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Global Fund Observer

NEWSLETTER

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BY CHRISTELLE BOULANGER

Viviana Mangiaterra became the Global Fund's Head of Resilient and Sustainable Systems for Health in 2014, hired to design the Fund's approach to health system strengthening. Soon to leave the Global Fund for an academic position, Ms. Mangiaterra spoke to the Observateur du Fonds Mondial about her five years at the Fund in this critical role.

6. FEATURE: OIG Head of Investigations describes 'changing fraud landscape' in Global Fund grants

BY ADÈLE SULCAS

The Office of the Inspector General's 2018 annual report to the Global Fund Board included a section on changes in the global fraud landscape, on which the OIG's Head of Investigations Katie Hodson commented further in a blog on the OIG website. The GFO spoke further with Ms Hodson on the evolution of fraud as observed by the OIG in the Global Fund's grants. This is the first of two articles featuring the OIG's work.

7. OF INTEREST: IAS 2019 conference on HIV science reveals hopeful new treatment and prevention approaches

BY ADÈLE SULCAS

The International AIDS Society's bi-annual conference on HIV science, held this year in Mexico City on 21-24 July, unveiled a number of pioneering clinical advances, including implantable, long-lasting pre-exposure prophylaxis, the potential for four-day-a-week antiretroviral treatment being as effective as everyday treatment in patients who are already virally suppressed, and clarification on the use of dolutegravir during pregnancy.

8. REPLENISHMENT: Global Fund launches "promise to all 7-year-olds" call to action, to end epidemics of AIDS, TB and malaria by 2030

BY AIDSPAN STAFF

The Global Fund launches an 'open letter' to all 7-year-olds, everywhere – the latest element in its 'Step up the Fight' campaign in advance of the Sixth Replenishment funding conference in October.

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ARTICLES:

1. NEWS: Global Fund Board approves initiatives worth $18 million from the Unfunded Quality Demand Register

A private sector contribution of $2 million will support RAI grant in Southeast Asia; others through portfolio optimization

David Garmaise **31 July 2019**

On 24 July 2019, the Global Fund Board approved funding in the amount of $18.0 million from the 2017-2019 allocations for several interventions on the Unfunded Quality Demand (UQD) Register. The funds will be added to three existing country grants and one existing multi-country grant. The sources of these funds are portfolio optimization and a private sector contribution. (See Table 1 below.)

The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC). This was the 21st batch of approvals from the 2017-2019 allocations.

Table 1: Additional funding for UQD interventions from the 2017-2019 allocations ($ million)

Applicant	Com-ponent	Grant name	Principal recipient	Funding source [1]	Amount approved	Revised program budget
Multi-country RAI2E	Malaria	QSE-M-UNOPS	UNOPS [2]	PSC	2.0 m	245.7 m
Pakistan	HIV	PAK-H-NZT	Nai Zindagi	PO	5.0 m	22.5 m
Philippines	TB	HPHL-T-PBSP	PBSP [2]	PO	10.0 m	118.5 m
Rwanda	TB	RWA-T-MOH	Ministry of Health	PO	1.0 m	15.1 m
				Total	**18.0 m**	

Notes:

1. *PO = Portfolio optimization | PSC = Private sector contribution*
2. *UNOPS = United Nations Office of Project Services (UNOPS) | PBSP = Philippine Business for Social Progress*

The funds for portfolio optimization come from the $500 million identified as being available for this purpose by the Audit and Finance Committee.

Portfolio optimization - background

The purpose of portfolio optimization is to enable the Global Fund to improve impact, react to changing disease circumstances, and ensure high absorption of funds. The Secretariat began to introduce its operational mechanism for optimizing the portfolio following the September 2014 meeting of the Finance and Operational Performance Committee (FOPC, the precursor to the Audit and Finance Committee).

In June 2017, the Strategy Committee approved a prioritization framework for funds (and a prioritization tool) that become available for portfolio optimization and financing Unfunded Quality Demand (UQD); this framework is based on four principles relating to maximizing the impact and use of available funds, identifying and addressing root causes of bottlenecks in implementation, opportunities to re-invest within the disease portfolio, and aligning with the aims of the allocation methodology and the need for sustainability of Global Fund investments.

The Strategy Committee also defined clearly the prioritization criteria for portfolio optimization and financing UQD. These criteria include maintaining essential life-saving services and programs, prioritization relative to need, and strategic investments to strengthen sustainablity of national programs and/or address specific transition challenges.

The Audit and Finance Committee is responsible for allocation funds available for use as portfolio optimization. The Grant Approvals Committee is responsible for making decisions about additional funds from portfolio optimization resources for specific grants, on the basis of investment cases put to the committee.

Monthly Grant Approval Committee reports to the Board reflect the committee's recommendations for Board approval of grant revisions that integrate additional funds awarded to countries through portfolio optimization, into already approved Global Fund grants. This is the mechanism through which the additional funding for Pakistan, Philippines and Rwanda described in this article is being invested.

In its report, the GAC provided comments on all of the awards. Below, we provide a summary.

Regional Artemisinin-resistance Initiative (RAI) – Phase 2 grant

The $2.0 million funding award from the private sector will support the RAI grant, the Global Fund's largest regional initiative to eliminate drug-resistant malaria. The grant covers the Greater Mekong region of Southeast Asia. The award brings to $245.7 million the total budget for this grant.

This is the first private sector contribution to the RAI. The investment was provided by the Dhanin Tawee Chearavanont Foundation (DTCF). According to a post on the Global Fund's website, the Dhanin Tawee Chearavanont Foundation (DTCF) is an international nonprofit organization with the founding principle "Respect for People and Planet." The DTCF works to bring about a healthy society and sustainable world by providing infrastructure, research, strategy, technology and financial support to empower people and organizations to reach their fullest potential.

The post explains that the RAI was launched in 2014 to counter the growing threat of drug-resistant malaria in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam with the aim of eliminating the most dangerous strain of the disease by 2025. (For a fuller description of the grant, see the GFO article in Issue 354 (17 April 2019).

The $2.0 million contribution will increase the detection of malaria cases and surveillance of hard-to-reach, mobile and migrant populations living along the Thai border.

Pakistan HIV grant

Initiatives totalling $5.0 million from the UQD Register, funded through portfolio optimization, will support reducing risk of HIV transmission and expanding treatment coverage for people living with HIV in Pakistan.

According to the GAC, Pakistan's HIV prevalence has been rising among people who inject drugs, with prevalence rates of up to 70% in that population in major cities in Punjab province. The Government's commitment to fund 36% and 59% of the country's HIV program in 2018 and 2019, respectively, has not materialized, the GAC said.

Despite efforts to reprogram savings from the implementation of the HIV grant in 2018, a funding gap remains, leaving 75% of the people who inject drugs without access to services.

The new funding will support initiatives to address programmatic gaps by expanding comprehensive services for key populations to eight cities that were not previously covered by the grant. Specifically, the funds will:

- Provide HIV prevention packages to 26,000 people (an increase of 7% compared to previous targets);
- Provide antiretroviral therapy to 6,535 additional people living with HIV; and
- Increase from 2,304 to 3,325 the number of HIV+ people who inject drugs and their spouses who are linked to HIV care and treatment services.

The GAC said that it noted "with concern" that a general population HIV outbreak (mostly in children) has been reported in the Larkana district in Sindh province, "the full implications of which are still being assessed and determined." GFO provided a comprehensive report on this outbreak in Issue 359 (26 June 2019).

The GAC recommended that the Secretariat and technical partners "closely monitor the situation in Pakistan as additional evidence is gathered to better understand the magnitude

and underlying causes of the recent outbreak, and while the government's response to the outbreak is further developed."

The GAC stressed the need to better understand the underlying fundamental health systems issues that precipitated this outbreak and to prepare for an increased demand for HIV prevention and treatment services in Pakistan. In addition, the GAC said, considering the unsafe injection practices, there is a need to harmonize HIV-related initiatives in Pakistan with investments by Gavi, the Vaccine Alliance. Pakistan is the largest recipient of Gavi funding (*source: Gavi website*).

Philippines TB grant

The $10.0 million investment from portfolio optimization will offset upfront costs related to implementing the World Health Organization's new MDR-TB treatment regimen.

Philippines, an early adopter of the new regimen, had already received funding from a previous portfolio optimization award in March 2019 (see GFO 353 article) to support shifting patients to the new regimen. Nevertheless, a funding gap remained. The GAC said that the new funding will cover the procurement of second line anti-TB drugs (including new drugs) and GeneXpert cartridges; drug safety monitoring; and patient support.

Rwanda TB grant

The focus of the TB grant is on prevention and care, with specific attention to increasing TB screening by supporting the roll-out of chest radiographs in identified high risk groups, particularly people living with HIV. The GAC said that Rwanda continues to face constraints within the health system that hinder the optimal use of x-ray screening. In addition, the GAC noted, there are challenges in accessing radiography services.

To address these gaps, the $1.0 million in new funding through portfolio optimization will enable Rwanda to invest in five digital radiography machines for district hospitals in an effort to increase early detection and treatment, leading to reduced mortality and morbidity from TB/HIV co-infections; and to conduct a "catastrophic cost survey." This survey will enable Rwanda to establish a baseline for the country's End TB Indicator 5, where the goal is that zero families face catastrophic costs related to TB by 2020. The determination of costs will also support efforts towards developing a national policy on reducing TB patient costs, which will lead to further improvements in diagnosis and treatment adherence.

Grant extension

In its report, the GAC noted that the Secretariat has approved a one-year no-cost extension for the Multi-Country Regional Malaria Elimination Initiative (RMEI) grant in Latin America. The grant is now scheduled to run until 31 December 2023.

Most of the information for this article was taken from Board Document GF-B41-ER03 ("Electronic Report to the Board: Report of the Secretariat's Grant Approvals Committee"), undated. This document is not available on the Global Fund website.

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2. NEWS: OIG's follow-up audit of Global Fund grants to Democratic Republic of Congo highlights need to improve stock management and data quality

Progress noted especially in HIV treatment coverage and decline in malaria mortality

Adèle Sulcas **31 July 2019**

A new Office of the Inspector General (OIG) audit of Global Fund grants in the Democratic Republic of Congo acknowledges successes across the three diseases achieved under extraordinarily challenging circumstances, but also highlights stockouts or insufficient stocks of health commodities, data inaccuracies relating to people living with HIV, inadequate financial management by the Principal Recipient and limited Secretariat oversight.

This audit is a follow-up to the 2016 audit in which the OIG identified a number of deficiencies in the implementation of Global Fund grants, ranging from programmatic oversight to delivery of quality health services and inadequate internal financial controls.

The report was published on 16 July 2019, along with a message from the Executive Director, Peter Sands. The audit covered the period January 2016 to August 2018.

The follow-up audit's overall objective was "to provide reasonable assurance on whether the Governance, Risk Management and Internal Controls underlying grant management and implementation" have improved since the 2016 audit. The specific elements assessed were whether improvements in the supply chain have increased the availability and traceability of health products, whether program management and delivery are effective enough to ensure quality of services, and whether adequate and effective controls over financial management are in place.

Key issues and key achievements

Among 'key issues and risks', pervasive stockouts of HIV test kits, insufficient stock of malaria commodities at health facilities, inaccuracies in data on the number of people living with HIV (PLHIV) who are on treatment and a lack of monitoring of PLHIV lost to follow-up, and inadequate financial management at the Ministry of Health level, with an absence of quality assurance over the work of the Fiscal Agent and limited Secretariat oversight. (See separate article in this GFO on issues relating to the work of fiscal agents.)

The OIG also acknowledges 'key achievements and good practices': Despite its numerous and sizable challenges, the country has achieved remarkable successes and lasting impact against the three diseases over the course of its Global Fund-financed programming. The achievements include an increase in HIV treatment coverage from 34% in 2012 to 59% in 2017 and a halving of HIV-related deaths over this period, TB treatment success rates climbing from 77% in 2013 to 87% in 2018, and the successful rollout of a mass campaign to

distribute Long-Lasting Insecticide-treated bednets that has contributed to a decrease in malaria mortality, from 43 to 28 deaths per 100,000 between 2015 and 2017.

Ratings

The OIG report has rated the DRC's supply chain process (Objective 1) as "partially effective", the quality of services (Objective 2) as "partially effective", and financial management (Objective 3) as "needs significant improvement". (See 'Findings' below for more detail on each of these.)

Active Global Fund grants

The Global Fund's active grants in the DRC, from 2018 to 2020, amount to $542,961,124 (signed amount) with three Principal Recipients (PRs) managing the five active grants across the three diseases.

Table 1: DRC's active Global Fund grants included in the OIG audit (2018-2020) under New Funding Model

Component	Grant no.	Principal recipient	Grant period	Signed amount (USD)
Malaria	COD-M-SANRU	Santé Rurale (SANRU)	Jan 2018 – Dec 2020	275,717,435
HIV/TB	COD-C-CORDAIN	Stichting Cordaid	Jan 2018 – Dec 2020	149,742,258
HIV	COD-H-MOH	Ministry of Health and Population (CAGF)	Jan 2018 – Dec 2020	23,913,524
Malaria	COD-M-MOH	Ministry of Health and Population (CAGF)	Jan 2018- Dec 2020	74,908,613
Tuberculosis	COD-T-MOH	Ministry of Health and Population (CAGF)	Jan 2018 – Dec 2020	18,679,294
Total				**542,961,124**

Source: OIG audit 16 July 2019 (report number GF-OIG-19-014)

Country context

The Democratic Republic of Congo (DRC) has signed a total of $1.99 billion in Global Fund grants since 2003, making it one of the Global Fund's three largest portfolios. With 10% of the world's malaria deaths, success of the DRC grants makes the country's programs critical to the Global Fund's success globally.

The DRC implements its grants in a challenging operating environment, where repeated Ebola outbreaks, armed conflict and weak infrastructure continuously undermine successful grant implementation.

DRC is currently experiencing yet another Ebola outbreak, which the WHO has declared a 'public health emergency', officially escalating the gravity of the international threat. As of 31 July, 1696 deaths and 2577 cases and have been confirmed.

The DRC's population of 81 million people is widely dispersed over a land mass of more than 2.3 million square kilometers, the DRC is Africa's second largest country, with a health system comprising 516 health zones across 26 provinces. There is a scarcity of doctors, nurses and midwives: 6 per 10,000 people, which is far below the WHO's recommendation of 23.

Overall, the Global Fund has (to date) signed grant agreements with the DRC worth $2.028 billion (it was $1.99 billion at the time of the OIG's report writing) and disbursed $1.717 billion. The DRC is a 'high-impact' country for the Fund (very large portfolio, mission-critical disease burden), and is also categorized as a Challenging Operating Environment with Additional Safeguard Policies.

Summary of main findings

The OIG's three main findings, summarized below, resulted in four Agreed Management Actions (AMAs), which are listed at the end of this section. The findings are:

4.1 While anti-malaria drug traceability has improvied, stock-outs of health commodities at facility level persist.

Various corrective actions to improve the in-country supply chain have been taken since the 2016 audit, including incentivizing health workers to transport commodities from district warehouses to health facilities (in the absence of a stronger distribution system); revising the terms of reference for sub-recipients and putting in place measures to improve their accountability; and implementing reviews of stock availability at health facilities. The end result of these actions, the OIG found, has been that:

- Drug traceability has improved and the level of expiries has reduced
- The availability of malaria health commodities at health facilities needs to improve

AMA 1: This AMA has three sub-sections, which cover

- supporting the design and implementation of a real-time stock-out warning and reporting system
- supporting the decentralization of the Bluesquare supply-chain dashboard to allow sub-recipients and provincial health directorates to systematically analyse stock situations in provinces
- and ensuring that the SR terms of reference will be modified to include monthly review of stocks at zonal warehouses (BCZ) and confirming to provincial health authorities and the PR that there is adequate buffer stock (all due by 30 June 2020).

4.2 HIV drug traceability and treatment has improved, but pervasive stockouts of HIV tests remain.

Within this finding, the OIG noted several main points:

- There has been no major disruption of HIV treatment (based on OIG visits to 15 hospitals and health facilities, representing 8% of the national reported number of PLHIV on treatment)
- Pervasive stockouts of first-line HIV test kits has affected the detection of new HIV cases
- There is better traceability of HIV commodities
- There has been overstatement in the number of PLHVI on treatment and inadequate monitoring of HIV patients lost to follow-up.

AMA 2: The Secretariat will support the Ministry of Health to develop a new screening tool and communications materials to promote targeted testing at the site level in line with the new HIV differentiated service delivery models, and to improve the use (and expand coverage) of Tiernet software to monitor HIV patient data (due date: 31 March 2020).

4.3 Financial management controls for government grants and the risk mitigation measures set up by the Secretariat need significant improvement.

Given the findings of the 2016 audit, the Global Fund has strengthened its financial safeguards for CAGF, the Government Principal Recipient that manages three of the five active grants, by putting in place mitigation measures designed to address ongoing high fiduciary risks. Following the 2016 audit's AMA relating to enhanced controls, CAGF's performance was evaluated, with the OIG finding that "the unit was well positioned to manage Global Fund grants [but] areas for improvement remain". These include:

- Limited capacity and control mechanisms to produce accurate financial reports
- Absence of a quality assurance framework at the Fiscal Agent, and limited Secretariat oversight
- Incomplete coverage of financial activities in the CAGF procedure manual

AMA 3: The Global Fund will revise the Terms of Reference of the Fiscal Agent to clarify its scope and responsibilities, by integrating a Quality Assurance mechanism to address gaps in the independent verification of transactions, reconciliations and validation of financial reporting, before submitting to the Global Fund (due date: 30 April 2020)

AMA 4: The Secretariat will provide support to strengthen CAGF's internal capacity for adequate processing of financial transactions, effective management of advances, and accurate presentation of financial reports and accounting information. In addtion, the Fund will define a revised set of minimum performance requirements for CAGF (due date: 30 September 2021).

All AMAs are owned by the Head of Grant Management, Mark Edington.) For the complete Table of Agreed Actions, see page 20 of the audit report.)

Editor's Note: The 2016 OIG audit was the first country audit of the DRC by the OIG; in 2014 the OIG published an investigation report into irregularities in sub-recipients' implementation, and in 2010 performed an in-country review.

Further reading:

- *This audit report, 'Follow-up audit of Global Fund Grants in the Democratic Republic of Congo' (GF-OIG-19-014)*
- *The 2016 OIG audit report (GF-OIG-16-022)*
- *The Global Fund Executive Director's message to the Board on publication of this follow-up audit report.*

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3. ANALYSIS: Fiscal agents reduce financial risks within Global Fund grants but do not build implementer capacity

Concept is sound but 'model' could be improved

Djesika Amendah **30 July 2019**

Fiscal agents have been part of the Global Fund Financial management system in countries with high or moderate fiduciary risks since 2012. According to the Global Fund Guidelines on Financial Risk Management, fiscal agents reduce financial risks originating from weak financial management of principal or sub-recipients of Global Fund grants. This article aims to foster an understanding of the place of fiscal agents in Global Fund grants, and of fiscal agents' successes and challenges.

Data for this article comes from Global Fund public policy documents, reports from the Office of the Inspector General, interviews with the Global Fund Secretariat's Finance and risk departments, Country Coordination Mechanism (CCM) representatives from Burkina Faso and Malawi (examples of countries that have fiscal agents) as well as technical assistance providers to Global Fund grants.

Fiscal Agents - a risk-mitigation measure

Fiscal agents work in 23 countries, among them 15 that are classified as high- or very high risk, according to the OIG report on Global Fund Grant Management in High Risk Environments. According to the financial risk management guidelines of the Global Fund, fiscal agents' first objective is to "mitigate the risk of fraud or misuse of grant funds and minimize ineligible expenditures on the use of grant funds". In this role, the fiscal agents verify that requests for funds are in line with the implementer's and Global Fund policy. Once payments are made, fiscal agents assess the appropriateness of supporting documents and ensure that records are properly maintained. The fiscal agents also aim to ensure that implementers produce accurate and timely reports. One of the Global Fund principles is performance-based funding: implementers submit a progress-update and disbursement request report containing financial and program achievements against agreed-upon targets at a regular frequency, usually every six months. Fiscal agents should help build the capacity of

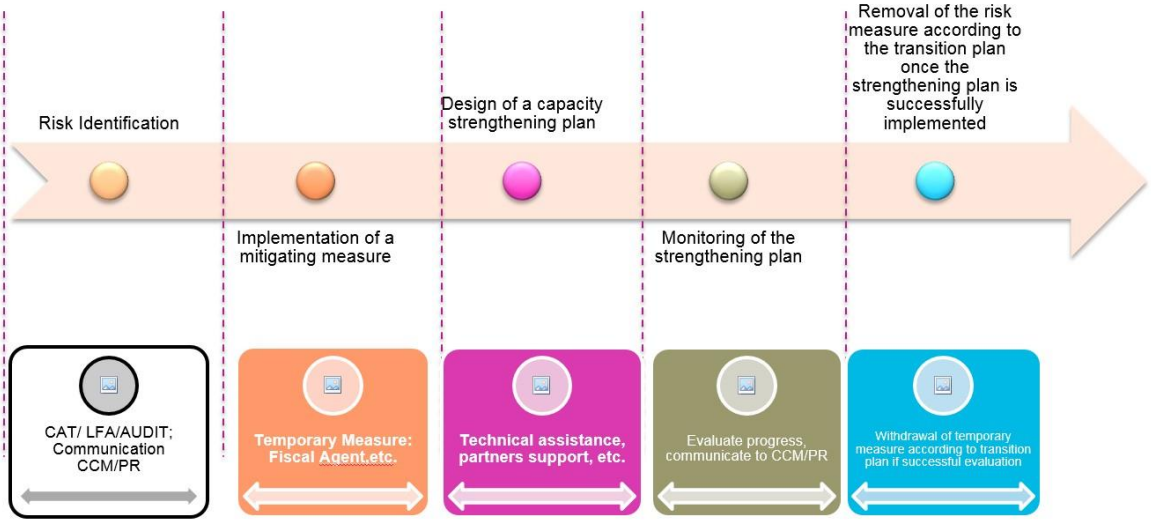
the implementers to manage the grant over time. Part of fiscal agents' role is to help the Principal Recipient (PR) or sub-recipient (SR) develop and implement good financial management policies.

Fiscal agents operate through two possible modalities. The first is that they are signatory to the PR's bank account that holds the Global Fund grant monies. When this co-signature mode is not acceptable to the PR (sometimes the case with state PRs because of national laws or regulations) another modality is that fiscal agents sign purchase vouchers prepared by the PR to approve expenditures before Global Fund money leaves the PR's bank account.

Often, fiscal agents are set up after the Local Fund Agent (LFA) and external audits identify financial management issues, and the Secretariat and the CCM decide to maintain the PR or the SR, either because the Global Fund believes that the identified financial risks can be mitigated or because the risks emerge in the middle of an implementation period, when it would be complicated to change an implementer.

Fiscal agents, although independent from implementers, work on a daily basis with the PR's staff. Fiscal agents are often large companies and their staff report to the Global Fund Secretariat quarterly and to the headquarters of their own organizations. According to the Secretariat, fiscal agents are selected through competitive bids. The GFA consulting group, headquartered in Germany, covers 44% of the Global Fund's fiscal agent work.

Figure 1: Fiscal agent in the risk management process with stakeholders



CAT: Capacity Assessment Team, LFA: Local Fund Agent, CCM: Country Coordination Mechanism
Source: The Global Fund Guidelines on Financial Risk Management

Other Global Fund risk-mitigation measures

The Global Fund has devised other risk-mitigation measures that add layers of assurance and staff to implementers' operations. Three such noteworthy measures are fiduciary agents, procurement agents and payment agents.

The fiduciary agents report to the PR; they are in charge of the financial functions at the PR level. The procurement agents report to the Secretariat; they are in charge of the purchasing of non-health commodities (health commodities are often bought through the Pooled Procurement Mechanism managed centrally at the Secretariat). Procurement agents follow the Global Fund procurement policy, which upholds the principle of competition and the values of impartiality, transparency and accountability. Finally, payment agents make "payment of physical cash in areas of high risk and limited banking services" on behalf of the PR to the intended beneficiaries. The Global Fund grant implementers use payment agents in cases of weak banking and control environments where cash payments are necessary.

Notable successes of fiscal agents in some countries

Fiscal agents have been relatively successful in their main role of reducing the risk of fraud and misuse of the Fund's monies, according to several reports published by the Global Fund's Office of the Inspector General.

Fraud and other misuse of Global Fund monies used to be common characteristics of grants in Nigeria. The country is one of the Global Fund's biggest portfolios owing to the size of its population (about 190 million) and the high prevalence of malaria. However, a 2016 OIG audit did not find any material irregularities, after the Secretariat had, in 2014, increased the scope of fiscal agents' work, along with changing the PR and instituting other risk-management measures. A related success was that the presence of fiscal agents enabled the Secretariat to continue funding grant activities through some sub-recipients in Nigeria, when principal recipients had been suspended because of financial mismanagement.

According to the Secretariat, the timeliness of reporting by PRs who have fiscal agents has also improved. An additional advantage of fiscal agents is that their presence allows the State PR (which they often support) to remain the grant implementer. (When a PR performs poorly, the PR can be changed; when the non-performing PR is a government entity, like a Ministry of Health, usually the Global Fund contracts an international non-governmental organization or a United Nations agency to serve as PR instead.)

As an illustration, in Malawi, the fiscal agents help the Ministry of Health, which is the PR for HIV/TB and malaria grants ,submit error-free and timely reports, according to Maziko Matemba, vice-chair of the Country Coordinating Mechanism. Both of these grants are now rated A1 and A2 (the two highest ratings out of five). Maziko Matemba explained that the fiscal agents follow up on planned activities, to remind the PR to conduct them on time. They even attend CCM meetings as observers, not participating during discussions but listening in order to gather important insights that can be used for their work.

Fiscal agents' limits

Financial fraud and misuse still occur in grants that have fiscal agents, though at a much-reduced rate and scale. The reason is twofold: first, fiscal agents concentrate on the fiscal aspects of the grants, leaving the program side to other assurance mechanisms, notably Local

Fund Agents; second, fiscal agents cannot and do not control all financial aspects of the grants but focus on areas that are considered higher risk.

An illustration of how financial fraud and misuse still occurs comes from a technical assistance provider to a Global Fund grant, who was not able to speak on the record but is familiar with the implementing environments in several African countries. He explained that implementers bent on stealing Global Fund resources and familiar with Global Fund grant writing and submission processes sometimes orchestrate the inclusion of certain activities into the grant at the time of concept-note development, or grant making. Then, once those activities are approved as part of the program, fiscal agents—whose mandate focuses only financial risk mitigation— cannot stop them. Even when the fiscal agents have a strong suspicion that those activities were designed to enable the misuse of resources.

Another example, given by the Global Fund Secretariat, illustrates fiscal agents' limits: Fiscal agents based in a PR's office at the central level authorize an expense for training to occur in a rural area. The PR staff then takes the money intended to finance the training and steals some through inflated bills, or outright forgery of invoices. In such an occurrence, the fiscal agents are not held responsible and the PR is required to reimburse the Global Fund. The OIG report on grant management in high-risk countries (cited above) also highlighted the fact that seven grants in 14 countries received qualified audit opinions because of ineligible and undocumented expenses.

Problematic issues with fiscal agents

The fiscal agent concept faces several fundamental issues.

The first issue is the lack of clear plans and milestones for fiscal agents' exit. Fiscal agents' support, which is supposed to be temporary, sometimes becomes a fixture in the grant. This finding is supported by the OIG review in West and Central Africa, which found that once a fiscal agent is installed in a country, the agent remains in place several years or grant cycles later without a clear exit plan. Fiscal agents have been supporting grants in Burkina Faso, Guinea, Guinea Bissau, Niger and Sierra Leone since 2013, or for at least 6 years (without counting the current year 2019) as the Table 1 below extracted from the OIG report indicates (grey shading indicates the presence of a fiscal agent).

Table 1: Countries and years of fiscal agents' presence in West and Central Africa

	Years					
Country	2013	2014	2015	2016	2017	2018
Burkina Faso						
Central African Republic						
Congo						
Congo (Democratic Republic)						
Côte d'Ivoire						
Guinea						
Guinea-Bissau						

Liberia						
Niger						
Sierra Leone						

Source: OIG review Grant implementation in Western and Central Africa (WCA) Overcoming barriers and enhancing performance in a challenging region

Plans are now underway for the exit of fiscal agents from Burkina Faso and Bangladesh, according to the Secretariat and the CCM Chair of Burkina Faso. These plans have been made after repeated criticisms by the OIG on the shortcomings of the fiscal agents in different countries like Chad, Guinea, or group of countries like the high-risk countries.

A second fundamental issue with fiscal agents is that they rarely build the capacity of the PR or SR although this function is an essential one as stated in the Global Fund financial risk guidelines. The lack of capacity building is due to the inherent conflict of interest in fiscal agents' objectives: Building the capacity of the PR would be a threat to their business. Consequently, fiscal agents "have an incentive to make the PR look bad so their contracts get extended," according to a technical assistance service provider on several Global Fund grants with a fiscal agent, who requested anonymity in order to speak to Aidspan. The lack of capacity building is compounded by a high staff turnover within the fiscal agent firm or at the PR level, according to the Secretariat.

Finally, little coordination occurs among fiscal agents and other institutions that provide assurances for the Global Fund. For instance, fiscal agents do not have a system of regular consultations with Local Fund Agents (LFA) or Country Coordinating Mechanisms to understand or address existing and emerging risks. This lack of systematic, formal meetings has been acknowledged by both the Secretariat and the CCM representatives who talked to Aidspan. The OIG also highlighted inconsistent assessments of the fiscal agents by country teams.

Note that fiscal agents are paid out of grant funds meaning their presence reduces the amount available for grant implementation.

Way forward

According to the Secretariat, the way forward is to "retain the fiscal agent concept but improve the model," for instance by clearly defining measures of success and potential exit strategies. The OIG report on West and Central Africa also recommended that the fiscal agents' role should not include capacity building.

Further reading:

- *OIG Review The Global Fund Guidelines on Financial Risk Management, November 2017, Geneva, Switzerland*
- *Audit Report - Global Fund Grant Management in High Risk Environments - 23 January 2017 (GF-OIG-17-002)*

- *OIG Investigation Final Report of Investigation of Global Fund Grants to Nigeria - Part One: Principal Recipient Yakubu Gowon Centre for National Unity and International Cooperation (YGC)31 October 2011 (GF-OIG-11-011)*
- *OIG review Grant implementation in Western and Central Africa (WCA) Overcoming barriers and enhancing performance in a challenging region 31 May 2019*

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4. ANALYSIS: Domestic financial contributions to HIV, TB and malaria programs remain low in Global Fund 'high-impact' Asian countries

Contributions are especially low for the malaria response

Ann Ithibu **30 July 2019**

The role of domestic resources has taken centre stage as the Global Fund approaches the Replenishment Conference for the next implementation period, which will take place in October in Lyon, France. The Global Fund, in its Investment Case for the Sixth Replenishment, projects that domestic funding for HIV, TB and malaria programs will grow by 48% to $46 billion in the 2021-2023 implementation period. However, increasing domestic investments in health remains a tall order for some countries.

A new analysis Aidspan, published today, assesses the domestic contributions to the health sector and to the three disease programs globally, focused on nine Asian countries, classified as 'high impact' by the Global Fund: Bangladesh, Cambodia, India, Indonesia, Myanmar, Pakistan, the Philippines, Thailand and Viet Nam. The Global Fund Observer published a similar analysis for high-impact African countries in 2018.

The analysis found that domestic contributions to the HIV, TB and malaria responses remain low in high-impact Asian countries, particularly for malaria. Domestic resources accounted for 64% of the total available funding for HIV, 55% for TB and 46% for malaria, in the 2015-2017 implementation period. The share of domestic resources rose, in the 2018-2020 period, to 81% for HIV, 63% for TB and 65% for malaria. Despite this increase, the countries still face huge funding gaps in the current 2018-2020 period.

The high-impact countries have a high burden of one, two or all three diseases. They have low HIV prevalence – compared to sub-Saharan African countries – but the epidemic is growing, particularly among the key populations in some countries. All nine countries have a high burden of TB, according to the World Health Organization (WHO). Two countries – India and Pakistan – are also high burden for malaria; the rest of the countries are endemic for malaria. In addition, four of the nine countries – within the Greater Mekong region – have reported resistance to artemisinin, the chemical compound in some of the best anti-malarials. Investments in the high-impact Asia countries account for 24% of the $10 billion raised for the 2017-2019 funding cycle.

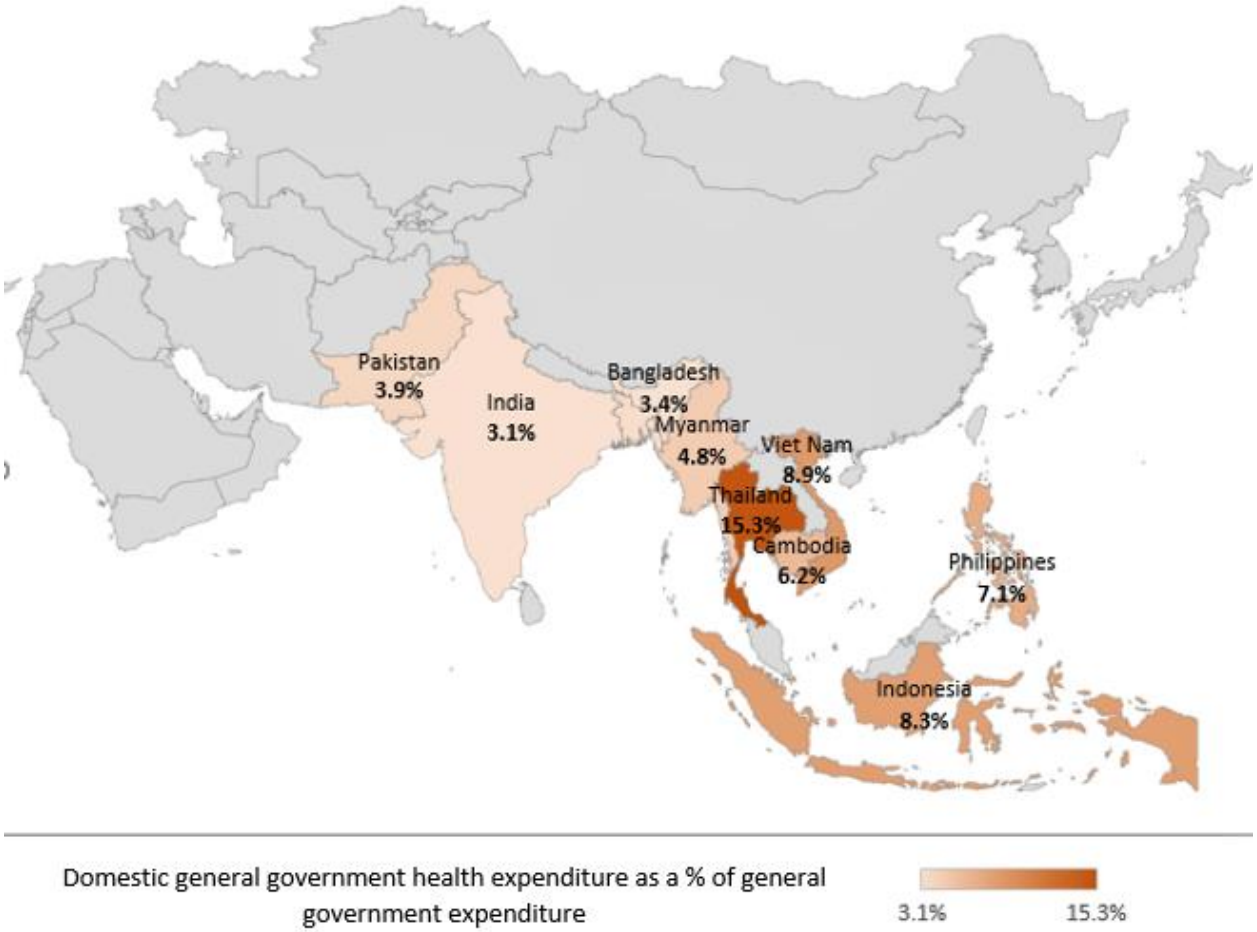
Data for this analysis came from three databases – the WHO Global Health Expenditure Database, the World Bank Open Data, and the Global Fund – as well as from Global Fund grant application documents, particularly the funding landscape submitted to the Global Fund by the sampled countries.

The funding landscape reports total funding needs, anticipated funding, and the resulting funding gap for each disease for the 2018-2020 implementation period; and disease-specific expenditures for the 2015-2017 period. Funding landscapes information was available for eight of the nine countries (Myanmar's was unavailable). The Philippines malaria funding landscape was also unavailable.

Countries spent less than 10% of domestic government expenditure on health

Most of the high impact Asia countries spent less than 10% of their total government expenditure on health in 2016, the most recent year for which data are available, except for Thailand – the only upper-middle income (UMI) country in the sample – which spent 15.3% (Figure 1, below).

Figure 1: Domestic general government health expenditure as a percentage of general government expenditure for the high impact Asia countries in 2016

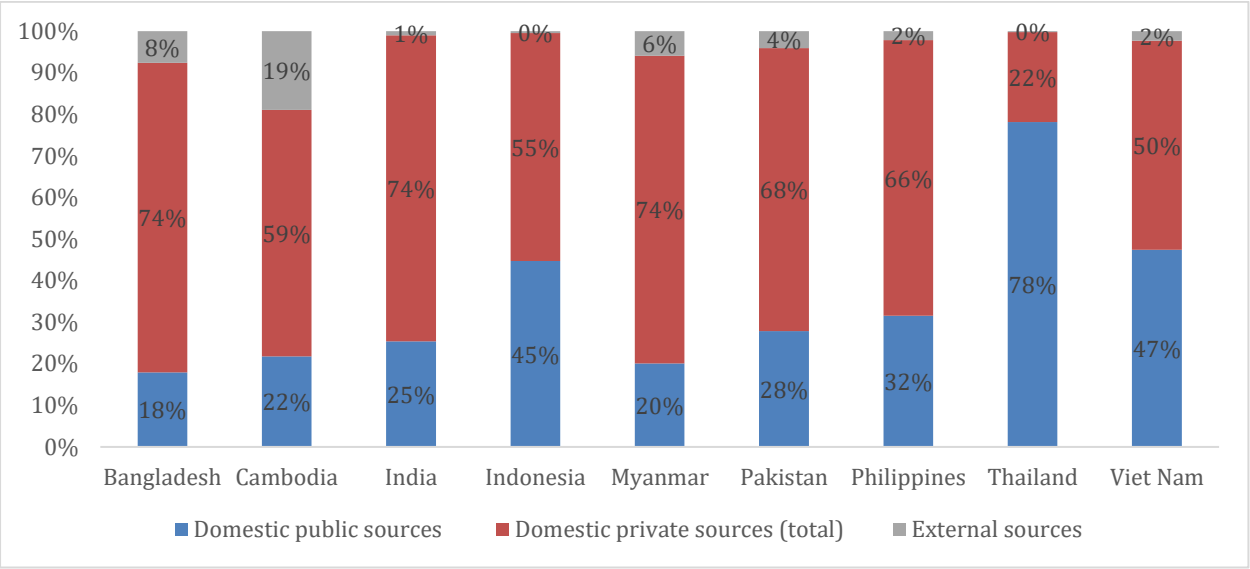


No ideal target exists for what proportion of the total government expenditure countries should spend on health as this depends on the country's priorities. However, researchers have proposed an alternative measure – government spending on health relative to the total economy (the Gross Domestic Product; GDP) – which considers the affordability of health services within a country context. They also proposed that government should spend at least 5% of the GDP on health. None of the sampled countries reached this percentage. Thailand was the closest at 2.9%, closely followed by Viet Nam (2.68%). The proportion was lowest in Bangladesh (0.42%).

Private sources funded most health expenditures in 2016

Most of the high-impact Asia countries relied on private sources of funding such as out-of-pocket payments (OOPs) – as compared to domestic public and external resources – to finance the health sector in 2016. In fact, private spending dominated in eight of the nine countries (Thailand was the exception) as private sources paid for more than half of the current health expenditures: Private spending ranged from 50% in Viet Nam to 74% in Bangladesh, India and Myanmar (Figure 2, below). Only 22% of Thailand's national health expenditures came from private spending.

Figure 2: Current Health Expenditure (CHE) by source (2016)



Most of the private resources came from cash payments by individuals at the point of health service delivery while others came from prepaid payments via voluntary health insurance – such as through an employer or non-profit community-based schemes. These out-of-pocket payments were as high as 74% of Current Health Expenditure (CHE) in Myanmar and 72% in Bangladesh. Share of the voluntary health insurance was highest in the Philippines (11% of the CHE), followed by Thailand (7%).

Domestic resources played a less significant role in funding national health expenditures relative to private resources in eight of the nine countries (Thailand was the exception) where public spending accounted for 78% of the national health expenditures (Figure 2, above). For the rest of the countries, the share of domestic public resources ranged from 15% in Bangladesh to 47% in Viet Nam.

External resources – including multilateral sources such as the Global Fund, and bilateral sources - contributed the least to countries' CHE. In fact, in two countries – Indonesia and Thailand – external resources contributed less than 0.5% of national health expenditures. Top donors to the health sector in the Asia region, in general, include the International Development Association (IDA), which is part of the World Bank Group, the United States, and the Global Fund, according to the Organisation for Economic Co-operation and Development (OECD).

Domestic resources funded more than half of the expenditures for the three diseases

Domestic resources accounted for 60% of the $4 billion raised by the high-impact Asia countries – where data was available – for the three diseases in the 2015-2017 implementation period (see Table 1, below). The Global Fund and other external sources accounted for 28% and 13% respectively (percentages do not add up to 100% due to rounding). Domestic contributions were highest for HIV (64%), then for TB (55%) and lastly for malaria (46%).

Table 1: Available funds (US$) in the 2015-2017 implementation period for the High Impact Asia countries by source

	HIV (n=8)	TB (n=7)	Malaria (n=4)	Total
Total domestic resources ($)	1,537,399,275 (64%)	620,680,592 (55%)	208,616,306 (46%)	2,366,696,173 (60%)
Total Global Fund resources ($)	475,423,167 (20%)	385,043,181 (34%)	240,282,693 (53%)	1,100,749,041 (28%)
Other external resources ($)	376,135,898 (16%)	119,359,716 (11%)	4,527,426 (1%)	500,023,040 (13%)
Total ($)	2,388,958,340 (100%)	1,125,083,489 (100%)	453,426,425 (100%)	3,967,468,255 (100%)

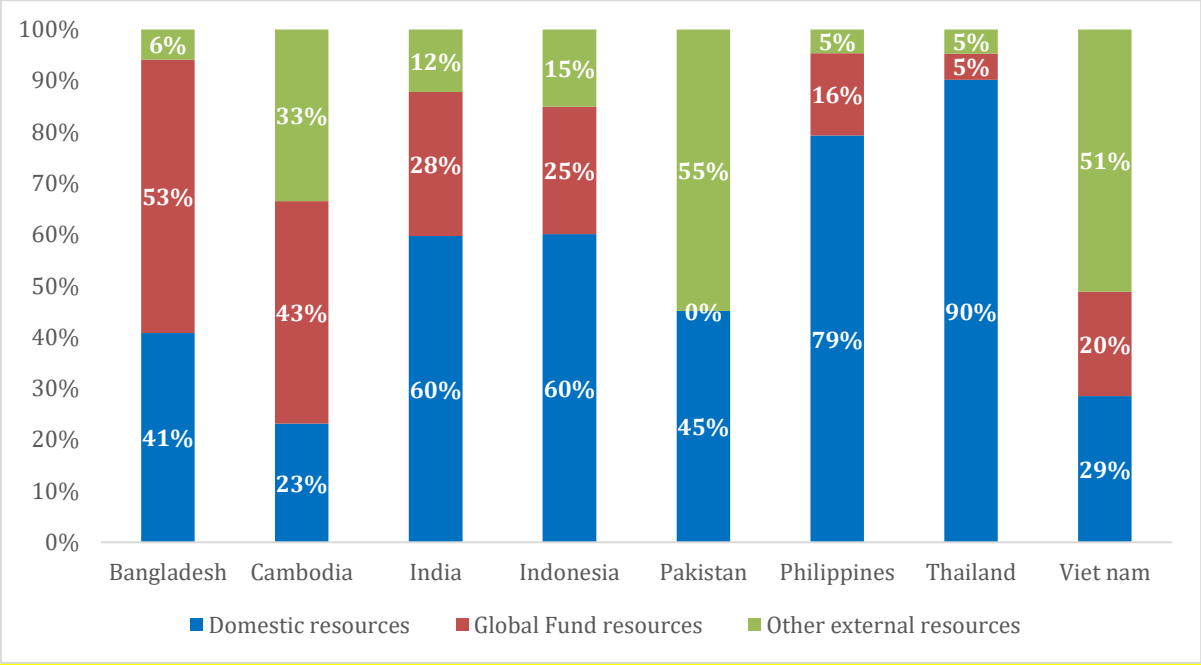
Notes:

1. Countries:
   HIV: Bangladesh, Cambodia, India, Indonesia, Pakistan, Philippines, Thailand and Viet Nam (funding request for Myanmar was unavailable)
   TB: Cambodia, India, Indonesia, Pakistan, Philippines, Thailand and Viet Nam (TB funding data unavailable in the funding request for Bangladesh; and the funding request for Myanmar was unavailable)
   Malaria: Bangladesh, India, Indonesia and Pakistan (Four other countries - Cambodia, Myanmar, Thailand and Viet Nam - received funding through the RAI; the funding request for the Philippines was unavailable)
2. Global Fund grants from the 2015-2017 implementation period (excludes amounts included in the 2018-2020 funding request)
3. Percentages represent column percentages (not row) i.e. the percentages are calculated from the column totals
4. The 'Total' column percentages do not add up to 100% because of rounding.

Domestic contributions varied widely across countries

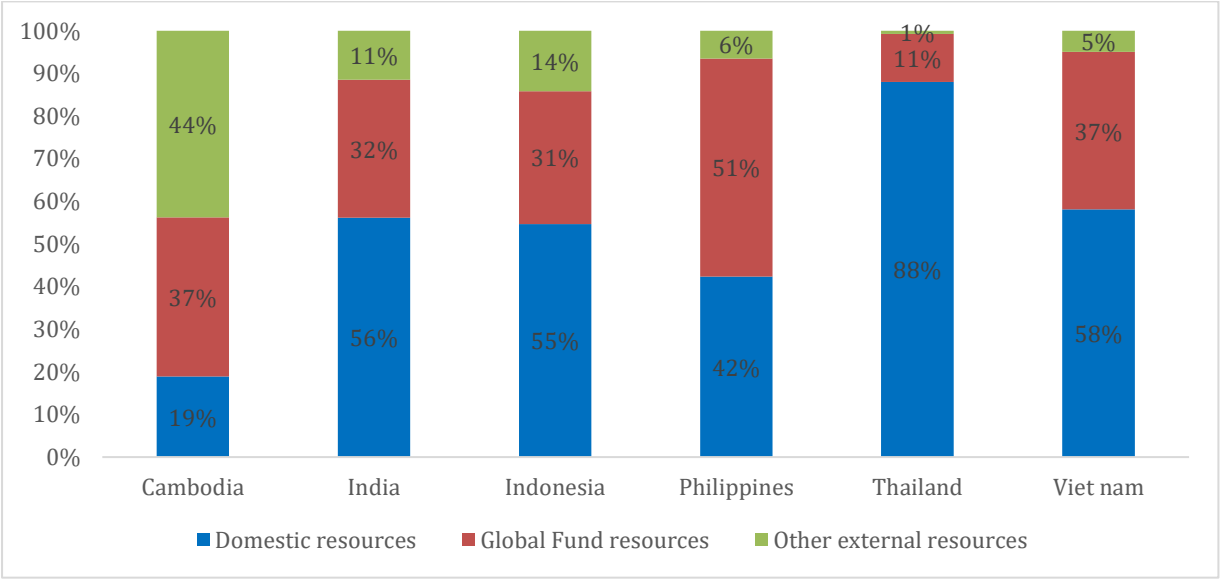
Domestic contributions varied widely across the countries for the three diseases. Some countries are doing better than others. For instance, Thailand and the Philippines funded most of the HIV response through domestic resources: 90% and 79% respectively, whereas Cambodia and Viet Nam funded less than a third – 23% and 29% respectively – in the same time period (see Figure 3, below).

Figure 3: Percentage of HIV funding by source for the 2015-2017 implementation period



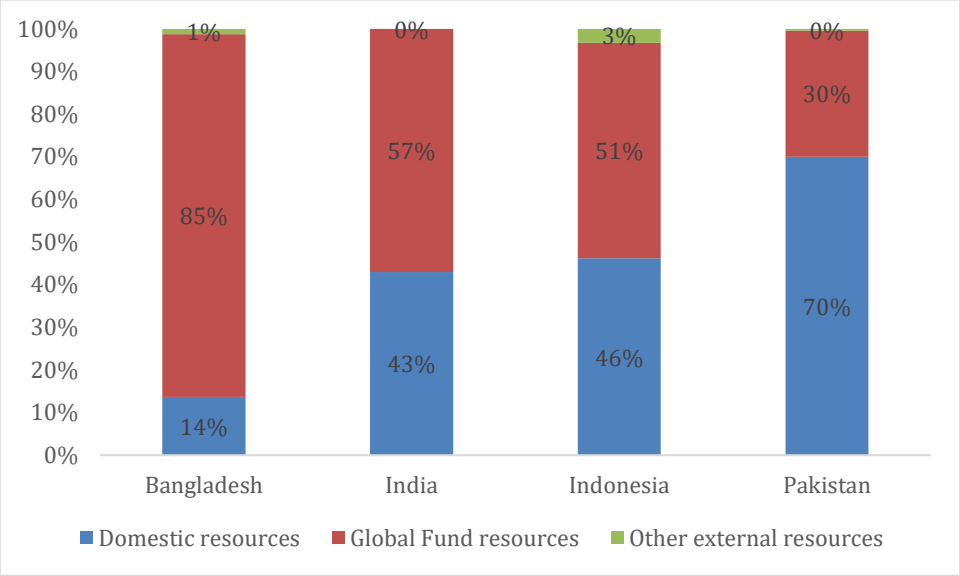
Similarly, domestic contributions for TB were as high as 88% of the total available resources in Thailand but as low as 19% in Cambodia (see Figure 4, below).

Figure 4: Percentage of TB funding by source for the 2015-2017 implementation period



Malaria was the only disease component not to receive a huge share of funding from domestic resources. Domestic contributions accounted for more than two thirds (70%) of available funding in Pakistan but less than half in the three remaining countries: Bangladesh (14%), India (43%) and Indonesia (46%) (see Figure 5, below). The Global Fund was the main source of funding for malaria in these three countries: 85% in Bangladesh, 57% in India and 51% in Indonesia.

Figure 5: Percentage of malaria funding by source for the 2015-2017 implementation period



Large funding gaps for TB and malaria in the 2018-2020 period

The sampled countries require $5 billion, $5.3 billion and $1.6 billion (for four countries) to fully fund the HIV, TB and malaria strategic plans, respectively, during the 2018-2020 implementation period.

At the time of submission of each of their funding landscape, the countries collectively had raised $3.9 billion for HIV, $2.7 billion for TB and $617 million for malaria, creating a funding gap of 23% (HIV), 49% (TB) and 61% (malaria) (see Table 2, below).

The majority of the countries raised more than two-thirds of their total HIV and malaria funding needs from both domestic and external sources. For TB, five of the eight countries raised at least half of the total funding needs.

Table 2: Funding needs and availability for the 2018-2020 period for the sampled countries

Disease component	Total Funding needs	Total anticipated resources	Funding Gap	
			US$	%
HIV (n=8)	5,027,796,909	3,870,467,926[a]	1,157,328,983	23%
TB (n=8)	5,260,591,834	2,689,189,527	2,571,402,307	49%
Malaria (n=4)	1,585,094,422	617,286,109	967,808,313	61%

Share of domestic resources rose in the 2018-2020 implementation period

Shares of domestic resources for the three diseases rose in the 2018-2020 period as compared to the 2015-2017 period. Of the total estimated available funding for 2018-2020, domestic contributions for HIV accounted for 81% (vs. 64% for 2015-2017), for TB 63% (vs. 55% for 2015-2017), and for malaria 65% (vs. 46% for 2015-2017) for malaria (see Figure 6, below).

However, the proportions may change as more funding becomes available in the course of the implementation period. In the long run, the proportions will also depend on the actualization of the financial commitments by the government, Global Fund and other donors.

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TOP

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5. Global Fund Head of Resilient and Sustainable Systems for Health describes evolution in the approach to health systems strengthening

Christelle Boulanger **30 July 2019**

Viviana Mangiaterra, Head of Resilient and Sustainable Systems for Health at the Global Fund since 2014, spent most of her career working in the field of maternal and child health services at the WHO and later at the World Bank. Hired to conceptualize the Global Fund's commitment to health system strengthening, she designed the tools and framework that underpin the RSSH pillar of the 2017–2020 strategy. Having accepted a position as Associate Professor at Università Bocconi in Milan, Mangiaterra will write a report on progress made with respect to health system strengthening before leaving the Global Fund in September.

What were the main challenges when you joined the Global Fund team in 2014?

In 2014, the funding for activities aimed at strengthening health systems and including it in programs was already comprised in the grants, but the reflection process and paradigm shift really began in 2016 as part of preparations for the 2017–2020 strategy.

There was already consensus on the importance of investing in health systems, which is needed to achieve the GF's expected outcomes, so we refined the strategy and started fine-tuning the work. The Ebola experience proved to be crucial: the crisis resulted in progress being erased in three countries by considerably weakening their health systems. As a result, activities targeting pandemics came to a halt, and patients stopped visiting the health centers for testing and treatment. As ties with the community system were quite weak, for months there was no strategy for reaching patients.

The reflection process is also placed within the perspective of the Sustainable Development Goals, which aim to be more inclusive and systematic than the Millennium Development Goals, and require responses that are cross-cutting, systemic and sustainable.

The entire team, together with Mark Dybul, worked hard to put in place baseline studies in the different countries, and for the first time, investing in RSSH became a strategic goal in and of itself and, more generally, an action point. The concepts of resilience and sustainability contained in the name RSSH bear witness to this shift, does not indicate a significant change in terms of the investment figures (about 27% is earmarked for health systems), but we worked on identifying the priorities.

What organizational changes did this shift involve?

First, we developed a methodology to track and measure investments in RSSH because we didn't have a sense of the big picture; the information was scattered among different sources and nobody had a clear idea of the nature or volume of the Global Fund investment in this area. Using the tool we developed, which consisted of a dashboard, enabled us to better understand what was being funded and done in the field. It also allowed us to develop a culture of how to better optimize the investments. In addition, we engaged in a reflection process with the Secretariat and the operations group to look at the priorities for funding, given the global momentum created by all the donors working on health systems.

In operational terms, this paradigm shift also translated into moving towards a patient-centered approach. The success of such an approach will depend on strengthening ties with the patient environment and the community system. The latter, when operating, is crucial to reaching patients and is also a resilience factor in the event of a system crisis.

The discussions also addressed how we can better track health system indicators. Previously, the teams had made significant investments in health information systems and the supply chain; the data was provided by supply chain audits. But it was necessary to complement that analysis with data on health human resources, a crucial topic, and on the organization and performance of the community system. Activities such as strengthening national strategies, developing community health strategies and defining good governance and the role of community health workers have become very important. Together with the operations teams, we worked on the concept of integrating patient-centered services. Sustainability is based on interventions that are well aligned with and included in comprehensive service packages provided at the local level by community actors.

Which beneficiary countries were early adopters in this area?

Some countries have demonstrated the value added of integrating GF investments into national health system strengthening plans. Some evaluations have been very positive and have shown that political leadership was an essential element in early adopter countries in terms of primary and community health. The GF did not lead the way in these processes, rather, it aligned itself with the will of the presidents of the countries in question. The Global Fund placed its trust in them, and the positive outcomes are encouraging.

There is now growing scientific proof that investing in primary and community health is key to offering accessible and quality health services. The more global momentum that has coalesced around achieving the SDGs and universal health coverage has made it possible to establish partnerships supported by the World Health Organization. The Global Fund is a stakeholder in this process through the funding it allocates, and through its participation in primary health platforms and in the G7, guided by France. So, the time is right.

Some interesting examples have not yet been documented, such as Benin, and Afghanistan, which provides integrated services via "family health houses", in which community health workers provide integrated packages of services, and to which patients are referred by midwives and community health workers who send them for HIV and TB tests as well as pre- and post-natal consultations.

How is the Secretariat preparing for the upcoming cycle by integrating RSSH?

We are in the process of fine-tuning the tools designed to assist with drafting concept notes and technical guides to help countries reflect on their investment priorities for RSSH in their national strategies. The needs are many, and so it may be useful to set priorities that consider financial constraints and the relatively short term of grants (three years). We are now in a better position than we were three years ago; efforts have been made to strengthen the process of developing national strategies, which specify those priorities. If this strategy is sufficiently robust, integrated and supported by a budget, it will help guide the choice of priorities for those three years. In addition, the joint work being done with the governments of beneficiary countries to define their capacity to mobilize domestic resources is crucial. These investments in health will have a positive impact on the economy and development of these countries and their leaders are conscious of that.

It is important to acknowledge that our investments are still limited and have a "catalyzing" effect. They do not, in any way, cover all the needs, a situation that calls on us to also engage in dialogue with the other technical and financial partners.

What are you discussing with the other health system partners?

I've seen big changes; we have many more partners than we did five years ago. Donors have a real desire to align their efforts and provide support to the governments of recipient countries. The Global Fund no longer makes investments that are not aligned with the national health development plans of recipient countries, we avoid spreading ourselves thin and support national strategies. We are working hard to align ourselves with Gavi, the Vaccine Alliance, and others. We hold quarterly meetings to analyze the DHMIS results and we plan to integrate immunization indicators into our HSS dashboard to align our country dialogue activities. Integrating our data will help better identify investment priorities.

The Global Financing Facility (GFF) and the World Bank have shown interest in the dashboard, which will also be used in the GFF's next wave. This would enable us to use the same analysis of the health system situation and develop a global financial plan to reflect the needs of all partners. Partnerships are also being established with bilateral partners like the French, Germans and Scandinavians. These countries also sit on the CCM, which could help bring these topics to the discussion table. Our discussions with France center on the community system and health system strengthening through integrated health centers as a first-line investment. As for Great Britain, it would like to focus on universal health coverage.

Conclusion

The next three years will be crucial in terms of investing in sustainable and resilient health systems. The climate is conducive to this, especially with regards to the universal health coverage conceptual framework, which is becoming an umbrella for all activities in this field. The next deadlines (G7, G20 and UHC) and the restructuring of the WHO are all converging on health system strengthening. The planets are now aligned for positive results.

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TOP

6. OIG Head of Investigations describes 'changing fraud landscape' in Global Fund grants

Data falsification, salary kickbacks among 'emerging fraud risk areas'; procurement-related frauds decline

Adèle Sulcas **30 July 2019**

The "I Speak out Now" website, the news and resources website of the Office of the Inspector General (OIG), features frequent updates on matters of risk-related interest to Global Fund implementers, ranging from 'How to protect against school fee fraud' to 'Fighting back against phishing' and 'Speaking out about human rights violations'.

A recent blog by Katie Hodson, the OIG's Head of Investigations, focused on the 'changing global fraud landscape' as observed in the OIG's assessments of Global Fund grant implementation. Part of Hodson's role is ongoing monitoring of this 'landscape', for the purpose of protecting the Global Fund's assets and reputation.

Underpinning Hodson's theme (also expressed in the OIG's 2018 annual report) is evidence, in numbers, that the nature of the most frequent frauds perpetrated in Global Fund grants has substantially shifted, from primarily procurement-related frauds to training-, supply chain- and programmatic data-related fraud. Five years ago, most fraud allegations the OIG received (11 cases in 2014-2015, or 80% of the total) were related to procurement; today, there are far fewer (2 cases in 2018, or 20%).

Hodson says that the Global Fund's pooled procurement mechanism is thought to be a positive contributing factor to the reduction in procurement-related frauds, but this in turn has meant that dedicated fraudsters now look for areas that have weaker controls, for example components of in-country supply chains such as warehouses and government distribution mechanisms.

Hodson's blog addresses different types of fraud (procurement, training-related, per diem-related, embezzlement, data falsification) and highlights "emerging fraud risk areas", which are also identified in the OIG's 2018 annual report, including programmatic data fraud (the OIG's 2018 Guinea data fraud investigation was the first case of this kind) and salary kickback schemes (See GFO article from 3 September 2018).

Currently, the OIG's fraud-related investigations break down into a few main 'buckets': 33% of investigations concern training-related frauds, 20% are supply chain-related issues, 7% relate to instances of embezzlement, 7% to data manipulation, and 13% to other schemes such as salary kickbacks and school fee-related frauds.

Alerting the OIG – fraud allegations

In 2018, the OIG received 208 allegations of fraud (just one more than in 2017), including 107 from 'whistleblowers' and 35 directly from the Secretariat, which Hodson says are generally 'credible', because leads that come from the Secretariat often come "from LFA

[Local Fund Agent] eyes and ears on the ground". (The OIG opened investigations into 64 of these cases, or 31%.)

"[The LFAs] are the ones that have access to the books and records," Hodson says. "They're the ones that are looking into the accounts, so often the information received [by the OIG] from the Secretariat has already been verified."

Whistleblowers remain critical, though, Hodson affirms. "We always encourage people to speak out and encourage people to tell us – but timely reporting is one of the things that keeps me awake at night," she says, meaning that sometimes whistleblower reports come in long after the wrongdoing has occurred. "When the Secretariat hears about something, we want them to tell us at the earliest possible opportunity. [And] we encourage whistleblowers to report 'red flags', things they see that that aren't usual."

Emerging types of fraud

When speaking to the GFO, Hodson expanded on the emerging types of fraud the OIG is now seeing more of, notably the relatively new issue of data falsification (as in the Guinea 2018 example) and salary kickbacks, areas in which the OIG currently has three new investigations underway. Hodson pointed out that the Guinea case had a relatively low level of financial loss associated with it (non-compliant expenditures totalled $114,366), but that this has led to the OIG taking a sort of 'broken window' approach to investigations (where a seemingly minor offence may signal or trigger other more serious infractions).

In another data falsification case that the OIG is currently investigating, Hodson said procurement fraud was identified first, and that had led to further investigation. "Perhaps where the OIG might have stopped in the past, we've said that if they're prepared to commit fraud on expenses and procurement, what other services and activities are they delivering and is it possible that they're falsifying [data] in that work? So we've turned our attention to that, too."

Another recent method of committing fraud involved a phishing email. This is a type of social engineering attack, occurring when an attacker, masquerading as a trusted entity, dupes a victim into opening an email and then clicking a malicious link. That link can lead to the installation of malware, revealing of sensitive information, or important data, that the attacker can use to breach a system or account. *(Source: www.imperva.com.)*

This is the first report of a successful phishing attack on a Global Fund implementer that led to a loss of funds, Hodson said, and the OIG's investigation report will be published once the OIG has received a reply from the implementer to the 'letter of findings,' which the OIG has already sent. Hodson could not yet make public the country name or the details of the case, but the lesson learned from this case will be shared with other implementers to increase awareness of the risks.

"We know from colleagues in different [international] institutions that this isn't the first time that our NGO-type communities have been targeted," Hodson said. "It seems to be quite a targeted scheme that has been successful in other organizations as well." The OIG is now developing 'ispeakoutnow' material (to add to its collection of resources and e-learning

materials) for Global Fund implementers on how to spot the red flags and minimise the impact of similar scams.

"It's all very well detecting these [schemes]," Hodson told the GFO, "but we want to make sure that we mitigate the risk of this happening again, investing our resources into areas that can really help the Global Fund achieve its objective."

A future article in the GFO will focus on the Office of the Inspector General's proactive investigations, as well as oversight investigations.

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7. OF INTEREST: IAS 2019 conference on HIV science reveals hopeful new treatment and prevention approaches

Early indications that PrEP implant and four-day-a-week treatment could work

Adèle Sulcas **30 July 2019**

The International AIDS Society's 10th Conference on HIV Science took place in Mexico City from July 21 to 24, and featured a number of noteworthy developments relating to clinical care and treatment of HIV.

Implantable PrEP

Pre-exposure prophylaxis, or PrEP, has proven highly effective in preventing HIV infection, but for some taking PrEP, taking the daily pill can be challenging, and in these cases its efficacy is lessened. A new study, whose results were unveiled on the last day of the conference amid great anticipation, showed that a slow-release implant from pharmaceutical company Merck provided effective long-lasting protection against the HIV virus. The drug used in the implant, known as MK-8591, or islatravir, is experimental, and is considered to be ten times more powerful than many other antiretrovirals (making very small doses effective). The study, which aimed only at this point to test the safety and tolerability of the drug, lasted only three months, but scientific projections showed that the 62mg dose would maintain sufficiently high levels of the drug in the blood to stop HIV replication (a 54mg dose did not show the same outcome). The drug's "extraordinary persistence," in the words of Dr Randolph Matthews, the study's lead researcher from Merck, made it particularly suitable for long-lasting applications. Further clinical trials will follow.

Read the article in the New York Times …
Read the article in Aidsmap…

'Four days on-three days off' antiretroviral treatment strategy shown to work

A study led by the French national HIV research agency, the ANRS, has shown that taking HIV treatment four days a week was just as effective as daily treatment, for people who already had a fully suppressed viral load. Some types of antiretroviral medication maintain sufficient levels in the blood for several days, keeping HIV under control even when a single dose was missed. The QUATUOR study recruited 647 people whose viral load had been fully suppressed for at least 12 months, and who had no resistance to HIV medications. The participants were on a variety of different antiretroviral regimens, and were randomized to take their medication seven days a week or for four consecutive days. Results were measured after 48 weeks, with 'therapeutic success' defined as undetectable viral load as well as no interruption of the assigned treatment strategy. Results for the four-day-a-week strategy were 'non-inferior,' and there was no difference between different categories of antiretrovirals.

Read the full story on the Aidsmap website…

WHO recommends dolutegravir as preferred HIV treatment

On the basis of new evidence publicized at the IAS conference, the World Health Organization has recommended that the antiretroviral medication dolutegravir (DTG) be used as the preferred first-line and second-line treatment for all populations, including pregnant women. This recommendation is especially important following a May 2018 study in Botswana that raised the possibility of a link between the use of DTG during pregnancy and neural tube defects in infants born to women who had been using DTG at the time of conception. However, the new data, which comes from two large clinical trials comparing the safety of DTG and efavirenz (EFV) have confirmed that the risk of neural tube defects as a result of DTG use is significantly lower than initially suspected.

Read the WHO press release…
Read the Aidsmap press release…

Best practices from 6 HIV treatment locations

Friends of the Global Fight, AVAC, and amfAR launched a new report at the IAS conference, that shows how "dramatic reductions in HIV incidence and mortality have been achieved in six very different settings" across the globe: Thailand; Malawi; Rakai, Uganda; New South Wales, Australia; London, England; and San Francisco, in the United States. According to the report, the six different locations all highlight a number of most-effective interventions to end the epidemic: Campaigns to encourage HIV testing, particularly among the most affected groups; free and easy access to HIV treatment at the time of diagnosis (regardless of CD4 count); the scale-up of evidence-based HIV prevention techniques (such as voluntary medical male circumcision, PrEP, and harm reduction); and concerted efforts to provide human-rights-based services and social supports alongside programs to fight stigma and discrimination.

Read more at www.endaids.org...

ECHO study finds high rates of HIV and STIs

The Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial was a clinical trial conducted in four African countries (eSwatini, Kenya, South Africa and Zambia) over 18 months, which compared the HIV risk to women using the three most common contraceptive methods: the DMPA-IM injection, a copper intrauterine device, and a levonorgestrel (LNG) implant. The trial found that HIV infection risk does not differ significantly by contraceptive method, putting to rest long-standing fears that the use of come hormonal contraceptives might have increased women's risk of becoming infected with HIV. The study also found very high rates of HIV incidence among young women involved in the trial, whose cohort comprised sexually active, HIV-negative women from age 16 to 35. The women were followed for 12-18 months across nine sites in South Africa, and another three sites in the other three countries.

Read the IAS's full press release…

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8. OF INTEREST: Global Fund launches "promise to all 7-year-olds" call to action, to end epidemics of AIDS, TB and malaria by 2030

Campaign in support of the Sixth Replenishment target of 'at least $14 billion'

Aidspan staff **30 July 2019**

"We want to make a promise to you. Not a promise we can keep today, but a promise you can count on when you turn 18."

Thus begins the 'open letter' from the Global Fund – signed by a large number of high-profile artists and athletes – to 7-year-olds everywhere, who will be 18 in 2030, the target date of the Sustainable Development Goals.

The letter acknowledges the list of weighty issues on the children of today's to-do list – fighting injustice, promoting equality, protecting the planet – and recounts a brief history of the Global Fund and its impact. But it also addresses head on the threats to the progress already made against the three diseases, and appeals to the world leaders who will meet at the Global Fund's Replenishment conference on October 10, in Lyon, to raise at least $14 billion to help save 16 million more lives over the next three years, and end the three diseases as epidemics by 2030 – the year that today's 7-year-olds turn 18 and become adults.

The celebrity signatories to the letter include Annie Lennox, Baaba Maal, Charlize Theron, David Oyelowo, Ed Sheeran, Ndileka Mandela, Richard Curtis, Sir Elton John, Stephen Fry, Thandie Newton, Trevor Noah, as well as Amandine Henry, captain of the French women's national football team, and more.

The campaign aims to collect as many signatures from the public as possible in support of the appeal to the world leaders representing the Global Fund's major donors. After signing the open letter (there is a short form fill out on the 'Step up the fight' web page), participants can click on the 'full list of signatures' and see the names of everyone who has signed the letter so far, as well as download campaign images and banners designed for sharing on social media.

A Global Fund spokesperson told the GFO: "This is intended to be a broad campaign to gather public support for the fight against HIV, TB and malaria and to raise awareness that the diseases are still a global challenge. The outcome will be used at the Replenishment conference in Lyon, and is part of our ongoing planning for that date."

Read the full press release from the Global Fund…

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This is issue #361 of the GLOBAL FUND OBSERVER (GFO) Newsletter. Please send all suggestions for news items, commentaries or any other feedback to the GFO Acting Editor at adele.sulcas@aidspan.org. For issues relating to Francophone countries or the French edition of the GFO, the Observateur du Fonds Mondial (OFM), please contact OFM Editor Christelle Boulanger at christelle.boulanger@aidspan.org. To subscribe to GFO/OFM, go to www.aidspan.org.

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

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