for improved treatment outcomes through scaling up of evidence-based PMDT services. (PMDT stands for "program management of drug-resistant TB.")

Innovative approaches including systematic screening, engagement of private providers and using more sensitive and specific diagnostic tools, are also required, the GAC noted.

The GAC said that it supported an investment to improve systematic screening; TB case finding; and reporting among high-risk groups, community-based organizations and the private sector. Of the $10.0 million approved through portfolio optimization, $7.0 million was for MDR-TB interventions and $3.0 million was for drug-susceptible TB interventions.

In-country optimization

The GAC has also recommended $27.6 million as in-country optimization to fund high impact interventions from the UQD Register. The Secretariat told Aidspan that the savings identified through in-country optimization were the result of significant efficiencies in procurement within individual country portfolios. These reinvestments at country level do not have to be approved by the Board. The GAC report did not identify the countries affected.

More to come

The Secretariat has informed Aidspan that in October 2018, the AFC made available another $100.0 million for portfolio optimization. A second portfolio optimization assessment is in the pipeline. GAC award recommendations from this assessment are expected before the end of 2018.

Source:

The source for most of the information in this article is the *Electronic report to the Board; Report of the Secretariat's Grant Approvals Committee*, GF-B39-ER12. This document is not available on the Global Fund website.

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7. COMMENTARY: The Allocation of Responsibility

The highest obligations are to people and communities—not countries

Jesse B. Bump **5 November 2018**

Who lives? Who dies? Who is responsible? As the Global Fund Board convenes for its 40th Board Meeting where it is expected to discuss the 2020–2022 allocation cycle, no doubt members will prefer the first of these questions. Even so, it will not be easy. Allocation is one place where intention is converted into action; a rare thread binding inclusive rhetoric to difficult rationing decisions that prioritize some needs and deny others. Throughout the

history of the Global Fund, allocation discussions have tried to forecast the conversion of resources into preventative, curative, or therapeutic actions that directly reduce burden. The quest to allocate toward efficiency is cast often as a matter of maximizing the number who live and minimizing the number who die. This conceptualization distracts from the third question, but in fact responsibility looms largest at the center of allocation.

Allocation begins with the Global Fund's defining responsibility to address HIV/AIDS, tuberculosis, and malaria. This mission was driven by rights arguments, reflecting the approach pioneered early in the HIV epidemic by the gay men's communities of New York and San Francisco. Activism by and for people living with HIV transformed a stigmatized, denigrated individual condition into a collective, enthusiastic, and audacious bid to realize the right to health on a global scale. Within the confines of its three diseases and a financial focus, the Global Fund was launched as the institutional embodiment of this ambitious responsibility: to provide access to urgently needed treatments and services for millions of people in low- and middle-income countries (LMICs).

Under the initial allocation system, Global Fund processes would have been more recognizable to the advocates whose movement it embraced. Funds were allocated based on proposal quality and in the early years there were enough resources to support all of the ones judged adequate. But over time allocation processes drifted further from this ideal for various reasons, including more limited resources, a greater appreciation for the enormity of the original ambition, and concerns that expansion might threaten existing programs under some circumstances. All of these factors pointed in the direction of more challenging rationing exercises.

Current allocation practices are based on a formula, which was intended to make the process more consistent and more equitable. However, this approach also obscures the original, rights-driven imperative to provide all needed interventions for all who need them. Against that standard, the allocation process is not so much a question of who will get what as it is an exercise in assigning responsibility away from the Global Fund and then looking after the remainder. There are times when the Global Fund can and should decline some responsibility, but upholding its core principles means that every such instance must be considered carefully and rigorously justified. Further, the Global Fund needs to consider how it can advocate for those in need, even if it decides not to provide financial resources.

Each element of the current allocation formula includes responsibility questions that require examination. To clarify this proposition and its consequences, this article offers four examples, beginning with the quantification of burden. For HIV, it is calculated based on the number of people infected, with some adjustments for the difficulty of reaching key populations. For malaria, the number of cases is used with an adjustment for incidence and mortality as reported in data from the year 2000. Neither captures the dynamics of introducing or expanding programs, which usually is more resource intensive than maintaining. Trends in both infection and response capacity must be considered for a more accurate picture. By neglecting to account for this variation, the allocation process shifts responsibility for scaling up away from the Global Fund without clearly assigning it to any other party.

For years the Global Fund (and others) have considered Gross National Income (GNI) per capita as an indication of ability to pay, but in practice it is used to determine responsibility to pay, with the assumption that countries with greater income can and will attend to the needs of their populations. Without rehashing the many well-known measurement problems with GNIpc, the operative question is this: what responsibility does the Global Fund have toward people affected by one or more of its three focus diseases, regardless of the income of the country in which they live?

There are many opportunities for the Global Fund to help people obtain the services they need, even if financial resources are better concentrated elsewhere. To name three options, this might include advocating with governments, providing advice to civil society, or extending access to pooled procurement mechanisms. These and other options are critical to the lives of many in countries with actual (or calculated) incomes rising beyond Global Fund eligibility thresholds.

Similarly, the responsibility to provide access calls for greater flexibility in allocation and partnership arrangements, which might help quell rising HIV in Russia even though national income is ostensibly too high, or address the TB epidemic in North Korea, where the Global Fund has ceased operations, citing transparency and risk management issues. Both of these cases represent humanitarian disasters of epic proportion and global significance—precisely the scenario the Global Fund was designed to address.

A similar issue arises from the cap on country allocations, which limits Global Fund responsibility if affected groups are large, as might be expected in populous countries such as Nigeria or India. Similar caps by disease disadvantage people suffering from concentrated burdens, as with malaria in the DR Congo. What logic justifies these limits? Especially where national boundaries were drawn by exploitative colonizers, it seems particularly unfair to further punish those contained within on the grounds that their needs are either too large in the aggregate or too large within a given disease. Returning to the greater sense of responsibility toward all victims of the three diseases reveals that the abject inequity of these caps.

Finally, the Global Fund allocation formula is subject to non-transparent qualitative adjustments as well, which raises the troubling scenario of downward revisions. High-burden settings further disadvantaged by a government unwilling or unable to help may receive only minimal resources. Partly, this decision can be justified by the expectation that resources would not be converted into health. But once again, this is an assignment of responsibility away from the Global Fund and toward a government that is expected to default. How can the allocation process better protect the entitlements of these citizens?

As illuminated in these examples, a discussion of allocation rests on an underlying determination of responsibility. The founding intention of the Global Fund is that it serves as the ultimate guarantor of access for anyone affected by HIV/AIDS, tuberculosis, or malaria. Accordingly, the Board must meet a very high bar to decline assistance where it is demonstrably needed. This is not about the precise variables or coefficients used to weight

them; it is a question of whether Board members can feel confident in the reasoning behind every negative decision. Whenever full support is not provided they must complete the sentence in plain language:

"We will not help you because…"

Is it acceptable to deny access to HIV therapies for marginalized migrants "because you are in Russia, an upper-middle income country?" Is it defensible to deny TB treatments to North Koreans "because you live under an autocratic regime incapable of managing a complex emergency on its own?" Or is there a justification for reducing support for malaria treatment and control in the Democratic Republic of Congo "because we do not want to exceed 10% of our malaria budget in one country?" Whenever such answers are uncomfortable, make the right decision—find a way to assure access for all who need it.

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8. INTERVIEW: Q&A with Eliud Wandwalo, the Global Fund's senior disease coordinator for tuberculosis

On challenges, 'missing people', and integrated TB/HIV programming

Friends of the Global Fight **6 November 2018**

Friends: Thank you for joining us, Dr. Wandwalo. While there has been progress over the last 15 years, tuberculosis (TB) is still the world's leading infectious disease killer. What would you say have been the greatest challenges in the fight against TB?

Dr. Wandwalo: The biggest challenge we have faced over the last few years is the growing threat of drug-resistant tuberculosis. Drug-resistant tuberculosis is very complex and difficult to treat, with treatment being more expensive compared to regular TB and almost half of patients are not successfully treated. We also find that drug-resistant TB accounts for nearly one-third of all antimicrobial resistance (AMR) related deaths in the world, presenting a major global health security issue.

The fight against TB is also seriously underfunded. We need about $10 billion every year to properly respond, but we have less than $7 billion available. The BRICS (Brazil, Russia, India, China, and South Africa) countries pay for the majority of their own TB response, but other developing countries that have a high rate of TB rely on international funding, most of which comes from the Global Fund.

Friends: About 40 percent of new TB cases are not reported to the authorities. Why are there so many 'people missing' from treatment, and what is the Global Fund doing to address them?

Dr. Wandwalo: They are missing for many reasons, including not having access to health care, being misdiagnosed or not being reported to the national authority. When patients are not diagnosed or are improperly treated, they may spread the disease within communities. Last year, the Global Fund started an initiative to find missing people with TB in 13 countries with a high TB burden, in order to bridge the gap between the number of people who are estimated to have TB and those who are notified by the TB programs.

We are also piloting and scaling up innovative approaches together with different partners. For example, in parts of Asia, most people get medical care from private facilities. These health centers are unregulated and often do not report cases. Because they are businesses, we cannot approach them the same way we do for public hospitals. In India, for example, private-sector providers are engaged through the Public-Private Interface Agency (PPIA) model. This model has worked very well, and we hope can be scaled widely in different contexts.

Friends: During this year's International AIDS Society (IAS) meeting, one of the main takeaways was the need for greater integration between TB and HIV programming. Can you give us an overview of what this actually means on the ground, and the role that the Global Fund plays in this integration work?

Dr. Wandwalo: About three years ago, the Global Fund started requiring countries with high rates of TB and HIV co-infections to submit a joint funding application, which takes into consideration an integrated approach for managing patients who are co-infected with TB and HIV. About 37 countries applied using this modality, where the aim was to maximize the impact of investments and provide comprehensive care to co-infected patients so that individuals do not have to go into two separate health clinics to receive TB and HIV services.

Friends: How is the fight against tuberculosis changing and what should its next steps be?

Dr. Wandwalo: In the last year, we have seen more momentum than ever when it comes to advocacy and high-level discussion. In September 2018, the UN had its first high-level meeting on tuberculosis, and we hope to see new tools, new drugs and new funding come out of it. We would also like to see the political document agreed on in New York translated into action with clear metrics for each country, with a robust accountability mechanism. Going forward we need to see increased investments in TB both for implementation and research, we need new tools in diagnosis, new drugs and a vaccine. Success stories in the fight against tuberculosis start with strong government leadership, innovative strategies, quality research and consistent funding.

For more on opportunities for the U.S. and partners to work toward ending the epidemics of AIDS, TB and malaria, see Friends' Tipping Point report.

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9. PRESS RELEASE: Bi-partisan group of senators requests increased United States pledge to the Global Fund

Friends of the Global Fight **6 November 2018**

On October 11, 2018, a bipartisan group of 18 U.S. senators urged Secretary of State Mike Pompeo and the Administration to increase the United States' pledge to the Global Fund to Fight AIDS, Tuberculosis and Malaria for 2020-2022. The U.S. pledged $4.3 billion for the last three-year funding cycle in 2016.

In a letter led by Senators Lindsey Graham and Patrick Leahy and also signed by Sens. Alexander, Bennet, Booker, Boozman, Brown, Casey, Coons, Corker, Durbin, Isakson, Moran, Rubio, Sullivan, Van Hollen, Warren and Wicker, the senators note:

"The Global Fund partnership has saved many millions of lives since 2002. Given the Global Fund's impressive results and the continuing, urgent priority to save lives and end three of the major infectious disease killers in the world, we believe the United States should make a 6th Replenishment pledge for 2020-2022 that exceeds the last Replenishment."

"We applaud the leadership of Senator Graham and Senator Leahy, and of all the Senators who wrote to Secretary of State Pompeo," said Chris Collins, President of Friends of the Global Fight Against AIDS, Tuberculosis and Malaria. "U.S. support for the Global Fund continues to produce tremendous results, and because the U.S. contribution leverages funding from other donors, it remains a smart, strategic investment. The Global Fund is highly effective, but a stepped-up global effort is needed to end the epidemics of AIDS, TB and malaria. That is why an increased U.S. pledge is so important this year."

The world's largest global health financing organization, the Global Fund is a partnership between governments, civil society, the private sector and people affected by HIV/AIDS, tuberculosis and malaria. It invests nearly $4 billion a year to support programs run by local experts and governments in countries and communities most in need. Global Fund-supported programs have saved more than 27 million lives since the organization was founded in 2002.

"Next year donors will meet for the Global Fund's 6th replenishment," said Jonathan Klein, Board Chair of Friends and Co-founder and Chairman of Getty Images. "Now is a critical time to show the world that the U.S. is committed to effective programs making steady progress toward ending the most devastating epidemics. Since by law the U.S. cannot contribute more than 33 percent of total Global Fund financing, a bold U.S. pledge encourages other donors to increase their own investments in the Global Fund."

The Senate letter notes that in addition to saving millions of lives, Global Fund-financed programming advances U.S. national security and economic interests:

"The U.S. investment in the Global Fund does more than save lives and fight diseases – it helps keep Americans safe and benefits our diplomatic and trade relationships. The rapid spread of a new infectious disease is among the most likely scenarios to cause the deaths of tens of millions of people. U.S. global health investments, including through the Global Fund, build stronger disease surveillance and health delivery systems, helping the United States by addressing health threats before they reach our shores. It is an investment in U.S. security, and in countries that are critical markets for U.S. exports."

The full Senate letter to Secretary Pompeo is available on the Friends of the Global Fight website.

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