Global Fund Observer

NEWSLETTER

Issue 268: 20 July 2015

Independent observer of the Global Fund

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A high-level meeting of global stakeholders took place from 13-16 July in Addis Ababa to develop a strategy to finance the post-2015 sustainable development goals, against a backdrop of donor fatigue, the enduring global financial crisis and a growing insistence on improved domestic financing for development issues. The conference could provide a window into donor attitudes and positions ahead of the Global Fund's 5th replenishment, set for mid-2016.

At the Asia-Pacific partnership forum, civil society and community-based stakeholders emphasized the need for stronger community interventions and a bigger voice for implementers in the new Global Fund strategy. Assurances from the representatives of

the Secretariat that their voices were being heard, however, were met with some skepticism.

3. NEWS: The call to radically change the face of TB in the new Global TB strategy

A radical change is needed in the global strategy to prevent, and manage, tuberculosis if new targets are to be met, participants in an Asia-Pacific consultation session said.

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6. NEWS: South Africa submits $380-million concept note for HIV/TB

South Africa on 15 July submitted a joint HIV/TB concept note for some $380.5 million in funding, more than half of which is to support prevention interventions specifically targeting key populations including young women and girls, men who have sex with men and people living in disease hot spots.

7. NEWS: Watchdog uncovers reasons for ARV stock-outs in Tanzania

Tanzanian NGO Sikika has uncovered the cause of shortages and stockouts of ARVs over 2014, which led to some patients receiving fewer supplies and others having their treatment regimens and medicine brands changed, prompting some patients to experience new side effects. Among the reasons stock management was so poor was a failure to properly implement the Global Fund's pooled procurement mechanism and failure to adhere to government requirements and procedures.

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1. NEWS: At Financing for Development conference, the outlines of a plan to fund the post-2015 development agenda

Lauren Gelfand 17 July 2015

Outcomes of meeting should offer insight into donor postures ahead of Global Fund's own replenishment campaign in mid-2016

A high-level meeting of global stakeholders took place 13-16 July in Addis Ababa to develop a strategy to finance the post-2015 sustainable development goals, against a backdrop of donor fatigue, the enduring global financial crisis and a growing insistence on improved domestic financing for development issues.

Draft outcome documents already under development suggest that the broad lines of a roadmap to finance the sustainable development goals are in place: the fine print, however, including the estimated size of the envelope needed to make a meaningful impact, has yet to be written.

"The Addis Ababa Accord will be evidence of our ambition for the future and our commitment to justice and equality," said Hannah Bowen, director of ACTION, in a statement prepared for the opening of the conference ending 16 July. "Life has improved for many over the last 15 years, but decision makers must come to FFD ready to say how we all – civil society, businesses, governments – will finance continued progress that reaches the poorest and most vulnerable people in our world."

Funding strategies under discussion at the conference are taking a multi-pronged approach to resource mobilization, drawing on public and private funds, both international and domestic, in an attempt to provide a much-needed boost to the development agenda, which has seen investments flatline in recent years, particularly in the countries that need them the most.

Figures released ahead of the conference by the United Nations show that while official development assistance increased to $130 billion in 2013, the share commanded by least-developed countries was in decline. Among the consequences of that decline: the lack of access to at least one basic health service of an estimated 400 million people worldwide.

The Global Fund was one of the multi-stakeholder partnerships acknowledged during the conference as helping to achieve results in the field of health, and was included in the call for enhanced international coordination and enabling environments at all levels to strengthen national health systems and achieve universal health coverage.

Suggestions floated during the lead-up to the FfD conference to provide the "enhanced global support" required for least-developed countries included the across-the-board allocation of 50% of official development assistance and duty-free and quota-free access to markets.

Stringent conditions attached to that aid, however, could mitigate their impact in countries which, despite their fragile economic positions, are loyal to the directives contained in the 2005 Paris Declaration on Aid Effectiveness. Even as there is a notably reduced appetite from donors to provide budget support to developing countries, it remains the preferred vehicle for foreign investment in many countries, a delegate from Tanzania reiterated during one of the conference pre-meetings.

Investment also takes many forms, reminded one African finance minister quoted by the Center For Global Development: it's about jobs, resources and growth – it's not just aid.

Moving away from reliance on aid is also a strategic decision, illustrated by a report on reduced donor appetite for development investment that was released on the sidelines of the event by UNAIDS and the Kaiser Family Foundation. The report found that funding to address HIV in low- and middle-income countries from nine of 14 donor governments assessed either declined or remained flat in 2014.

The report showed that most of the overall increase in HIV support in 2014 was attributable to the UK, which increased both bilateral support and its contribution to the Global Fund.

Garnering considerable attention during the four-day conference were discussions about increased domestic finance, reflecting the changes in the global and regional context and global shifts of economic strength. Participants were reminded that while official development assistance remains both relevant and critical, it will never be enough given the magnitude of the agenda.

Countries have primary responsibility for their own economic and social development, it was reiterated during a series of sessions. And, from a historical perspective, no country has ever developed by relying primarily on foreign resources.

African states, which make up the largest proportion of least-developed countries, have, however been making major strides in mobilizing domestic resources, participants at a Global Fund-organized roundtable on 14 July heard.

In the last four years, African countries in the aggregate have increased domestic resources to respond to HIV by 150%. This has only added to a doubling in global domestic investment

between 2006 and 2011 in national responses to HIV, TB and malaria.

Such increases are likely to be sustained amid a recent acceleration of commitments to universal health coverage from a number of countries following the first African Ministers of Health conference convened in April 2014 in Luanda, Angola.

The conference should provide a window into donor attitudes and positions ahead of the Global Fund's 5th replenishment, set for mid-2016.

"We're looking ahead to the replenishment as one of the first opportunities for countries to show that the Addis Ababa Action Agenda is more than just words on paper," said ACTION's Bowen.

[This article was first posted on GFO Live on 17 July 2015.]

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2. NEWS: The Global Fund that we want: civil society speaks on the need for stronger community-based interventions

Anna Maalsen 10 July 2015

Participants emphasize need for stakeholders to come together as equals

More than 120 people gathered on 23-24 June in Bangkok for the Asia-Pacific partnership forum: the second of its kind convened by the Global Fund to solicit voices from civil society and a range of stakeholders to feed into strategy development for the 2017-2021 period.

The expressed wishes and needs of the implementers representing 20 countries in both the Asia Pacific and Middle East and North African regions were made clear from the keynote statements delivered by Maura Eliarpe and Zakaria Bahtout, two prominent HIV activists in Papua New Guinea and Morocco respectively.

We need to "come together as equals, not as beneficiaries," to foster an environment that "does not leave anyone behind," they said – signature concerns among communities facing the likelihood of transitioning away from Global Fund support and losing the only resource envelope currently available to support programs for key populations and marginalized groups.

But while the concerns and specific needs of key populations are addressed better through the Global Fund ecology than any other existing bilateral or national mechanism, it is not all perfect, emphasized Eliarpe, highlighting feelings of "disrespect" and tokenism that colored the participation and engagement of disease-affected groups in the conversations at national level, even as part of country dialogue.

This feeling, including a sense of being ill-prepared and without the same degree of technical acumen as other participants, meant that even the interventions and activities that have been conceived to target key groups such as people living with HIV, men who have sex with men, sex workers and others, do not fully consider their needs.

One of the most obvious examples is in the consideration of funding to treat opportunistic infections. There is no point in investing in scaling ARV treatment if people are going to be unable to access drugs for Hepatitis C, noted Eliarpe, who has also called for nutrition support – such as multivitamins – for people whose ARV treatment is paid for with Global Fund resources.

Ensuring a gender balance in programs that were aligned to a human-rights approach will be critical to achieving success and the best possible impact of Global Fund-supported programs, participants said during plenary sessions. Steve Krause, the Asia Pacific regional director for UNAIDS, called the Fund's draft strategy ambitious and urged stakeholders to "stay hungry" in order for sustainable impact to be achieved, both operationally and in terms of the legislative environment.

Ninety percent of countries in the region criminalize sex work and 50% make it a crime to be gay, he noted, demonstrating the need to develop a broader advocacy model to engage at policy levels that complements targeted interventions.

The two-day event also afforded participants the opportunity to explore ways to influence the Fund's own structures beyond the development of this next strategy, including governance by a Board whose composition and voting block structure would appear to be at odds with the Fund's purported ambition for universality and community inclusiveness.

Other innovations, such as the inclusion of a strategic objective focused on health and community systems, were well-received, though with caveats that ownership by communities themselves was essential. It is not enough for an objective to be declared at the global level, noted Edgar Vernon Cruz from the Pilipinas Shell Foundation; proper tools must be made available in countries to adapt the objective to the national context and to have it embraced by communities themselves.

Other thematic areas were the subject of small-group discussions on day two; below is a brief summary of some of the main areas of interest:

Tailored approaches to challenging operating environments, sustainability and transition

Group discussions demonstrated the need for more work to define what constitutes a challenging operating environment, as well as greater flexibility from the Fund and a tailored approach to each individual country's particular challenges. Acute crises need a different range of responses than protracted ones do, and the needs in a conflict scenario are different than those in the aftermath of a natural disaster, participants noted. Also important is an approach that responds to how crisis can affect neighboring countries, particularly when large populations are displaced across borders.

Countries in transition would also benefit from a differentiated approach that acknowledges the need to maintain a national platform for state and non-state actors to engage and interact. One of the greatest strengths of the Global Fund approach is that it brings a disparate group of actors to the decision-making table; post-transition the risk is that not only would that group fracture but the table itself would disappear.

Disease-specific priorities and a new allocations methodology

Basing allocation of Global Fund resources only on disease burden and economic classification – with some nebulous and unexplained qualitative factors thrown in – is not only unsound but potentially dangerous, participants said.

The next allocations methodology must be more differentiated, factoring in unmet need, concentrated epidemics and key populations – even in countries where the overall disease burden is declining. Co-morbidities and co-infections are an emerging challenge in Asia Pacific, such as the interaction between Type II Diabetes and TB in Fiji, or the threat that the Hepatitis C virus poses to achieving universal access to HIV prevention, treatment, care and support in Indonesia.

Key priorities outlined by the forum were:

- Better balance between treatment and prevention activities for key populations
- Supporting countries with concentrated epidemics through incentives to "go the last mile and leave no one behind"
- Wider engagement at country-level dialogue beyond traditional health sector partners to match health priorities with state budget allocations

- More of a regional approach to disease elimination that considers other criteria beyond disease burden and individual income

Human rights and gender

Human rights are an emerging priority for the Global Fund at the global level that has yet to be fully articulated in countries. More elaboration is needed about the level of support the Fund is prepared to provide to countries with human rights challenges – particularly those preparing to transition away from Fund support. In those countries where key populations are criminalized, it is critical that the Fund establishes what sort of role it is prepared to play to provide ongoing support to advocacy on behalf of human rights, key populations and women that may have limited sources of alternative funding.

The risk that those advocacy efforts are suspended for want of financial support is great, many stakeholders emphasized. One recommendation centered on the provision of a package of technical support and financial assistance being made available to those countries to improve knowledge and understanding of the removal of legal barriers, to try and improve access to justice as well as education of so-called gatekeepers: the health workers and law enforcement officers who are at times barriers rather than facilitators to access to services.

Discussions of gender were primarily shaped by the need by the Global Fund to move towards real gender programming, inclusive of transgender people, men and boys, while also paying more than just lip service to the particular needs of women and girls. Indicators should be developed to measure equitable gender outcomes, improving gender dimensions in malaria and TB programming and to encourage better attention to gender-based violence in concept notes, especially in crisis settings.

Engaging with, and on behalf of, young people was also promoted as a human rights issue.

Resilient and sustainable systems for health – health and community systems strengthening

Robust and lively discussions around health and community systems strengthening, clearly called for a conceptual shift in thinking: a move away from siloed disease-specific programming towards a holistic systems for health approach. Overwhelmingly, delegates agreed that community and health systems are inextricably linked and that any new strategy from the Global Fund would be incomplete without a policy, process and funding environment conducive to inclusive systems for health models.

Continued investment in data and information systems remains a priority so as to capture much-needed and glaringly incomplete sub-national unmet need and KAPs data. Here, too, the benefit of differentiation and inclusion was emphasized, as different actors in different systems play different roles – and have decidedly different levels of both capability and capacity. When provincial and municipal level health systems rely on paper-based reports that are often hand-carried in plastic bags to central health facilities, the system has to reflect and respond to those limitations, rather than ignore or gloss over them.

In adopting the series of recommendations to be shared at its conclusion, forum participants also highlighted the need for the Global Fund to remain cognizant and contextually relevant outside of sub-Saharan Africa, despite that region being the largest recipient of Fund support and commanding most of its attention.

Participants questioned whether the Fund will be able to accommodate these regional nuances in its strategy and in the development of the allocation methodology for the next allocation period. Others expressed concerns that the Forum itself was an exercise in self-congratulation and was likely to have only negligible impact on the deliberations surrounding the development of the strategy, the broad lines of which have already begun to take shape.

[This article was first posted on GFO Live on 10 July 2015.]

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3. NEWS: The call to radically change the face of TB in the new Global TB strategy

Anna Maalsen 10 July 2015

New targets require a new approach, Asia Pacific stakeholders say

Radical change in the approach to TB prevention, diagnosis and case management is needed if new global targets are to be achieved, participants in a 23 June consultation hosted by the Stop TB Partnership said.

The event, one of several in-person discussions being held alongside Global Fund partnership forums, is part of a new consultative approach being promoted by the Stop TB partnership to

develop its 2016-2020 strategy (see article here).

A draft document in circulation during the day-long event attended by 35 participants outlines a strong and detailed approach to "*bending the curve*" against TB, reflecting the determination to dramatically change the annual decline of new TB cases, which has been stagnating at 1.5%.

This disappointing trend continues despite concerted efforts and good economic growth in many of the countries with high disease burdens, demonstrating the need for new approaches to diagnosis if progress is to be made towards the goal of ending the TB epidemic by 2035.

The strategy centers on ambitious 90-(90)-90 targets:

- Find and diagnosis at least 90% of people infected with TB and place them on appropriate therapy
- Make a special effort to reach at least 90% of the key populations groups: the most vulnerable, underserved, at risk populations
- Reach at least 90% treatment success through affordable treatment services, promoting adherence and social support

The new approach aims to inspire communities, governments and global partners, drawing on some of the successes learned from comparable HIV or vaccination campaigns, invigorating the fight against the world's oldest human disease.

Differentiation at country level

The draft strategy makes a first attempt at defining – and responding – to the different country contexts for the highest-burden countries. Epidemiological factors, health system constraints, and TB socio-economic factors are used to define nine country categories. Due to the size and circumstances for India and China, two of the highest proportional burden TB countries, they are given their own categories. However, despite the nuanced categories, there are still countries, such as those in the Pacific, that do not fit neatly.

For Papua New Guinea, which is facing a challenging emerging drug-resistant epidemic, this could be particularly problematic when trying to access future funding for TB. If countries such as PNG and Fiji do not fit within the country categories of the Global Stop TB Strategy, there are concerns about what this will mean for future donor funding for these programs.

Key populations

The draft strategy also has a a strong focus on reaching key populations.

People who have increased exposure to TB bacilli due to where they live or work	People living in urban slums, contacts of TB patients, or prisoners; Workplaces that are overcrowded, without ventilation, dusty; Healthcare professionals, hospital staff, and hospital visitors.
People who have limited access to quality TB services	People from tribal populations, migrant workers, people who are homeless, women in some rural areas, children, refugees, hard- to-reach areas, fishermen, illegal miners. Old-age homes, homes for people with mental or physical disabilities, or people facing legal barriers to access care.
People at increased risk of TB because of biological or behavioural factors that compromise immune function	People living with HIV, diabetes, or silicosis; people undergoing immunosuppressive therapy, people who are undernourished, smokers, alcohol abusers, or people who use drugs.

Source: http://stoptbplan2020.org/wp-content/uploads/2015/06/Global-Plan-to-Stop-TB-2016-2020_Draft-9-June-2015_.pdf

Key population categorization is not a one-size-fits-all model for countries. The participants strongly recommended that the key population group definitions should not be considered an exhaustive list, but rather an indication of priority groups to be considered at country level. There were very strong recommendations from the group to ensure that adolescents and students were also included as key population groups for TB interventions.

Who pays?

The preliminary costing of the plan was presented based on two scenarios. If the scale-up to reach the 90-(90)-90 targets is completed by 2020, global costs would top out at 9.5 billion USD per annum up to 2020, but would reduce thereafter. A more realistic plan of scale-up by 2025, will require $42 billion over the life of the strategy, and a higher financial need after 2020 than the first scenario. Dr Lucica Ditiu, the executive secretary of the Stop TB Partnership, highlighted the funding issues, noting that “by 2017 there would be a $6 billion funding gap”.

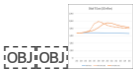

Figure 1: Cost of the Global Plan (Source: http://stoptbplan2020.org/wp-content/uploads/2015/06/Global-Plan-to-Stop-TB-2016-2020_Draft-9-June-2015_.pdf)

Another risk to TB funding comes from the fact that it relies heavily on a single donor: the

Global Fund, which finances 72% of TB programming worldwide. Of the remaining 28%, 83% comes from domestic resources. With 50% of the world's TB burden in the BRICS (Brazil, Russia, India, China, South Africa) countries, it is clear that more money needs to be found locally, even to maintain current diagnosis and treatment levels.

Two clear themes emerged from the Bangkok consultation: how to highlight the paradigm shifts in TB control and how to expand the role of the private sector in carrying out that shift. Changing attitudes and action begins with a change in the narrative – moving away from TB control to TB eradication and shifting the focus from saving lives to stopping transmission.

Meanwhile, more attention should be paid to bolstering private sector engagement in TB, through fostering innovation and incentives. Participants highlighted that the days of top-down government models with limited private sector engagement were over; the time is nigh for a collaborative model. This will require greater integration of TB with other health programs in private service delivery. Success will depend on an environment that is more accepting of revenue generation in social business models, such as the one being used in Pakistan where increased GeneXpert testing in the private sector is combined with lung health and diabetes care..

Future consultative processes would do well to adopt some of the elements of the Stop TB strategy development. In providing the draft strategy in advance, the Secretariat ensured that participants were well-informed and thus able to fully engage in discussions. However, the inclusiveness only went so far. Despite a diverse mix of private sector, civil society, parliamentarians, donors, TB patient and advocacy groups, that there was no representation from the any of the Pacific countries in the Western Pacific Region. The consequence is countries like PNG are at risk of facing rapidly developing drug-resistance TB epidemics that could threaten gains elsewhere in the region without adequate levels of support because the simply do not fit the definitions outlined in Global Strategies.

The Stop TB Partnership has made the draft strategy available online for comment and consultation until 10 August. Regional consultations are also planned for Istanbul in late July and Buenos Aires in September. The resulting Global Plan to Stop TB 2016-2020 will be launched at the 46th World Union on Lung Health in Cape Town in December 2015.

[This article was first posted on GFO Live on 10 July 2015.]

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4. NEWS: Georgian concept note priorities reflect national strategies, WHO says

Tinatin Zardiashvili 17 July 2015

More must be done to improve case detection rates in both HIV and TB in order to improve health outcomes

Georgia's concept notes for both HIV and TB are closely reflecting the priorities identified in their national strategic plans, a recent WHO evaluation has found, but must ensure that more interventions focus on improving case detection rates for the two diseases.

The country submitted its HIV proposal in April and its TB proposal on 15 July, in anticipation of disbursement of the country allocation of $56.4 million. The HIV concept note is proceeding to grantmaking, while the TB proposal will be reviewed in the next window by the Technical Review Panel.

The HIV concept note prioritized interventions targeting key populations. Georgia's HIV burden is concentrated in key affected populations, such as people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW). Conducting representative surveys of PWID has been challenging, resulting in estimates of HIV prevalence ranging fom 0.4 – 9.1%. Among MSM, infection rates rose to 10% in 2012 from 7% two years earlier.

Improved care and treatment for people living with HIV was also identified as a top priority. There are currently 3,714 registered cases of HIV in Georgia – yet estimates included in the NSP (for 2016-2018) suggested the number of infections was nearly double that figure, at 6,580, suggesting that more than 40% of the target community is unaware of their status.

Among the recommendations included in the WHO review of the HIV program was the need for tandem testing with Hepatitis-C, which could significantly increase the number of tests administered to key populations. Georgia has one of the world's highest rates of Hep-C infection, also concentrated among key populations. In a new pilot program sponsored by Gilead Pharmaceuticals, free testing and treatment will be made available to at-risk groups. Those who enrol in the program will also be tested for HIV, which will help to improve HIV case detection rates.

The approved HIV concept note aligned with review recommendations to emphasize leadership, governance and advocacy to open policy discussions on health and social issues to a wider complement of institutions. This would include reinforcement of the Ministry of Labor,

Health and Social Affairs as a leader in HIV-related policy debates, and better-definition of the roles of HIV partnership members including the National Center for Disease Control and Public Health: a principal recipient under the new HIV and TB grants.

Also at the heart of the concept note is more concerted engagement with the private sector – particularly in terms of sensitizing health service personnel to reduce stigma – which is in line with recommendation of WHO evaluators. Some 95% of health facilities in Georgia are privately operated.

Loosening the currently restrictive policy environment would also contribute to an improved outlook on the expansion of harm reduction including OST and needle and syringe exchange programs. The HIV CN envisions scaling these programs both geographically and in terms of reducing structural barriers to access to existing programs, such as the currently banned "take-home" practice.

In the TB portfolio, the WHO review noted that control activities beginning in 2016 align closely with recommendations made in 2014 during a high-level WHO mission. Among these are improved case detection, treatment adherence and success rates; MDR/XDR treatment; and the strengthening of the TB control system, which suffered under the rampant privatization of health care facilities including TB outpatient services in 2012.

Widening the space for civil society to participate in decision-making for TB will continue to be a priority in Georgia, as it is relatively immature compared to civil society engagement in HIV. How this will translate beyond the life of the Global Fund's engagement in Georgia, however, remains to be seen. The state already covers more than half of the national outlay on TB, including, by late 2015, the entire cost of first-line TB medication. According to the NTP notifications data, a total of 3,850 TB cases (all forms and including penitentiary sector), were registered in the country in 2014, rougly 103 per 100,000.

While Georgia can rely on Global Fund support through 2018 for its TB program, there is a risk that a funding gap will accompany the presumptive end of Fund grants in 2019. There are growing concerns that the spread of MDR/XDR TB and the growing disease burden will strain existing TB budgets, leaving a gap in some elements of the program. Collaborative work has begun between the CCM and MolHSA to plan the transition to avoid any vacuum in access to TB diagnostics and treatment.

The HIV program review was performed in March 2015 prior to the submission of the concept note, aiming to review the key components of the program and the draft NSP for 2016-2018. An extensive review of TB prevention, control and care system in Georgia was done in

November 2014 to inform the development of both the NSP and the TB concept note. The reviews are expected to be published by the WHO in coming months; near-final drafts were shared privately with Aidspan.

[This article was first posted on GFO Live on 17 July 2015.]

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5. NEWS: Burundi crisis demonstrates need for flexible health systems

Aurelie Fontaine 10 July 2015

No stock-outs reported but extent of defaulting on treatment as yet unknown

Violent clashes between demonstrators and security forces in Burundi sent tens of thousands of people fleeing both inside and beyond the borders of the central African state. These displacements were only one consequence of the crisis in the capital that stretched the capacity of an already-strapped health system: demonstrating a need for flexibility in resourcing in so-called challenging operating environments.

"Health centers have been confronted with an increase in demand for drugs and treatment, without being prepared for it," said Ferdinand Niyonzima, deputy head of the health promotion program for Caritas Burundi: a principal recipient of Global Fund resources for malaria and a sub-recipient for HIV.

"Others are taking refuge in the interior of the country, and the same problem is presenting itself in those health centers. Fortunately we have a small stock of ARVs and drugs for opportunistic infections. Once the situation calms down, we will re-stock."

The situation in Burundi illustrates the need for flexibility in Global Fund grants, in order that implementers are able to adapt rapidly in the case of crisis. A 2014 report from the Fund's TERG (article here) provided a series of recommendations for flexibility in grantmaking to ensure that service providers – like Caritas Burundi – are able to respond to, rather than be compromised by, changes in the prevailing political environment in their countries of operation.

Burundi's crisis, though short, was a textbook example of how a system can be compromised in

an instant by an acute shock. In the capital, health workers fearing violence stayed home rather than go to work, leaving facilities understaffed and patients deprived of access to their medications.

In order to prevent a widescale problem, demonstrators and the health ministry collaborated to ensure that no harm would come to personnel trying to access hospitals and health facilities. When necessary, vehicles were made available to transport employees to and from home, said Thaddée Ndikumana, director of the national TB program (PNLT).

In a report sent to the Global Fund, the national AIDS commission (CNLS) also said that efforts were being made to ensure continuity of service when conditions permitted, although staff were at times blocked at home in neighborhoods where demonstrations were being held. Some staff didn't make it to work; others arrived late.

Outreach and prevention activities that were planned for secondary schools and universities were postponed and work that was to have been done with local media partners was also delayed, since some of the media houses were shuttered, the CNLS report said.

The crisis also had an impact on disbursement of Global Fund grant money. "We have been waiting since March for around $2 million, but when the crisis erupted, the Fund told us that a decision was made to limit the amount being disbursed to principal recipients," said Ignace Bimenyimana.

Several epidemiological studies that were to begin in April were also postponed, including a nationwide facility-level study of the effectiveness of anti-malarial drugs, as well as another demographic health survey (DHS) measuring key malaria indicators. "Study investigators have had difficulties going to work, organizing planning meetings and preparing for field work. Some of our international partners have also repatriated their expatriate staff, which also complicates things," said Bimenyimana.

Fortunately, however, there were no stock-outs of the drugs used to contain the epidemics, and the health system, despite delays and staff shortages, continued to function. Noted Ndikumana of the TB program, only three of the 45 health districts in Burundi are in the capital.

The supply chain to other parts of the country, too, continued to function. While one route out of the capital towards the south normally passes through the troubled Musaga neighborhood, which remains a flashpoint for confrontation between demonstrators and police, it was possible to avoid the area and continue trucking medicine elsewhere in the small country. Stock orders continued without noticeable interruption; 75 of the 90 facilities that were to make orders in

May for HIV-related commodities were able to do so, the CNLS report said, and all deliveries were made on time.

Burundi remains locked in poltiical crisis – and the continued lack of dialogue has evoked concerns. Niyonzima said that all of the Burundi PRs are warning of the same potential consequences: "if the situation persists, the health system will be affected – especially if the crisis reaches the interior provinces," he said. "This will have consequences on access to health, and medical stocks."

[This article was first posted on GFO Live on 10 July 2015.]

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6. NEWS: South Africa submits $380-million concept note for HIV/TB

Gemma Oberth 17 July 2015

Emphasis on prevention could make Global Fund single largest investor in targeted programming for key populations

South Africa on 15 July submitted a joint HIV/TB concept note for some $380.5 million in funding, more than half of which is to support prevention interventions specifically targeting key populations including young women and girls, men who have sex with men and people living in disease hot spots. Of this, $142.2 million constitutes an above-allocation request.

The proposed slate of interventions would position the Global Fund as the single biggest investor in key populations programming in the country, complementing the government's annual budget for its High Transmission Areas program ($9.3 million/year), and the PEPFAR/USAID budget for DREAMS, inmates and other key populations ($51.5 million/year).

The remainder of the funding would support improvements in quality of care through high-impact interventions that focus on gender-based violence, stigma, treatment adherence and strengthening health and community systems, supporting multi-sectoral work by the government of South Africa.

South Africa embraced good practice for an inclusive country dialogue. Health Minister Aaron Motsoaledi joined a prioritization discussion at the CCM in March, and consultations included a wide range of constituencies. A series of smaller technical consultations was led by South African National AIDS Council (SANAC): a coordination and oversight body that deliberately does not take funding from the Global Fund. The CCM also published a Civil Society Priorities Charter, as well as a Key Populations Supplement: important guiding documents for the prioritized interventions in the concept note.

Brian Kanyemba, a civil society representative for the LGBTI communities in the country coordinating mechanism (CCM), drove the development of the Key Populations Supplement.

"Key populations are too often ignored and stigmatized, or patronized in trials and studies, rather than being truly engaged in solutions to the epidemic," said Kanyemba.

While the final concept note was indubitably strengthened by the extensive consultations, it bore a high cost: three times higher than development of proposals under the rounds-based system.

The decision to focus on key populations and specific geographic hot spots was informed by emerging evidence supporting a more targeted approach to HIV and TB resource distribution in South Africa. Preliminary results from a first geospatial mapping show that there are clear hot spots and cold spots within provinces, and that a district-based approach that strategically saturates hyper-endemic hot spots (which could be as focused as $16km^2$ sub-districts) is a more efficient method.

Preliminary results from South Africa's recent Key Populations Size Estimate further highlight geographic areas with higher numbers of certain vulnerable people. This is the first survey estimating the distribution of transmen as well as transwomen in South Africa, providing important data on where efforts should be focused to reach these groups.

Other recent evidence from South Africa's People Living with HIV Stigma Index, launched at the South African AIDS Conference in Durban in June 2015, provided strong rationale for the inclusion of this critical enabler in the concept note. The results from the survey in 18 districts show that 43% of the more than 10,000 respondents reported having feelings of internalized stigma, and 31% blamed themselves for their HIV status. Feelings of being unclean or dirty in relationship to a TB diagnosis were reported by 27% of survey respondents.

The country's recent Investment Case also revealed which activities were the most cost-effective. Adherence clubs emerged as one of the only money-saving interventions, with the potential to reduce HIV treatment spending by 13%. Further, the Investment Case highlighted the need for South Africa to dramatically increase funding for antiretroviral therapy (ART). Government is bearing an increasing proportion of the cost for ART, with Global Fund support

filling the gap. Supporting the request for ART are also requests for strategic investments in health systems strengthening, including procurement and supply chain management, and monitoring and evaluation. There is also the intention to introduce a unique patient identifier system, to improve treatment monitoring.

In addition to offering a comprehensive package of services to key populations in targeted districts, South Africa has also presented innovative activities for consideration for incentive funding, including mobile smartphone applications and sustainable finance mechanisms.

The broad slate of innovative and highly targeted interventions are not without potential hurdles. There are eight principal recipients (PRs) proposed in the concept note, which poses a significant coordination challenge. To mitigate this, there has been concerted effort in the early stages of planning to clearly articulate PR responsibilities by geographic location and by expertise. The country submitted prioritization maps as an attachment to the concept note, which delineate PR accountability for each program element in each priority district, by implementing partner.

There are also challenges associated with the sheer size of the HIV and TB epidemics in South Africa, which add an element of risk to the success of most interventions. South Africa is home to the greatest number of people living with HIV globally (at 6.4 million people), and has the third largest TB burden (next to India and China). The country has set ambitious targets, aiming to screen nearly 7 million people for TB in the next year and have 7.5 million people on ART by 2019.

“The resulting concept note is a well-balanced proposal that supports the very ambitious treatment program that has made South Africa a world leader in the AIDS response,” said Dr. Fareed Abdullah, CEO of SANAC. “The program also scales up interventions for previously neglected key populations such as sex workers, men who have sex with men, transgender women and men, people who inject drugs and prison inmates, to levels that will have a national impact."

[This article was first posted on GFO Live on 17 July 2015.]

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7. NEWS: Watchdog uncovers reasons for ARV stock-outs in Tanzania

Angela Kageni 20 July 2015

Poor implementation of the Global Fund's pooled procurement; weak communication and coordination by national agencies cause ARV stock-outs

Tanzanian NGO Sikika has uncovered the cause of shortages and stockouts of ARVs over 2014, which led to some patients receiving fewer supplies and others having their treatment regimens and medicine brands changed, prompting some patients to experience new side effects. Among the reasons stock management was so poor was a failure to properly implement the Global Fund's pooled procurement mechanism and failure to adhere to government requirements and procedures.

The report also uncovers contradictory perceptions by country level actors; development partners blame weak government systems, and the government blames the Fund's PPM.

Tanzania has been a member of the PPM since 2013. It enrolled voluntarily to purchase commodities across all three disease components and to benefit from reduced product and agency costs, overall savings, shorter lead times, and fewer requirements. However, increased challenges within the procurement system, inadequate procurement management and poor communication and coordination between responsible procuring implementers and government agencies have meant that the country is now mandated to participate in the PPM.

Sikika found that the usual effectiveness of the mechanism was hindered by delays in product delivery from the manufacturer level. Also delayed were the re-registration of expired licenses for the required ARVs by the Tanzania Food and Drugs Authority (TFDA). Anothing contributing factor was a global shortage in the market during the same time.

"The GF had high expectations of early deliveries but several procedures from different institutions had to be followed before final deliveries were made," the Ministry of Health and Social Welfare (MoHSW) said in the report.

Some stakeholders attributed the stockouts to what they consider to be Tanzania's reliance on donor money. Members of parliament have urged a greater government commitment to HIV to cover such emergencies. Between the Global Fund and PEPFAR, 86% of the total budget for HIV/AIDS in Tanzania is covered, with the Fund primarily responsible for purchase of ARVs.

Using data obtained from routine monitoring of health facilities, the researchers examined the availability of medicines in seven regions in Tanzania, including Dar es Salaam: the country's largest city.

Stockouts meant that facilities were unable to give patients their routine supplies, for example reducing someone's drug supply from two months to two weeks. Others had their treatment regimens and medicine brands change. The risk of these kinds of modifications is reduced adherence and new side effects. Sikika confirmed from patients that these changes are widespread and are forcing patients to use regimens they had discontinued due to side effects. As a result, some are experiencing new side effects such as dizziness, high blood pressure and a drop in CD4 count.

The organization will use the report's findings to advocate for increased and more constant availability and accessibility of medicines and medical supplies in the country's health facilities.

The PPM was introduced in 2007 and now controls procurement of commodities worth $1.2 billion annually. Direct control of procurement is predominantly limited to high-risk countries. Although largely voluntary, PPM is made a requirement for countries with weak procurement systems.

[This article was first posted on GFO Live on 20 July 2015.]

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