Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

Issue 234: 08 January 2013

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Aidspan is pleased to share three recently published peer-reviewed articles that support our work as monitors of the Global Fund. All conclusions drawn within these academic papers remain the purview of their authors and do not reflect the opinions of Aidspan.

See section near the end of this newsletter listing additional articles available on GFO Live.

ARTICLES:

1. NEWS: Procurement irregularities and over-pricing in Madagascar identified by OIG

Suppliers alleged to have colluded on bids

An investigation by the Office of the Inspector General (OIG) into procurement contracts for five malaria grants to Madagascar has found evidence of non-compliant expenditures, over-priced goods and collusion among suppliers. A report on the investigation was released on 3 January.

Procurement activities from four Round 9 grants under investigation involved two government and two non-government bodies: the central support office for health sector projects (UGP: Unité de Gestion des Projets d'Appui au Secteur de Santé) and the central governments health products

procurement office (SALAMA: Centre d'Achats de Médicaments et de Matériel Médical); Pact and the Madagascar intercooperation association (AIM: AssociationIntercoopération Madagascar). Procurement activities under a Round 7 grant were also investigated, with UGP as the PR.

By April 2012, when the investigation was launched, some $70.8 million had been disbursed over the five grants; expenditures of $12.2 million were examined.

The investigation has implicated three of the four PRs in non-compliant expenditures worth some $1.1 million, including $462,670 in over-pricing; only AIM was exonerated for any suspect spending.

Table: Summary of non-compliant expenditures and amounts of over-pricing identified by the OIG

PR	Grant	Disbursed as of 30 April 2012	Reviewed by the OIG	Amount of non-compliant expenditures	Of which, amount of over-pricing
UGP	MDG-910-G17-M	$8,867,217	$6.0 m.	$843,600	$382,937
	MDG-708-G09-M	$24,170,652			
Pact	MDG-910-G19-M	$13,741,533	$1.4 m.	$299,672	$74,464
SALAMA	MDG-910-G16-M	$16,397,630	$ 2.3 m.	$17,068	$5,269
AIM	MDG-910-G18-M	$7,652,053	$2.5 m.	NIL	NIL
Totals		**$70,829,085**	**$12.2 m.**	**$1,160,340**	**$462,670**

With respect to the grants administered by UGP, the OIG uncovered evidence that groups of vendors colluded and submitted bids for procurement contracts that had not been independently prepared. In a restricted national tender launched by UGP in 2010 for supplies and equipment for an indoor residual spraying campaign, the OIG found that contracts worth $640,146 were compromised; of this amount, slightly more than half was charged at above-market rates.

Such practices needed the collusion of a procurement unit official, according to the OIG.

The grant administered by Pact required the PR to use SALAMA as a procurement agent. During 2011–2012, Pact entered into three contracts with SALAMA. The OIG found that two of the contracts – $270,643 for laboratory equipment and $29,029 for rapid diagnostic tests – were overpriced by $74,464 in total. The OIG said that Pact exercised insufficient oversight of the

contracting process with SALAMA. However, the OIG acknowledged that Pact undertook corrective measures shortly after the issue was raised, and managed to recover some of the excess.

With respect to the grant for which SALAMA was PR, the OIG said that in January 2011, a contract was awarded for $17,068 to IDA Foundation to supply an anti-malarial medicine manufactured by REMEDICA, a supplier approved by the World Health Organization.

However, the medicines actually delivered by IDA and distributed by SALAMA were produced by another manufacturer, Guilin Pharmaceuticals, which was not an approved supplier, resulting in an overcharge of roughly $5,000. IDA has since committed to refund the excess charges.

The OIG found fault with SALAMA, IDA and the local fund agent (LFA) for the fact that the wrong drugs were distributed to patients.

An annex to the report included detailed comments from the UGP, Pact and SALAMA on an earlier draft of the report. These comments prompted changes to the final report.

In an attached letter, the Global Fund's executive director, Mark Dybul, said that the Secretariat has moved to respond to the findings, including limiting the scope of the grants to essential malaria activities; suspending the signing of Phase 2 of the UGP NSA grant; moving to 100% verification by the LFA; and requiring pooled procurement for most commodities. SALAMA has also been removed as a PR, and its grant is in closure. A recovery plan should be in place by March 2014, Dybul added.

Separately, the OIG said it had been advised of the findings of a forensic audit commissioned by Pact and conducted on one of Pact's sub-recipients. The OIG said that the audit identified procurement irregularities, which will be followed-up directly by the Global Fund Secretariat.

The report of the OIG investigation can be found on the Global Fund website here.

[This article was first posted on GFO Live on 08 January 2014.]

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2. NEWS: African HIV programming failing to respond to acute needs of sexual minorities

The studies show that MSM in the region have specific HIV acquisition and transmission risks that differ from those of the general population

Global Fund efforts to target key affected populations including sexual minorities in the fight against HIV may continue to face an uphill battle in sub-Saharan Africa, new studies have shown, because of prevailing stigma and marginalization even within existing programming.

In releasing the series of studies about the HIV burden among men who have sex with men in sub-

Saharan Africa, the Journal of the International AIDS Society sought to expose the worrisome trend towards an AIDS epidemic among MSM across the continent, while challenging "the attitudes of complacency and irrelevancy among donors and country governments that are uncomfortable in addressing key populations," according to an editorial introducing the series.

Current estimates from UNAIDS place HIV prevalence among MSM in sub-Saharan Africa at 17.9%.

Studies conducted in Cameroon, Senegal, South Africa, Swaziland, Kenya and Malawi suggested that the silent epidemic is largely unacknowledged by health policymakers despite exhortations from external funders, including the Global Fund, that targeting this key population is one of the best ways to bring the spread of HIV under control.

A lack of data has been identified as one of the largest barriers to intervention, the studies suggest, with few countries collecting or analyzing the size of the MSM population within their borders.

South Africa, which has one of the largest HIV burdens on the continent, has also generated the largest body of data, beginning with a 1983 study of 250 MSM that revealed a high prevalence of HIV, syphilis and Hepatitis B virus. Another study of rural South African men found that approximately 3.6% of men studied reported a history of having sex with other men. Among these men, HIV prevalence was 3.6 times higher than among men not reporting male partners.

A study that was conducted in 2008 with a sample of 378 MSM to establish HIV prevalence and associated risk factors among MSM in Soweto found a prevalence rate of 13.2%. Another study conducted in Cape Town in 2010 involving 542 MSM found a prevalence rate of 10.4%. These studies suggest the existence of an epidemic among MSM in the country.

HIV prevalence among MSM has also been quantified in Senegal and Nigeria, while a sero-prevalence study has been conducted among male sex workers in Côte d'Ivoire, where HIV prevalence was measured at 50% among a sample of 96 men in the economic capital, Abidjan.

Another critical barrier identified by the studies – which were also conducted in Cameroon, Kenya, Malawi and Swaziland – was the criminalization of homosexuality in many countries in sub-Saharan Africa: an estimated 38 countries on the continent have made it illegal for any sexual relations to occur between two men or two women.

"Due to the criminalized nature of male-to-male sex in all countries where studies from this issue took place… MSM are often afraid to visit healthcare services; and when they do go, they are reluctant to disclose their sexual histories to healthcare providers for fear of rejection, derision or other negative reactions," the editorial said.

Even South Africa, which has legalized same sex unions and is considered among the more progressive countries in Africa in relation to respect for sexual minorities, a prevailing stigma has prevented outreach, prevention and treatment programmes from being optimally effective. One study

identified a correlation between a higher risk of an MSM contracting HIV and his limited knowledge of prevention measures.

Stigmatizing or marginalizing behaviour by healthcare workers was also examined in the compendium of studies published by the Journal. Healthcare workers displayed negative attitudes towards their MSM patients; in one Kenyan study, healthcare workers told the researchers that they were afraid of being perceived by their communities to be MSM themselves when treating MSM patients.

The research concluded that there is not enough specific training provided to healthcare workers in sub-Saharan Africa to respond to the particular needs of MSM and other key populations, which limits their effectiveness in recommending changes to behaviour that can mitigate the risk of HIV transmission. Equally, training is limited in terms of how to encourage appropriate care and treatment among MSM and other sexual minorities. Healthcare worker training was identified as a priority intervention to support the provision of essential services for MSM.

Existing strategies in sub-Saharan Africa have until now focused on heterosexual transmission – a decision that the research authors suggest is the wrong approach to ensure successful interventions to thwart the spread of HIV.

The higher biological risks of HIV acquisition and transmission associated with unprotected anal intercourse compared to other forms of sexual intercourse require a more nuanced approach; one study, from Malawi, identified high-risk behaviours within its small sample of MSM including inconsistent condom use (32.5%), transactional sex (23.7%), low exposure to HIV messaging (17.5%) and a low history of HIV testing (58.8% ever tested).

Imprisonment was also identified as a specific high risk factor for transmission of HIV among MSM, in studies originating in Malawi and Swaziland. This was attributed both to the confined setting and the risk of transactional or coercive sex as well as the low availability of condoms and lubricants – commodities that, when used properly together, can help reduce the risk of HIV transmission.

One of the more interesting and intuitive conclusions from the studies related to the complicated nature of identity and self-identification of homosexuality among men in sub-Saharan Africa. Diversity in sexual orientation and practice among men on the continent make self-identification complicated which, in turn, complicates outreach and intervention efforts.

A study from Swaziland elaborated on this concept, with a majority of the sample of participants choosing to identify as homosexual or bisexual, but among them one-quarter of the participants also identifying as female. One third of those included in the study reported having had both male and female sexual partners in the previous 12 months.

The studies also took pains to highlight small victories being made across the continent to address and overcome the marginalization of sexual minorities. Community-based approaches in South Africa have had modest success in reaching marginalized populations with HIV outreach and

prevention services, using peer education and the facilitation of safe social spaces to provide HIV education, address stigma and behavioural risks and link individuals into HIV testing or care. Similar strategies have been used to reach MSM with HIV research, HIV-prevention information, and HIV counseling and testing.

Without addressing this underserved, stigmatized population of MSM in sub-Saharan Africa, the editors concluded, it will be difficult to slow or halt the transmission of HIV. The researchers uniformly argued for better and more complete data about the demographics of the populations of sexual minorities to ensure better targeting of the continuum of care for HIV, beginning with prevention and moving into treatment.

[This article was first posted on GFO Live on 06 January 2014.]

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3. NEWS: Global Fund awards $253.8 million in renewal funding

Largest awards go to Kenya, Somalia and Viet Nam

President The Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria has approved continued funding of up to $253.8 million for 13 applicants in a decision announced on 23 December.

In approving the funding, the Board was acting on recommendations from the Technical Review Panel (TRP) and the Secretariat, including the Grant Approvals Committee (GAC). The largest award went to Kenya ($79.7 million for two malaria grants). See the table for a full breakdown.

Table: Funding Awards for Grant Renewals, from GAC Report GF-B30-ER2

Country	Component	Grant Number	Ceiling ($US million)
Colombia	TB	COL-011-G05-T	1.4
		COL-011-G06-T	2.5
Guatemala	Malaria	GUA-M-MSPAS	10.8
Kazakhstan	HIV	KAZ-H-RAC	7.3
Kenya	Malaria	KEN-011-G13-M	69.6
		KEN-011-G14-M	10.1
MC: MENAHRA	HIV	MMM-011-G01-H	4.3
Peru	HIV	PER-011-G08-H	5.5

Sao Tome & P.	HIV	STP-011-G05-H	1.0
Sierra Leone	Malaria	SLE-M-CRSSL	8.2
		SLE-M-MOHS	20.6
Somalia	TB	SOM-T-WV	36.7
Tanzania	HIV	TNZ-405-G06-H	28.3
Viet Nam	HSS	VTN-O11-G10-S	36.2
Yemen	TB	YEM-911-G07-T	4.2
Zimbabwe	Malaria	ZIM-M-UNDP	7.1
TOTAL			**$253.8**

These amounts are ceilings and represent incremental funding for the grants; final committments could be less. Total budgets may be higher than shown as they include unspent funds from the last implementation period.

Below is a summary of GAC remarks for Colombia, Kazakhstan, MENAHRA, Peru, Sao Tome & Principe, and Zimbabwe. See article 8 for a summary of the separate articles on the renewal funding decisions for Guatemala, Kenya, Sierra Leone, Somalia, Tanzania, Viet Nam and Yemen.

Colombia (TB)

The $3.9 million in incremental funding approved for Phase 2 of two TB grants to Colombia will be used to help the grant achieve: (a) increased detection and treatment success; (b) stronger coordination between TB and HIV services; and (c) improved management of multiple drug-resistant TB. In Phase 2, the focus will be on municipalities with the highest TB incidence. The principal recipients (PRs) for the grants are the national funding for development projects, FONADE, and the International Organization for Migration, Colombia.

Kazakhstan (HIV)

The $7.3 million in incremental funding for the next implementation period of this single stream-of-funding HIV grant to Kazakhstan will be used by the PR, the Republican AIDS Centre in the Ministry of Health, primarily to maintain opioid substitution therapy (OST) in sites where it is already being provided. Expansion of OST across the civil service and introducing into prisons is also forecast under the grant. The GAC said that through various activities, including advocacy, the Global Fund will work with local authorities, the country coordinating mechanism and partners "to ensure the sustainability of the HIV programme in the country after the Global Fund programme ends."

MC: MENAHRA (HIV)

This regional HIV grant is implemented by MENAHRA, a regional network that supports, develops,

and advocates for harm reduction approaches for persons who inject drugs in the Middle East and North Africa. The $4.3 million in incremental funding for Phase 2 of the grant will be used primarily for (a) behaviour change communication and advocacy; (b) community systems strengthening; (c) M&E; (d) operational research; and (e) delivery of harm reduction services. Phase 2 activities will include working with partners to develop population size estimates for countries that have outdated or no data; and implementing outreach programming including OST for people who inject drugs in countries where there are limited or no harm reduction services.

Peru (HIV)

The $5.5 million in incremental funding for Phase 2 of this HIV grant to Peru will be used by the PR, the International Planned Parenthood Federation's Peruvian branch (INPPARES), to intensify efforts to ensure prevention and care for transgendered persons and men who have sex with men (MSM;) and to assist the transgender and MSM communities to implement a joint strategy for the promotion of human rights.

Sao Tome & Principe (HIV)

The United Nations Development Programme is the PR on this $1 million Phase 2 HIV grant to help Sao Tome & Principe significantly reduce the sexual transmission of HIV infection; reduce morbidity, mortality and improve the quality of life of HIV-positive patients, their partners and families, and HIV orphans; and eliminate mother-to-child HIV transmission. Some of the funding for Phase 2 will be used to increase the institutional capacity of the national AIDS programme, the ministry of health and civil society organisations.

Zimbabwe (Malaria)

The $7.1 million in incremental funding for the next implementation period of this single stream-of-funding malaria grant to Zimbabwe will be used by UNDP (the PR) to continue Zimbabwe's work to scale up the provision of long-lasting insecticide-treated nets (LLINs). The GAC said that due to resource constraints, the national malaria control programme had previously focused its efforts to achieve universal coverage of LLINs in 34 high-transmission districts. The programme's ultimate goal is to expand universal coverage to a total of 47 high-transmission districts and to promote consistent high use of LLINs, which could support a shift to malaria pre-elimination in large parts of the country.

The grant underwent an accelerated renewal process – the first implementation period was reduced from 33 months to 21 months – in order to obtain the extra resources for LLINs. The grant is currently rated A1.

Information for this article was taken from Board Decision GF-B30-EDP3 and from B30-ER2, the Report of Secretariat Funding Recommendations. These documents are not available on the Global Fund website.

[This article was first posted on GFO Live on 08 January 2014.]

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4. NEWS: Global Fund Board awards $53.3 million to three more interim applicants

Egypt, Suriname and Tanzania join ranks of interim funding recipients

by The Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria announced its approval of funding of up to $53.3 million for three interim applicants in the transition phase of the new funding model (NFM) on 23 December.

In approving the funding, the Board was acting on recommendations from the Technical Review Panel (TRP) and the Secretariat, including the Grant Approvals Committee (GAC).

This brings to 40 the number of interim applicants to whom funding has been awarded. When the transition phase of the NFM was launched, the Global Fund said that 48 interim applicants had been invited to apply. More approvals are expected in coming months ahead of the full roll-out of the NFM, expected by mid-2014.

Tanzania's award of $51 million for an HIV grant was by far the largest. See the table for the full breakdown.

Table: Interim Funding Awards from GAC Report GF-B30-ER2

Country	Component	Grant Number	Ceiling ($US million)
Egypt	TB	EGY-607-G02-T	2.1
Suriname	Malaria	SUR-708-G04-M	0.2
Tanzania	HIV	TNZ-809-G13-H	51.0
TOTAL			**53.3**

The amounts shown are ceilings; Final commitments could be less.

Below is an overview of the awards for Egypt and Suriname. See a more detailed article about Tanzania's award here.

Egypt (TB)

Most of the $2.1 million in new funding was allocated to health products and diagnostic equipment for use in high-risk groups. The interventions are aligned to the revised National Strategic Plan 2013–2017, which aims to reduce the TB burden in Egypt from an estimated incidence of 17 per 100,000 in 2012 to 13 per 100,000 by 2017. The new funding will supplement an existing TB grant

administered by the National TB Control Programme in the Ministry of Health.

Suriname (Malaria)

Suriname will receive $173,420 to prepare for the pre-elimination phase of malaria. Specifically, the new funding will be used to: introduce a tracking component for malaria testing and treatment; improve data quality; and improve active case detection. The new funding will be added to an existing TB grant, for which the PR is the Ministry of Health, extending it until December 2014.

Information for this article was taken from Board Decisions GF-B30-EDP3 and GF-B30-EDP4 and from GF-B30-ER2, the Report of Secretariat Funding Recommendations. These documents are not available on the Global Fund website.

[This article was first posted on GFO Live on 08 January 2014.]

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5. NEWS: Human rights, women and children, and sexual minorities dominate discussion at African AIDS meeting

ICASA 2013 addressed issues that align with the Global Fund's funding priorities

Since "Now More Than Ever: Targeting Zero," was the theme of the 7-11 December International Conference on AIDS and STIs in Africa *(ICASA 2013)*, urging activists and policymakers not to lose sight of the goal of an AIDS-free generation.

Zambia's first lady Christine Kaseba-Sata offered a keynote address that exhorted special attention be paid to women and young people in the fight against HIV/AIDS in the continent: two key population groups suffering from disproportionate rates of HIV infection.

"Africa must commit itself to ending practices that promote gender violence against women and girls if the goal of ending the AIDS scourge on the continent is to be achieved," Dr Kaseba-Sata said. The availability of contraception supported by targeted outreach to adolescents and young people to explain the importance of safe sexual activity will be critical to the fight against AIDS; the continent cannot afford to ignore that young people are sexually active, she said, and must do more to protect them than condemn them for sexual behaviours.

Dr Kaseba-Sata called for an integration of sexual and reproductive health education into schools around Africa, allowing youths to make informed, rather than risky, decisions.

Other speakers acknowledged the silence that most often accompanies discussions of men who have sex with men and sexual minorities in Africa. Ignoring these populations, which also have disproportionately high infection rates for HIV, comes at a peril for countries and risks undermining the real and legitimate progress being made to beat back the scourge. Entrenched hostility to sexual

minorities that is cloaked in legislation, religion or traditional values must be overcome with dialogue, compassion and understanding, delegates were repeatedly told.

Among the most intimate of the opening remarks were those from Cyriaque Ako, a health activist in francophone West Africa including his native Cote d'Ivoire, who talked about the hostile prejudice he was confronted with on a near daily basis.

Gay men in Africa "need to resist in order to exist", he said. Decriminalization of gay sex in the 38 countries in Africa where harsh penalties, including fines and jail time, are still meted out for homosexual behaviour, is one of the first and best ways to fight the spread of HIV on the continent. Decriminalization will also break the silence that prevents effective outreach to men who have sex with men, rendering many condom and safe sex promotion campaigns ineffective.

The Global Fund has outlined its priorities for funding in sub-Saharan Africa that make clear the importance of outreach to this key population, a position reiterated at ICASA by Mark Dybul, the Secretariat's executive director, at a workshop organized by the Women4GF lobby group.

"We are committed to ensuring that Global Fund money is used for programmes that focus on human rights in the fight against the three diseases. We believe that the rights of sexual minorities should be respected, as key populations hold the key to the effective fight against the pandemic," Dybul said.

[This article was first posted on GFO Live on 17 December 2013.]

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6. NEWS: Global Fund to end funding for HIV services in drug treatment centres in Viet Nam

by The Global Fund will cease funding HIV treatment services operating in compulsory drug treatment centres in Viet Nam.

When it signed an $85 million HIV grant with the country's Ministry of Health in May 2013, the Global Fund said its support for services provided at the drug treatment centres was contingent on the identification by government of an international, independent NGO to monitor conditions in the centres. Human Rights Watch (HRW) and other organisations have expressed concerns about human rights abuses in the centres, including forced labour and inhumane treatment of detainees. (See GFO article)

In mid-December, the Global Fund's director of communications Seth Faison told GFO that the Fund has informed the Vietnamese government it is not prepared to accept its proposed scheme to have the Vietnamese Red Cross visit some of the centres twice a year. "We intend within the next six months to negotiate an exit strategy and to reprogram our funding outside of [the drug treatment] centers,"

Mr Faison said.

The Global Fund has been financing HIV treatment at the centres for about 900 patients, and intends to divert this funding to a similarly sized cohort of patients outside. The Fund is also seeking a commitment from the government that it will fund the treatment of patients inside the centres.

“Given the concerns the Global Fund has expressed about drug detention centers in the past, we believe this will enable the Global Fund to uphold [its] institutional commitment to not funding interventions that infringe on human rights,” Mr Faison said.

The Fund has joined UN agencies and other international organisations in publicly calling for the closure of the centres.

“The Government of Vietnam has repeatedly expressed its willingness to transform and renovate [the] centers into community-based treatment centers,” Mr Faison said. “The ‘renovation plan’ in question has been redrafted seven times and has not yet been approved by the office of the deputy prime minister.”

Mr Faison added that the Global Fund has not yet seen a final version of the plan.

Joe Amon, director of Health and Human Rights at HRW, said that the decision by the Global Fund to end funding inside treatment centres “is the right one.” However, he said, “to date, and even with the promise of millions of dollars of donor funding, not a single detainee has been released, not a single centre has been shut down, and forced labor continues to be the mainstay of drug dependency treatment in Viet Nam. The plan that the government of Viet Nam has proposed envisions 10,000 drug users in compulsory treatment centers in 2020. This is not a plan towards closure. It is the continuation of a flawed, failed and abusive approach to drug use that violates fundamental human rights.”

[This article was first posted on GFO Live on 06 January 2014.]

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7. COMMENTARY: Why the private sector should increase direct funding to the Global Fund

by Njihia Mbitiru

In December 2013, the private sector representative to the Global Fund proudly announced that through a series of campaigns and initiatives, more than $108 million has been raised for the war chest in the fight against AIDS, TB and malaria. This included profits from sales of specifically

branded clothes and other items by Project (Red). What it did not include, however, was any contribution from the telecommunications and mobile phone sector.

This is a tremendous oversight by a sector that has a considerable number of devotees in countries grappling with the economic and health consequences of the three diseases. I can't think of anyone I know who has suffered from tuberculosis, who has contracted malaria, who is infected with HIV, and who *also* hasn't at one time or another owned a mobile phone. The trill of the Nokia or Samsung handset rivals the crow of the rooster in every village I have set foot in, in my native Kenya.

Let's do a rough, back-of-the-envelope calculation based on the Global Fund's estimate of 8.5 million lives saved due to programmes it has supported in 150 countries.

For many people in developing countries, the average cell phone costs between $30-$60, with smart phone technology adding three, or four, or ten times that to the price tag. But conservatively we can say that mobile phone manufacturers have earned about $380 million from those people, even if each of them has only bought one phone in the last 12 years.

Here's another back-of-the-envelope calculation. Amount given to the Global Fund by Nokia and Samsung: $0. That's right. $0. And not to single out these major manufacturers, so amount given by Rim for its Blackberry, or Apple for any iteration of its iPhone? $0. And in some of the countries where they have no shortage of customers, they don't even have to pay taxes.

So what has inhibited private sector support to the Global Fund, which, after all, is billed as a public-private partnership? Some suggest that there has not been enough 'return on investment' for results-oriented private sector companies, meaning that the lives saved methodology used by the Global Fund needs some tinkering to show that it has been and will continue to be the most efficient and best value for money way to fight AIDS, TB and malaria.

Another argument is that companies want to avoid double taxation; they say that money from the public sector that goes to the Fund comes from taxes levied on the private sector. So why should company X, headquartered in say, Germany, contribute directly to the fund after having indirectly done so through the German government's use of tax monies as contribution to the Global Fund?

I consider this to be a dubious argument. Directly supporting the Fund's fight against three diseases that can compromise your customer base seems like a good business practice – both economically and morally. Additionally, it is disingenuous to conflate the paying of taxes and a direct contribution to the Global Fund. Governments exercise discretion in their use of tax revenue. Corporations evaluate investments and then take decisions, which yields returns that are taxed according to legal obligations. Direct contributions to the Global Fund are not legal obligations; they are moral ones.

I would encourage corporations to see contributions to the Global Fund as a crucial investment to ensure their sustainable financial futures.

Think of it this way: every dollar spent on saving lives means a chance for that life to contribute in some way to the economic development of her country, which includes the purchase of goods and

services. Healthy people go to work, earning a living that they use to buy necessities: food, clothing and yes, increasingly, cell phones.

While the private sector should be encouraged to invest more in the Global Fund, the Fund itself also has an obligation to do more to encourage that investment. Until now, policies on private sector engagement have been rather vague.

In its 2009 policy paper *An Enhanced Strategy for Partnership with the Private Sector*, public-private partnership is described as "a less than optimal arrangement" due to the informality of arrangements, ambiguity of partner roles and a lack of clarity on funding technical assistance.

This paper – and the Fund's policies – need revisiting. Private-public partnerships are critical to the future of global development, because of what they can accomplish. The Global Fund must be more imaginative and proactive in developing its relationships with the private sector, and push for increased direct funding of the Global Fund by multinational corporations working in countries where the Fund supports programmes. It's the right thing to do. Corporate social responsibility does not end with promises; it ends with investment in saving lives, and the Global Fund is the right vehicle to invest in the fight against AIDS, TB and malaria.

[This article was first posted on GFO Live on 08 January 2014.]

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8. NEWS: Global Fund's decisions on renewal and interim grant applications

Read about the Global Fund's decision in December 2013 to approve funding for some interim applicants and to renew funding for some grants:

Phase 2 of Somalia TB Grant Will Focus on Case Detection and DOTS

The Global Fund Board has approved a $32.6 million grant to respond to the continued challenges posed by multi-drug resistant TB in Somalia, acknowledging the security and corruption concerns that make health service delivery in the country extraordinarily difficult.

New Funding for HIV Grants in Tanzania Will Reduce the ARV Gap and Scale Up Services to Sex Workers and MSM

Both interim and renewal funding for a total $79 million have been approved to assist in Tanzania's efforts to combat an HIV epidemic that has infected an estimated 1.6 million of the country's nearly 48 million people.

Renewal Funding for TB Grant to Yemen Comes Despite Concerns About Phase 1 Performance and Risks Associated with the Grant

The Global Fund has approved $4.2 million in incremental funding for Phase 2 of a TB grant to Yemen despite concerns about performance in Phase 1 and serious risks associated with programme implementation.

Phase 2 of HSS Grant in Viet Nam Will Scale Up Activities and Tackle Bottlenecks

Phase 2 of a health systems strengthening (HSS) grant worth $36.2 milllion in incremental funding for Viet Nam will scale up activities and address key bottlenecks. The principal recipient (PR) for Grant VTN-011-G10-S is the Ministry of Health.

Case management and procurement top list for Phase 2 of Kenya malaria grants

Kenya will use the bulk of two incremental funding Phase 2 grants worth $79.7 million to purchase and distribute 7.5 million new long-lasting insecticide-treated nets (LLINs), 17.2 million courses of artemisinin combination therapy (ACT) and 21.8 million rapid diagnostic test kits.
Guatemala Aims to Move to Malaria Elimination Phase

Guatemala is trying to move from malaria control to malaria elimination. The Global Fund recently approved $10.8 million in incremental funding for the next implementation period of malaria grant GUA-M-MSPAS, for which the principal recipient (PR) is the Ministry of Health.

Phase 2 of Sierra Leone Grant Aims to Scale Up Malaria Prevention and Treatment

Phase 2 of two malaria grants worth $28.9 million will scale up malaria prevention and treatment programmes in Sierra Leone, which is still rebuilding following a devastating civil war.

Renewal Funding for HIV and TB Grants in Eritrea Will Enable Scale-Up of Services

The Global Fund Board recently approved $24.5 million in renewal funding for an HIV grant and $8.5 million for a TB grant in Eritrea, both administered by the Ministry of Health.

[This article was first posted on GFO Live on 08 January 2014.]

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9. NEWS: Recently published peer reviewed articles that support Aidspan's work

Aidspan is pleased to share three recently published peer-reviewed articles that support our work as monitors of the Global Fund. All conclusions drawn within these academic papers remain the purview of their authors and do not reflect the opinions of Aidspan.

Regional and temporal trends in malaria commodity costs: an analysis of Global Fund data for 79 countries

When a market functions well, commodity prices are determined by the forces of supply and demand, with competition driving prices lower for consumers. Health care markets, however, do not often work this way. Asymmetrical information means that supply of commodities can be interrupted, creating an artificial monopoly that keeps prices high.

In a paper published in the Malaria Journal, authors Frank Wafula, Ambrose Agweyu and Kate Macintyre analyse trends in commodity purchases by the Global Fund for malaria. Procurement data from 79 countries for three malaria-related commodities are analysed to observe time and regional pricing trends.

The authors conclude that global procurement costs vary by region and have declined over time overall, suggesting that at the global level, a mature market for malaria-related commodities is operating. Regional variation, however, requires further attention with routine analysis to identify and correct market insufficiencies.

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Does global procurement and price negotiation through the Global Fund reduce HIV commodity costs?

The Global Fund spends between 40-60% of its annual budget on procurement of commodities for HIV, TB and malaria, necessitating complete, accurate and timely data about price changes over space and time. In a study published in the Journal of Acquired Immune Deficiency Syndrome (abstract can be found here) authors Frank Wafula, Ambrose Agweyu and Kate Macintyre analysed pricing data for three widely used commodities in HIV programmes: male condoms, anti-retroviral drugs (ARVs) and HIV rapid tests.

Comparing costs over seven years from 2005-2012, across regions and between national and a pooled procurement programme run by the Global Fund, the authors observed a generally flat line for pricing of HIV tests and condoms, with price drops noted for ARVs.
To ensure that global pricing for these life-saving commodities continues to decline to ensure greater access over time and across regions, the authors conclude with the need for regular and comprehensive analysis to identify and correct market insufficiencies.
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Responding to health challenges: the role of domestic resource mobilisation

The gap in unmet needs for AIDS and TB is vast and cannot be filled by international donors alone. More domestic investment, either through taxes or levies or more efficient spending of existing resources, is needed to tackle the two diseases.

Governments and donors must collaborate to promote a greater investment at the national level in health programming. If a proposal is sound and attracts external financing, it should be equally sound

for domestic investment. What must follow the 2015 conclusion of the work towards the Millennium Development Goals must be a new era of Domestic Resource Mobilization.

In a paper written by Alan Whiteside and Gavin Surgey, ten recommendations for countries to improve domestic financing to lead to better health are offered by the authors, including for governments to address rigid budgeting practices that make it hard to reallocate revenues toward health.

[This article was first posted on GFO Live on 29 March 2013.]

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AVAILABLE ON GFO LIVE:

The following articles have been posted on GFO Live on the Aidspan website. Click on the article heading to view the article. These articles may or may not be reproduced in GFO Newsletter.

NEWS: South Africa government under fire for failure to end drug stockouts

South Africa's progress in the fight against AIDS has been compromised by continued stockouts of drugs in health facilities nationwide, a national activist group charges.

NEWS: Campaign launched in Uganda to urge China to give more to the Global Fund

A group of civil society organisations in Uganda have launched a campaign to urge the Chinese government to contribute at least $1 billion to the Global Fund.

NEWS: Ethics Official Handles Conflict of Interest Situations and Other Ethical Issues

The Ethics Official deals with matters such as improper conduct by governance officials and potential conflicts of interests.

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This is issue 234 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.

GFO is a free service of Aidspan (www.aidspan.org), a Kenya-based international NGO that serves as an independent watchdog of the Global Fund, and that provides services that can benefit all countries wishing to obtain and make effective use of Global Fund financing. Aidspan finances its work through grants from foundations and bilateral donors.

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

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For GFO background information and previous issues, see www.aidspan.org/page/gfo-newsletter. For information on all approved proposals submitted to the Global Fund, see www.aidspan.org/page/grants-country. People interested in writing articles for GFO are invited to email the Editor, above.

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