Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

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1. NEWS: First NFM Regional Meeting Draws Questions and Concerns from High on Impact Africa 2 Countries

Participants leave Lusaka with more guidance on the new funding model, but concerns linger about the roll out

Representatives from all seven countries in the Global Fund's High Impact Africa 2 cohort plus South Africa met for two days in November to understand the nuances and idiosyncracies of the new funding model roll-out ahead of its launch in 2014.

Participants from government, non-government, civil society and private sector organizations from Ethiopia, Kenya, Mozambique, Tanzania/Zanzibar, Uganda, Zambia and Zimbabwe, along with international partners including UNAIDS, WHO and disease-specific technical agencies joined the Secretariat's country teams to unpack the processes that will drive each country to robust, approvable proposals to fight AIDS, TB and malaria.

The meeting emphasized the role of the country coordination mechanism (CCM) in the country dialogue and concept note development process for each of the three diseases. It served as a high-profile launch of the mechanics of the process entering its final stages at the Secretariat and presented an opportunity for Secretariat staff to engage at the country level with their CCM counterparts and identify where the trouble spots are likely to occur following the expected release of the country allocation envelopes in March 2014.

In touting the advantages of the new funding model for these seven countries – all of which have high burdens of disease and low ability to domestically fund a concerted response – the Secretariat representatives emphasized that unlike the rounds-based proposal process of the past, the new model

afforded the opportunity for regular and consistent engagement with the Fund's country teams.

Technical assistance from partners including the German development agency GIZ, the US government and others, was also on offer for CCMs for every stage of the process; countries can access up to $150,000 for the development of their country dialogue and concept notes, although it was strongly encouraged that these processes be done domestically without necessarily engaging the help of external consultants.

Zimbabwe, which has served as a test case for the NFM, presented its proposal process and estimated that, "including a lot of tea and chocolate" the cost for proposal development was under $40,000. When pressed, however, representatives of the Zimbabwe CCM avowed that external costs for consultations drove that price tag higher, for up to $100,000.

Plenary sessions engendered lively debate about the mechanics of the upcoming transition into the new model. One CCM member summed up the feelings of many in expressing trepidation about the "low level of orientation towards the architecture of the NFM" within the CCM and the country as a whole.

It was when the country-specific sessions began that the real challenges with the roll-out emerged. Countries that have received interim funding expressed confusion about where the spigot turned off and back on – when interim was over and 'new' began.

Many CCMs expressed concern about the new demands being made on them – both in terms of time and in terms of the minimum requirements they would be expected to achieve before being certified as fully eligible even to apply for new grants.

The distinction between indicative and incentive funding remained opaque for many, despite repeated explanations. Some CCM members, when asked after a particularly heavy technical session, to explain the process as they understood it, admitted that some of the language felt complicated and meant that they were unclear even as to what it meant to develop an 'investment case' as the basis for their concept note.

How to engage civil society and representatives of the affected populations was chief among the concerns of the CCMs. The new requirements for participation in CCMs – from representatives of the three diseases, from youth and an enhanced focus on gender with a minimum 30% representation of women – evoked concern from some countries where it was widely acknowledged that stigma against people living with disease, particularly HIV, would make it very difficult to encourage a public stand and regular participation in meetings with government officials. It was widely agreed that the majority of representation of disease communities in-country was from global organizations with local offices, rather than indigenous groups.

Also voiced was apprehension about the more stringent requirements for complete and timely data to justify proposals as evidence that countries were targeting the most vulnerable populations. While some countries acknowledged that they had available but unanalyzed data to identify gaps, others feared that their data were not good enough.

Commodity management was another area where countries expressed low confidence in their domestic ability to monitor and set up a transparent mechanism to feed into their concept note development.

But for all of their concerns, none of the CCM members, principal recipients, technical advisors or

Secretariat staff who spoke with Aidspan had any misgivings about the direction the Fund was taking its fight against AIDS, TB and malaria.

The timelines are tight and the responsibilities for the CCMs are pronounced – but the possible impacts of efficient, country-driven programming that fits into national strategic plans bring new energy and enthusiasm into the arena, one Fund Portfolio Manager said.

And, added one CCM member, somewhat ruefully, there's not much choice in the matter.

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2. NEWS: OIG Investigation in Cambodia Prompts Suspension of Two Top LLIN Suppliers Over $410,000 in Kickbacks

Two suppliers responsible for nearly 50% of all long-lasting insecticide-treated nets (LLINs) purchased by the Global Fund on behalf of malaria projects worldwide have been suspended following an investigation in Cambodia into widespread fraud and kickbacks paid to government officials.

The report on the investigation, the first report released under new Inspector General Martin O'Malley, was the result of a two years of investigative work by his predecessors. The report recommended that Vestergaard Frandsen and Sumitomo Chemical Singapore be sanctioned. Acting on a recommendation of the Sanctions Panel, the Global Fund Secretariat took the decision to suspend both companies from further tendering pending review.

The two suppliers were found to have paid kickbacks worth $410,712 to two Cambodian officials working at the National Centre for Parasitology, Entomology and Malaria Control (CNM): at the time, the principal recipient of malaria grants worth $11.8 million from 2006-2011. Cambodia has received some $331 million in grants since 2003 for its fight against AIDS, TB and malaria.

In emails responding to GFO's requests for comments, both companies said they had reviewed operations in the region and taken action. Sumitomo's spokesperson said "Sumitomo Chemical Singapore takes a serious stand against employee misconduct of any kind and has taken appropriate remedial measures."

Vestergaard's spokeswoman Meryl Rader said: "Vestergaard has reviewed the report of the investigation... into certain business transactions that occurred out of Vestergaard Frandsen India from 2007 - 2011.

"The matter under investigation by the Global Fund related to improper activities by two employees in Vestergaard Frandsen India. This was not known or approved by our management in Switzerland. Nonetheless, Vestergaard is ultimately responsible for the company and actions in any of its subsidiaries. We have implemented corrective actions that include improved controls and procedures in all our operations. We're committed to operating under the highest ethical and business practices. Vestergaard will cooperate fully with the Global Fund on this matter as we have done to date."

Additionally, among two sub-recipients of Fund grants, two staff positions at an entity called

MEDiCAM were improperly charged to the Fund in 2009 and a procurement officer manipulated procurements at the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS), according to the 216-page report released by the OIG. Those manipulations were worth an additional $20,000.

Cambodia contracts for nets for the two suppliers were themselves valued at $10.7 million for Sumitomo and $7.1 million for Vestergaard over the five-year period. Overall, around 50% of all nets supplied through Global Fund-funded projects in 2012 and 2013 were the purview of the two multinationals; in 2011, that figure was 80%.

Out of a total $17.8 million in contracts under the CNM, the OIG only found evidence of wrongdoing amongst contracts worth $11.8 million. Also the investigation found that all nets procured through the grants were provided as intended through the programmes.

In what Global Fund Executive Director Mark Dybul called the Fund's full commitment to "pursuing fraud and taking action when we find it," the CNM has also been replaced as the PR. Fidcuiary and procurement agents have been appointed to work with NCHADS, and it is anticipated that under the new funding model (NFM) that fiduciary controls for higher-risk sub-recipients will be strengthened.

Since September 2013, where Cambodia had previously been responsible for its own procurement through a direct procurement mechanism, UNICEF, has, following a Fund request, begun procuring all health products paid for by Global Fund grants.

The challenges in Cambodia reflect a need within the Fund to strengthen its procurement process to avoid the potential for abuse of an open tendering system. Prior to 2013, within procurement for LLINs alone, there were more than 220 specifications reflecting country- or supplier-specific requirements that carried with them the allure and possibility of improper procurement and graft.

As it begins to implement its NFM, the Fund will be moving to a new framework for procurement of health commodities, which could eventually cover all countries receiving Global Fund money. In 2012, sourcing and procurement together were valued at $2 billion of the $3 billion in disbursements by the Fund.

Already 83% of products in 55 high-risk countries are being supplied under a pooled procurement process (see GFO commentary) organised by the Secretariat and distributed based on needs identified at the country level.

LLINs are among the primary commodities to be covered by this new framework; as reported in GFO on 6 November, seven manufacturers have signed contracts for the largest-ever bulk purchase of LLINs, generating a projected savings of $140 million over two years and making possible the purchase of 190 million nets by the end of 2014.

A plan to recover the misused funds is already under way. Aidspan understands that recoveries are being sought from the responsible recipient entities. Any sanctions against the companies will be recommended by the Sanctions Panel, which operates separately from the recoveries process. There is no firm timetable for the recoveries, however.

The high-profile investigation was initiated in 2011 and it comes at a critical moment for the Global Fund as it heads into its Fourth replenishment conference in December, at which it is seeking $15 billion for the 2014-2016 cycle.

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3. NEWS: More information on the Global Fund's New CCM Performance Assessment

CCMs will from 2014 be required to conduct an annual self-assessment using a new Eligibility and Performance Assessment Tool to determine whether they are compliant with the Global Fund's minimum requirements and minimum standards and to assess how well they are functioning.

As reported in GFO, technical assistance to conduct the self-assessments will be required.

The assessment tool is available (in English) on the Fund's website here, with other-language versions of the tool available soon.

There are three components of the assessment: (1) the self-assessment, for which the CCM is responsible; (2) the stakeholder interviews, for which the TA provider is responsible; and (3) the preparation of an improvement plan (for certain CCMs), for which the CCM and the TA provider have joint responsibility.

The Global Fund Secretariat told GFO that the details for some parts of the assessment process are still under review.

Self-assessment

CCMs are expected to conduct an annual self-assessment and send a copy to the Secretariat. The TA provider may furnish support to the CCM for the self-assessment.

The CCM Performance Assessment Tool consists of a spreadsheet in Excel format with four tabs or sections: (1) instructions; (2) performance assessment; (3) summary of results related to eligibility requirements (formerly called "minimum requirements"); and (4) summary of results related to minimum standards. The last two sections are generated automatically based on information entered in the performance assessment section.

The tool is designed to assess performance against four of the six CCM eligibility requirements – specifically, the ones that relate to the functioning of the CCM (known as Requirements 3–6). Requirements 1 and 2 concern the process of preparing proposals and will be assessed whenever the proposals are submitted.

For each of the four requirements in the tool, one or more elements and one or more minimum standards are listed. "Elements" are aspects of the minimum requirement that the Global Fund believes are inherent in the requirement. "Minimum standards" are additional requirements that the CCM will have to meet from 2015 to be able to apply for funding.

Among the elements listed for Requirement 3, which calls for CCMs to have an oversight plan are:

- The CCM has an oversight plan which details specific activities, individual and/or constituency responsibilities, timeline and oversight budget as part of CCM budget.
- The CCM has established a permanent oversight body with adequate set of skills and expertise to ensure periodic oversight.
- The oversight body (OB) or CCM seeks feedback from non-members of the CCM and from people living with and/or affected by the diseases.

For each element the tool provides an indicator and "examples" of the criteria used to assess compliance. For the element above concerning feedback, the indicator reads:

> "Documentary evidence of consultations including oversight visits carried out by the oversight body or CCM, at least once every 6 months, to obtain feedback from non-CCM members and people living with and/or affected by the diseases or key affected populations."

The examples of the criteria for assessing performance against this indicator are as follows:

- **Non-compliant (NC) –** No documentation on feedback requests or stakeholder consultations in the past 6 months.
- **Indeterminate compliant (IC) –** OB or CCM has actively requested feedback but held no stakeholder consultations in the past 6 months.
- **Fully compliant (FC) –** OB or CCM has proactively held stakeholder consultations in the past 6 months.

Performance ratings are then converted to a numerical value – 1 for NC, 2 for IC and 3 for FC – and results entered into the results sections of the tool.

The Secretariat told GFO that the CCM may use additional or other criteria to arrive at a rating as long as they are reasonable.

For each eligibility requirement, one or more minimum standards are shown. (For a list of the minimum standards, see GFO article). As is the case with the elements, each standard has an indicator and examples of criteria for assessing performance.

Requirement 4 includes an assessment of representation on CCMs from key affected populations. The indicator explains that representation can be from organised groups or networks, or from individuals. In countries where some key populations are criminalised, the CCM may have "advocates" instead of direct representation.

One of the minimum standards attached to Requirement 4 calls for CCMs to have balanced gender representation. The examples suggest that Full Compliance includes 30% female representation. Under 30% but above 15% is Indeterminate Compliance; however, IC can also be awarded if "there is clear evidence of efforts being made by the CCM to ensure an active voice for women, through a designated female representative with expertise in gender issues who represents women's

organizations and participates regularly in meetings."

Anything under 15% female representation, or if there is no designated representative with expertise in gender issues and no evidence of efforts to ensure an active voice for women's issues, earns an NC rating.

Stakeholder interviews

Interviews conducted by the TA provider with CCM members and non-members comprise the second pillar in the assessment process. The interviews aim to generate additional feedback on the performance of the CCM in a less formal manner than the assessment tool. The interview process remains under review.

Certificates and improvement plans

The Global Fund Secretariat will review the self-assessments and the results of the interviews, and make a final determination of the CCM's rating. CCMs assessed as FC will be granted "CCM Eligibility Clearance" for one year from the assessment, which will allow them to submit a concept note without having to go through a CCM eligibility screening process for Requirements 3–6.

CCMs assessed as IC or NC will be required to prepare a milestone-driven improvement plan. The Secretariat told GFO that the plan should contain actions that can be taken fairly quickly. The Global Fund Secretariat must approve each plan.

Should a CCM assessed as IC or NC submit a concept note before the improvement plan is fully implemented, the Secretariat will review what progress has been achieved. If activities have generally been implemented on time, the Secretariat will declare that the concept note can proceed. If there has not been sufficient progress, the Secretariat will indicate that the CCM does not currently meet the eligibility requirements, and will tell the CCM that the outstanding issues need to be resolved before the concept note can proceed.

According to the Fund, "non-adherence to the improvement plan will impact current and future funding." The Secretariat told GFO that non-adherence to the plan will be interpreted as meaning that the CCM does not meet the eligibility requirements. Consequently, the CCM would not be eligible for new funding and could even see current funding reduced, delayed or suspended. The same is true for the funding that the CCM accesses to support the operations of the CCM itself. Note, however, that CCMs are not required to meet the new minimum standards attached to the eligibility requirements until 2015.

Funding the TA

Funds to pay for the TA for the self-assessments and the interviews will come from the TA providers themselves, if they already have a budget for this type of work, or from the Global Fund.

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4. NEWS: African Health and Finance Ministers Pledge to Increase Domestic Financing for Health

The Global Fund estimates that $37 billion out of the $87 billion it needs from 2014 to 2016 can come from domestic financing

Ahead of the Global Fund's replenishment push in December, countries are being strongly encouraged to boost domestic funding for the fight against AIDS, TB and malaria to bridge the gap in unmet needs.

A conference in the Ethiopian capital Addis Ababa on 11-12 November brought together ministers of health and finance, civil society groups and donors to discuss how to accelerate domestic spending on health in Africa.

Global Fund Executive Director Mark Dybul said increased domestic spending on health will be pivotal in defeating the three diseases.

“We are tremendously encouraged by the efforts African countries are making in this regard and will support them strongly,” Dr Dybul was quoted as saying by the African Union, which co-organised the meeting.

The Global Fund has estimated that domestic spending could finance $37 billion of the $87 billion required from 2014 to 2016 to reach all vulnerable populations in low and middle-income countries with essential services to bring the three diseases under control.

Yet this goal remains beyond the reach of many countries that receive both bilateral and multilateral assistance to support their health programming needs, conference attendees cautioned.

“The ever-increasing cost of health care and multiple competing priorities in resource-poor countries makes financial resources insufficient to make substantial improvements in access and quality of health care”, Ethiopian Health Minister Dr Kesetebirhan Admasu said.

The Addis meeting unfolded against a strong championing by global civil society groups of increased domestic funding for the three diseases, backed by a new report by the Friends of the Global Fund that provides six examples of a correlation in improved health outcomes with increased domestic spending.

The report, “Steps Toward Sustainability: Stories of Progress in Domestic Responses to AIDS, TB and Malaria,” identified six case studies where political will backed by domestic financial investment in health has reaped significant dividends for populations. The report suggested that strategies are country-specific but must include significant political will and a strong technical skills base among health care professionals alongside financial co-investment.

Indonesia’s success in reducing mortality from TB by some 4.1 percent annually since 1990 was attributed to both a financial and political commitment to improving health systems and the establishment of national health plans. The country is now ranked fourth, down from third, on the list of 22 high-burden countries, and mortality from the disease has decreased by 47 percent since 1990,

according to the report.

All first-line anti-TB drugs, including those to treat drug-sensitive TB, are now procured by government, along with malaria and HIV/AIDS drugs; government is also contributing to the procurement of second-line treatment for multidrug resistant TB (MDR-TB). Between 2011 and 2012 alone, the central government's budget for the National TB Program increased by 19 percent.

In absorbing many of its own health costs through the meticulous application of a National Strategic Framework, Namibia has made once-unimaginable gains against HIV/AIDS. More than 80 percent of people with HIV have access to lifesaving antiretroviral therapy, more than 90 percent of pregnant women are tested and treated, and AIDS-related deaths and HIV incidence have both fallen by more than half.

This framework, the report said, is the product of a broad, participatory process that brought together government, civil society, local communities and international partners, much like the "country dialogue" process the Global Fund helps foster.

Another southern African country is making great strides against HIV after a slow start undermined by a lack of political will. The change of leadership in 2008 allowed for a pivot in strategy for South Africa, building on exhaustive epidemiological and behavioural data to illustrate the toll AIDS has taken on the country.

Under President Jacob Zuma and Health Minister Aaron Motsoaledi, the report said, South Africa's fostering of open dialogue about HIV/AIDS, TB and sexually transmitted infections resulted in a National Strategic Plan in late 2011. The national government now covers more than 70 percent of the national HIV/AIDS expenditures.

Nicaragua has not let its low GNI interfere with its ability to bring malaria under control. The numbers speak for themselves: by 2008, the country recorded just 762 confirmed cases of the mosquito-borne illness, down from a peak of 70,000 in 1996. This is due to a happy marriage between external financing for prevention, including the purchase of rapid diagnostic tests and the purchase and distribution of long-lasting insecticide-treated nets, and domestic funding for treatment: the cost of all malaria medications.

A lack of resources in the early 2000s constrained the Dominican Republic from being able to fully fund the health needs of the population. But rather than remaining reliant on outside financing, the country passed laws in 2011 to reshape its national response and appropriate some domestic money to the fight against HIV.

The National Council for HIV and AIDS (CONAVIHSIDA) still receives external assistance, including from the Global Fund, but its integration of civil society groups and affected communities with government, donors and the private sector has been effective in targeting modest domestic funds to high-impact programming.

Finally, the report highlighted the achievements in Sri Lanka, where a combination of domestic financing and external support have reduced the incidence of malaria almost to the point of

elimination in just 13 years.

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5. COMMENTARY: Domestic Funding for the HIV/AIDS Response

There are just two years remaining on the clock for developing nations to achieve the Millennium Development Goals, including Goal Six, targeting the global fight against AIDS, TB and malaria. While some progress in some parts of the world has been made, it looks increasingly clear that the goal – of halting and reversing the spread of HIV; of achieving universal access to treatment by 2010; and of halting and reversing the incidence of malaria and other major non-communicable diseases – will not be met.

But even as the clock winds down, global health advocates are equally preoccupied with what comes next. There seems to be little political will to maintain health as a priority; indeed, the key words in the UN Secretary General's global development framework beyond 2015, known as the High Level Panel Report, are poverty, growth, partnership and access.

While WHO members have since 2005 made a commitment to achieve universal health coverage, there remain critical obstacles for those leading the fight against the three diseases.

Equally, the global health environment is stacked with new and emerging challenges, particularly with respect to non-communicable disease. A recent Global Burden of Disease study carried out by the Institute of Health Metrics and Evaluation in Seattle finds the major killers in low-income countries are lower respiratory infections: 98 per 100 000; followed by AIDS, at 70 per 100 000. Malaria comes in at 7th on the list at 38 deaths, followed by TB at 32. The ratios change as income increases: in lower middle income countries, heart disease and stroke top the list, with AIDS coming in 7th at 24 deaths per 100 000 and TB 8th at 22. Malaria does not even rank. And in upper middle and high income countries these diseases barely appear.

Yet AIDS, TB and malaria remain dangerous inhibitors of growth and development and central to the burden of disease across the developing world. In South Africa, a Human Sciences Research Council survey in 2012 estimated 12.3 percent of the population is living with HIV: over 6 million people.The 2011 Swaziland HIV Incidence Measurement Survey (SHIMS) found HIV prevalence among adults aged 18-49 has remained unchanged between 2006-2011 at 31-32%, and among women aged 30 to 34 the prevalence was 53.8 percent. In Uganda there is evidence of rising incidence.

The message that the AIDS and TB interest groups need to learn is one well-understood by those working in malaria. It is rare that diseases can be eliminated; at best we should expect to prevent, contain and control them. This requires vigilance, monitoring and resources.

In the first week of December, the Global Fund to Fight AIDS, TB and malaria will look to donors to provide $15 billion over the next three years to finance the best possible arsenal of prevention, harm

reduction and treatment options in the countries that need them most. All signs suggest that the fundraising targets will be achieved, but it is quite possible that this is the last time that multilateral financing mechanisms are prepared to shoulder the bulk of the burden. This must compel the countries afflicted with these diseases to develop their own domestic sources of funding, a theme that is emerging in boardrooms and conference halls the world over including most recently at a ministerial meeting in the Ethiopian capital, Addis Ababa.

Convened by the Global Fund and the African Development Bank, the conference on Domestic Financing for Health hosted by the African Union sought to help countries begin to conceive of strategic budget planning to include a greater share of health financing. The topic will again be taken up in December at the International Conference on AIDS and STIs in Africa, although it is important to remember that AIDS has been treated differently than most other diseases in poor countries.

With the ominous warning from the National Security Council in 2000 that AIDS was "a threat to US national security that could topple foreign governments, touch off ethnic wars and undo decades of work in building free-market democracies abroad," the government of former US president George W. Bush moved three years later to launch the President's Emergency Plan for AIDS Relief (PEPFAR), with funding of $15 billion. The US was also a major driver of the establishment of the Global Fund.

International support for the AIDS response grew dramatically, with developed-country advocates spearheading initiatives and foreign bodies pouring money into fighting the scourge. But this may have had an enduring negative legacy for developing-country governments, which ceded responsibility and management to their deep-pocketed and well-meaning supporters in the north.

The somewhat selective battles being fought by passionate and committed AIDS activists means that deep-rooted prejudice, which in many countries including Russia as well as in Africa has been transformed into ruinous legislation, has not received nearly enough attention.

Also preoccupying is the question of resources. Laurie Garrett of the Council on Foreign Relations has written a thoughtful paper on ‘Existential Challenges to Global Health’ in which she notes that “The spectacular growth of global health was propelled by urgency and activism, chiefly directed to the AIDS pandemic.” This meant the WHO’s importance and funding was diminished, and numerous new entrants into the field, “spawn[ed]confusion, complexity, even anarchy”.

In a corollary paper by the think tank Results for Development, a review of 12 PEPFAR countries found “deeply ingrained perceptions by finance and other senior government officials that “donors will take care of the AIDS program,” as they have for the past decade.

There is no question that the global community must ‘fund the Fund’. Because AIDS and TB have yet to be brought under control, costs will continue to rise. More people will require treatment in what remains a life or death issue. There is, however, room for more domestic investment. Whether through taxes or levies, or more efficient spending of existing resources, there are a number of bold and innovative things that can be done by individual countries to reduce their national burdens of disease.

People working on AIDS, TB and malaria are aware that the period of limitless resources is over.

There has to be a partnership between governments and donors. What is not perhaps yet fully appreciated by national AIDS control programmes and ministries of health is that this is an opportunity. If they can make a case to external funders then the same case can be made to the ministries of finance at home. What should follow the Millennium Development Goals is the era of Domestic Resource Mobilization.

Professor Alan Whiteside, director of the Health Economics and HIV and AIDS Research Division, University of KwaZulu-Natal, Durban. Dr Whiteside is a member of the Aidspan board of directors.

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6. NEWS: Aidspan Launches Pledges and Contributions Pages

Aidspan has officially launched a new data analysis tool designed to provide comprehensive information about historical and current pledges and contributions to the Global Fund.

As the Global Fund's Fourth Replenishment Conference nears, the data represent a critical tool for activists and governments alike to ensure accountability from and for the Fund to track its progress towards its goals of having every penny at its disposal for the fight against AIDS, TB and malaria.

The impetus for the tool came from Bernard Rivers, Aidspan's founding director and author of the 2012 publication: Donors to the Global Fund: who gives how much. The tool's development was led by Senior Systems Officer Kelvin Kinyua.

Data driving the tool were obtained from the publically available information on the Fund's own website.

The data rank and then rate all High Income and Upper Middle Income country-donors to the Global Fund by year from 2003. This arrangement demonstrates the changes in donor relationships with the Fund over time, and the evolution of those relationships.

Aidspan also applied a 'donor score' to each country for each year of its contribution. The score assesses a country's contribution to the Global Fund against its Gross National Income. It does not, however, reflect a donor's bilateral commitments to any particular country or a donor commitment through other multilateral mechanisms – only its commitment to the fight against the three diseases through the Global Fund's granting process.

The Pledges and Contributions pages can be found on the Aidspan website. The page also features a separate platform for feedback and comments.

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7. COMMENTARY: The Public Health Approach Makes Sense for the Global Fund

When the Global Fund to Fight AIDS, TB and malaria was created in 2002, its aim was to provide financial support to developing countries in their battle against the three border-crossing communicable diseases for which treatment and prevention options were available.

In the decade since the Fund has been providing grants to 150 countries around the world, it has evolved its financial model to respond to the unmet needs in the countries with the highest burden of disease and the lowest ability to pay for it. The Global Fund has decided to streamline eligibility for Global Fund grants along these lines, using prevalence data to assess burden of disease and per capita gross national income to assess a country's finances.

But as a longtime AIDS activist with a background in medicine and public health I would like to make the case that these markers of GNI and prevalence may leave some countries that have acute unmet needs out of the net of Fund financing, which could have serious consequences for their populations. Instead, the Global Fund should take a public health approach to financing, casting as wide a net as possible to help control the global spread disease.

There is a conventional wisdom about the three diseases that suggests they are afflictions of poverty -- that once a country surpasses a threshold of development, they tend to disappear. While that may be true for some communicable diseases, and while sub-Saharan Africa does have the highest regional prevalence of HIV in the world, it is a mistake to attribute infection and the spread of this epidemic to poverty as the main reason.

The reality about HIV is that high infection rates are correlated with sexual behaviours and practices -- not necessarily with poverty. So to my mind, basing eligibility for HIV funding by the Fund on financial benchmarks would deliberately neglect some countries where there is a real risk of a rising AIDS epidemic.

That risk is unacceptable, particularly since there have been so many advances in the understanding of the disease and how it is transmitted. In May 2011, the Fund board of directors called on the secretariat to work more closely with countries to re-program (this is the key word that was approved) existent grants to achieve the best possible impact. A day later, a first report of a major scientific study of people on anti-retroviral treatment concluded that those who are able to achieve an undetectable viral load reduce by 96% the chance of transmitting the virus to their sexual partners.

Taking these two events together shows how providing medical treatment can not only save a life but can protect the health of the population: demonstrating a clear public health benefit. Of the 35 million people estimated by UNAIDS to be living with HIV, only 10 million are taking ART. This means, globally, that 71% of people who have a highly infectious virus are not taking medication to control it, raising the risk that they will transmit it, even unknowingly, and furthering the spread of this global epidemic.

To get a sense of what this risk is, we should turn to six G-20 countries. Turkey, India, Saudi Arabia, China, Russia, Indonesia: in 2012, none of these countries had ART coverage above 20% of their total infected population. Not surprisingly, according to the 2013 ‘AIDS By The Numbers’ report released by UNAIDS, the two regions of the world where the HIV epidemic is still surging ahead

disproportionately are the two with the lowest average ART coverage rates: Eastern Europe/Central Asia and the Middle East/North Africa.

Compare that to a country like Uganda, where nearly 40% of people living with HIV are taking ART every day, or Haiti, at above 20% or Cambodia, which has gone above 60%. That a Russian citizen living with HIV would have a greater chance at prolonging his life by moving to Uganda seems unfathomable to me and underscores the need for a re-thinking of the eligibility parameters established by the Fund.

Taking a public health approach to controlling epidemics means not just measuring prevalence to assess disease burden; it means incorporating incidence rates as well as yearly volumes of new infections.

We welcome the move at the November 2013 Global Fund board meeting to approve support for ambitious regional initiatives for the eradication of malaria, irrespective of borders with countries with a different eligibility status, such as Nicaragua with Costa Rica, Haiti with Dominican Republic or Guatemala with Belize and Mexico. This shows that there is scope within the Global Fund to apply the public health approach to respond to cross-border and regional issues. Why can't this same support be applied to the HIV response?

The public health approach is not about providing financial resources to countries that do not need them; it's about using public health as the benchmark for decision-making.

At AIDS Healthcare Foundation, we acknowledge that there might be additional costs in applying the public health approach, but this is not an insurmountable obstacle. We are highly confident that the Fund's Fourth Replenishment will be fully funded for the $15 billion sought for the next three years. Equally, there are unspent resources within countries that need reprogramming to be more effective and we call on countries to work together with the Fund to do this without delay.

Finally, by establishing a more permanent and predictable replenishment model, which considers quotas to countries based on the example of other global financing mechanisms such as the IMF and the World Bank, we believe that investing fully in the Global Fund now will ensure that the need for resources in the future will decline alongside the rates of infection as we bring these diseases under control and towards elimination.

Dr Jorge Saavedra is a global ambassador for the AIDS Healthcare Foundation

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The following articles have been posted on GFO Live on the Aidspan website. Click on the article heading to view the article.

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This is issue 232 of the GLOBAL FUND OBSERVER (GFO) Newsletter.

We welcome suggestions for topics we could cover in GFO. If you have a suggestion, please send it to the Editor of GFO (see contact information below).

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GFO is an independent source of news, analysis and commentary about the Global Fund to Fight AIDS, TB and Malaria (www.theglobalfund.org). GFO is emailed to nearly 10,000 subscribers in 170 countries at least twelve times per year.

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