Independent observer of the Global Fund

# Global Fund Observer

NEWSLETTER

Issue 289: 08 June 2016

GFO is an independent newsletter about the Global Fund.

GFO Live >> | Aidspan Website >> | Contact GFO >>

## CONTENTS OF THIS ISSUE:

5. NEWS: Advocacy brief for UN High Level Meeting says The Global Fund and key populations are delivering results

An advocacy brief published by the Global Fund Advocates Network describes the vital role that key populations and vulnerable communities play in advancing results through Global Fund investments. The brief is targeting the people involved in the 2016 High Level Meeting on Ending AIDS on 8-10 June.

6. NEWS: Georgia NGO responds to large increase in HIV among MSM

Technical assistance from The Global Fund's Community, Rights, and Gender initiative is being used to help LGBT Georgia respond to an alarming increase in HIV among men who have sex with men.

7. NEWS: Funding of $164 million approved for 13 grants in 11 countries

In May 2016, the Global Fund Board approved another tranche of funding from the 2014-2016 allocations. In addition, funding was awarded to a shortened grant to permit services to continue to be provided through to the end of 2017.

## ARTICLES:

### 1. ANALYSIS: More is known about the impact of the new allocation methodology

*EECA's allocation will be cut in half; Southern Africa's share will increase 50%*

Gemma Oberth 7 June 2016

In April 2016, the Global Fund Board approved a new allocation methodology for the period 2017-2019 (see GFO article). While the formula for deciding how much money each country gets has not changed dramatically, there are several noteworthy instances where specific regions and disease components will receive significantly more money – or significantly less money – in the next grant cycle.

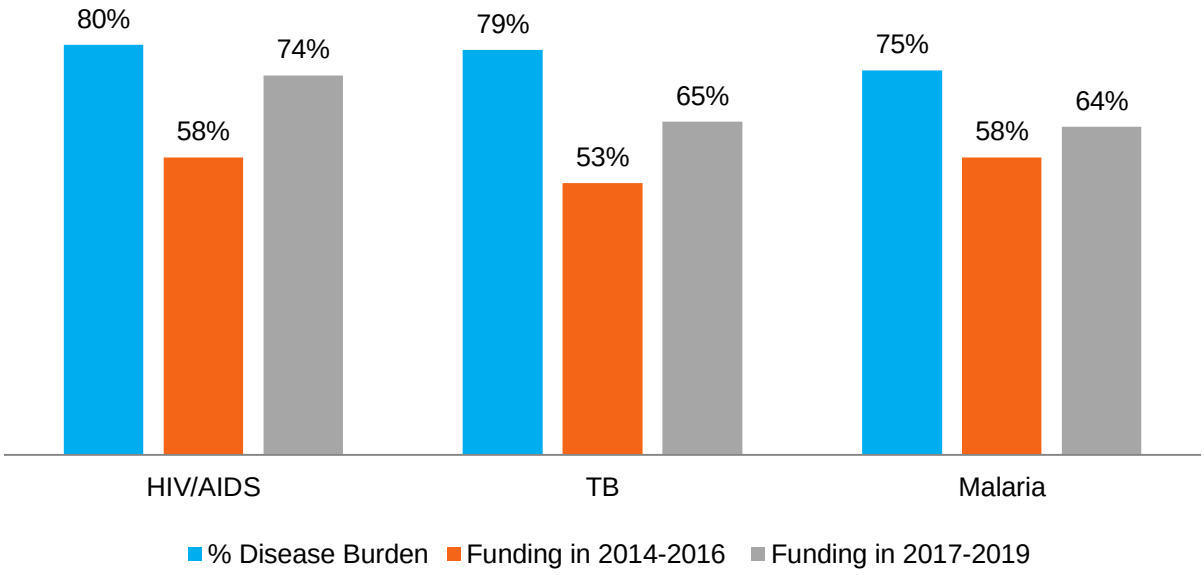
There are serious implications for countries about to receive less funding, most of which are in Eastern Europe and Central Asia (EECA), and in Latin American and the Caribbean (LAC). The changes also raise issues concerning absorptive capacity and the availability of technical assistance for counties that are about to receive significantly more money, most of which are in Africa.

The main difference with the new allocation methodology is that greater priority is given to low-income/high-burden countries. One repercussion of this is that low-income countries are the only grouping that will receive a proportional increase in 2017-2019. These countries will be allocated 44.3% of total Global Fund investment in 2017-2019, as compared to 41.9% in 2014-2016. Lower-middle-income countries will receive slightly less – 41% compared to

42.1%. So, too, will upper-middle income countries – 7.5% compared to 8.0%. Beyond allocation funding – i.e. catalytic funds for multi-country grants, strategic initiatives, etc. – will also be funded to a slightly lesser degree: 7.2% compared to 7.8%.

Another repercussion of the increased emphasis on low-income/high-burden countries is that countries with severe or extreme burdens of HIV, TB, or malaria are about to receive a significant boost. Indeed, the new allocation methodology brings funding closer in line with disease burden (Figure 1). The biggest proportional increase will be for the top 15 countries most affected by HIV.

**Figure 1 Implications of new allocation methodology for funding to the top 15 high-burden countries, by disease**




As a result of these changes, there will be:

- a 30% increase for sub-Saharan African countries with the highest HIV infection rates in women and girls;
- a 25% increase to the top 28 countries affected by multi-drug-resistant TB (MDR-TB); and
- a more than 10% increase for countries with extreme or severe malaria burden, and a more than 10% increase for malaria for all sub-Saharan African countries.

At a regional level, also, there are some important funding changes about to take place as a result of the new allocation methodology. The table below highlights the proportional changes in allocation by geographic region. Overall, four regions will receive an increase and four will receive a decrease.

**Table 1: Changes in proportional regional allocations for 2017-2019, as compared to 2014-2016**

| Region | Proportional allocation for 2014-2016 | Proportional allocation for 2017-2019 | Change in proportional allocation |
|---|---|---|---|
| East Africa | 21.0% | 22.1% | + 1.1% |
| Southern Africa | 15.1% | 22.2% | + 7.1% |
| West and Central Africa | 20.6% | 19.7% | - 0.9% |
| Middle East and North Africa | 8.3% | 5.7% | - 2.6% |
| South Asia | 10.7% | 10.9% | + 0.2% |
| Latin America and the Caribbean | 3.5% | 2.0% | - 1.5% |
| Eastern Europe and Central Asia | 4.7% | 2.4% | - 2.3% |
| East Asia and the Pacific | 8.3% | 8.9% | + 0.6% |

We do not yet know what the actual dollar amounts will be for each country for 2017-2019; The Global Fund is expected to announce these envelopes by the end of 2016. The amounts will depend, of course, on how successful the Fifth Replenishment is. The Global Fund has set a target of $13 billion. Secondly, the change in dollar amounts from the last cycle to this one will vary depending on levels of existing in-country funding. Existing funding was included in the 2014-2016 allocation totals.

The biggest shock will be felt be the EECA region, where proportional Global Fund investment will shrink by nearly half. The expectation is that countries in this region can and should be funding their disease programs by themselves to a greater degree. But, many have argued that transitions from Global Fund support to domestic reliance in the region have not been managed responsibly. “In five years’ time, ten years’ time, someone will need to start from scratch,” warns Anna Dovbakh, with the Eurasian Harm Reduction Network. “You can’t transition at the snap of a finger.” The EECA position document for the HLM echoes these sentiments.

Compounding the transition anxiety in EECA, a new global update release by UNAIDS in advance of the High Level Meeting (HLM) in New York shows that the number of new HIV infections in the EECA region grew by an alarming 57% between 2010 and 2015. This is in the context of (slightly) decreasing incidence, globally, over the same time period. The EECA region also has the highest rates of MDR-TB in the world. The growing disease burden, paired with tapering Global Fund investment, has many people predicting a looming crisis for the region.

The only other region in the world where new HIV infections are on the rise is in the Middle East and North Africa (MENA) (albeit by a much smaller proportion than in EECA). Here, too, the Global Fund will shrink allocations for the next three years.

In a recent survey conducted by the International Treatment Preparedness Coalition in the MENA region (ITPC-MENA), 47% of civil society organizations report reliance on The Global Fund to run the bulk of their programs. According to Mohamed Msefer, ITPC-MENA’s Regional Director, the new allocation methodology could spell disaster for an

already struggling local civil society, especially groups representing key populations. "We observe that in Algeria and Mauritania, individuals from key populations refuse to run for elections in CCMs [country coordinating mechanisms] from fear of stigmatization, even legal trouble. In Algeria we have observed a serious lack of cooperation between civil society groups," Msefer told GFO. "This decrease from the Global Fund will make it that much harder to achieve progress in a region already beset by stigmatization and criminalization of key population, war, conflict, and massive migration." ITPC-MENA is the host of the regional platform for communication and coordination for the MENA region, as part of the Global Fund's Community, Rights, and Gender special initiative.

(All of these figures in this article refer to initial allocations. Qualitative adjustments to the initial allocations could result in some minor changes to how the allocations break out.)

*Information in this article comes from a presentation delivered by the Global Fund at the Experts Group Meeting of Communities & Civil Society on The Global Fund Strategy 2017-2022, hosted by the Communities Delegation and GNP+ on 10-11 May, in Amsterdam. A copy of this presentation is available from the author on request (gemma.oberth@gmail.com). A copy of the ITPC-MENA survey is available on request from ITPC-MENA Regional Director, Mohamed Msefer (mohamed.msefer@itpcmena.org).*

TOP

---

## 2. COMMENTARY: The Global Fund should align its catalytic investments with global targets for malaria elimination and eradication

Rima Shretta and Erika Larson 7 June 2016

In 2015, the World Health Organization (WHO) reported that among the 106 countries with malaria transmission in 2000, more than half had achieved at least a 75% reduction in new cases. The Global Fund's investments have been, and continue to be, a key driver of this success. Dedicated funding for malaria has dramatically reduced the malaria burden and sustained these reductions. Future investments could continue this positive impact: the 2017-2022 Global Fund Strategy aims to achieve progress toward a world free of the burden of HIV/AIDS, tuberculosis, and malaria. To attain such a vision, investments in malaria must fully align with the WHO Global Technical Strategy for Malaria that seeks to eliminate malaria in at least 35 countries by 2030 and prevent re-establishment in malaria-free areas. The WHO estimates that 21 countries are in a position to achieve malaria elimination by 2020.

The Global Fund Board recently approved a revised methodology for its 2017-2019 allocations. Similar to the current methodology, a formula based on disease burden and income level will be used to calculate the initial country allocations for each disease. These initial allocations will be adjusted by a series of qualitative factors which have yet to be determined, but which may include willingness to pay, past program performance, and absorptive capacity.

The formula-based allocation is problematic for countries that are on the trajectory to eliminate malaria. By definition, these countries have lower disease burdens, and many are middle-income countries and are therefore marginalized by the formula. The Strategy, Investment, and Impact Committee (SIIC) of the Global Fund – now called the Strategy Committee (SC) – has proposed using malaria burden data from 2000 to avoid punishing successful countries that have recently reduced malaria incidence. However, in many of the countries that have substantially lowered their case burden – such as Bhutan, Guatemala, Indonesia, and Lao PDR (see Lancet article) – the decline in cases began before 2000 and, with respect to Indonesia, cases actually increased after 2000. Therefore, using burden data from 2000 does not adequately address countries' needs to reach zero and prevent reintroduction.

The Global Fund has historically allocated about 7% of its portfolio to malaria-eliminating countries, but under the current funding model, the Global Fund now allocates about 5%. In this current allocation period, 2014-2016, it was estimated that the eliminating countries would experience a 31% decrease in national allocations – a serious shortfall at a time when maintaining the gains and achieving elimination are in sight. Although most national governments in eliminating countries provide nearly 80% of funding for malaria efforts, The Global Fund's investments often fill a critical gap in providing access to care to high-risk populations, otherwise not supported through domestic efforts. The consequence of under-funding eliminating countries could result in costly and deadly resurgences, backsliding on the progress made with previous investments.

Notwithstanding its focus on high burden countries, The Global Fund has the opportunity to work with partners in achieving the global malaria elimination targets. First, The Global Fund should apply cogent qualitative adjustments in a transparent manner to demonstrate that it will not abandon countries that have used resources wisely and worked hard to drive down malaria. For malaria, this would mean including adjustments such as malariogenic potential, or the potential of introducing new malaria cases. This could be used as an important qualitative factor for malaria-eliminating countries that, despite having low transmission, are at high risk of having malaria surges. Second, The Global Fund should align its additional catalytic investments to support two focus areas in the fight against malaria that would otherwise be under-funded in the current allocation methodology:

1. countries with the potential of eliminating malaria by 2020; and
2. areas of multi-drug resistance in the Greater Mekong Subregion.

What could these two catalytic investments look like? Investing in countries that can eliminate malaria in the next five years will require a shift from funding mostly malaria commodities, like long-lasting insecticidal nets and malaria treatment, to investing in surveillance systems that are the cornerstone of an elimination program and often require intensive training, information technology, and human resources. Robust surveillance provides programs with an understanding of the gaps in tackling malaria – particularly among high-risk populations – as well as information about where to smartly target interventions.

The Global Fund's malaria elimination systems investments are central in its new strategy framework under the second objective to "build resilient and sustainable systems for health"

as well as a key pillar of the WHO Global Technical Strategy. Such an investment would also be an investment in health security. This is particularly true in the Greater Mekong Subregion where artemisinin resistance, according to the WHO, is a regional public health disaster and "the spread or independent emergence of artemisinin resistance in other parts of the world could pose a major health security risk as no alternative antimalarial medicine is available" (source: here). The Global Fund's investments in surveillance could extend beyond malaria and help fortify a rapid response against other emerging infectious diseases.

The incremental financing required to support these systems is relatively small. In Sri Lanka, the prevention of re-introduction program has a cost of about USD 0.50 per capita with a very compelling return on investment of 13 to 1. On the other hand, if the country's malaria program stumbled because of a funding gap, the country would lose out on an estimated $170 million in lost economic output over five years.

When considering global malaria goals and trends, it is tempting to view low burden countries as low priority. This is a serious mistake. Success in these countries is a crucial step towards eventual success in higher burden countries and, ultimately, success in realizing a malaria-free world. While the allocation formula is here to stay for the next allocation period, the SC at its meeting in mid-June needs to ensure transparency in The Global Fund's application of qualitative adjustments and secure previous investments by agreeing to a focus on malaria elimination in its catalytic investments. This would be a game-changer for countries that are pushing the boundaries of what we thought was possible.

*Rima Shretta and Erika Larson are with the Global Health Group at the University of California, San Francisco.*

TOP

## 3. ANALYSIS: Update on the second wave of regional concept notes

*Applicants note improvements in the process,*
*but observe that some challenges remain*

Charlie Baran 7 June 2016

Applicant experiences in the second wave of regional concept notes (RCNs) improved over last year, but challenges remain for the process.

The second and final window for RCNs closed on 1 February 2016. Fifteen RCNs were submitted this year. Each RCN was preceded by the submission of an expression of interest (EOI) in April 2015, and a subsequent invitation from The Global Fund to develop and submit a complete RCN. Applicants received the results of the Fund's assessments of the concept notes in April and May 2016 and are presently in the process of grant-making. The table below provides a list of approved concept notes.

**Table: Regional concept notes approved in the second window**

| Applicant | Countries | Comp. | Description |
|---|---|---|---|
| **SUB-SAHARAN AFRICA** | | | |
| Alliance Nationale Contre le Sida (ANCS) * | Burkina Faso, Cape Verde, Cote d'Ivoire, Guinea-Bissau, Senegal | TB + HIV | Harm reduction for people who inject drugs |
| Handicap International (HI) | Burkina Faso, Cape Verde, Guinea-Bissau, Niger, Mali, Sénégal | HIV | Human rights promotion, removal of legal barriers, and supportive services for people with disabilities |
| Intergovernmental Authority on Development (IGAD) | Djibouti, Ethiopia, Kenya, Somalia, Sudan, South Sudan, Uganda | TB + HIV | Improving access to HIV and TB services in key border areas, including refugee camps |
| International Treatment Preparedness Coalition - West Africa (ITPC-WA) * | Benin, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Senegal, Sierra Leone, Togo | HIV | Increasing access to ARVs through community monitoring and CSS |
| MOSASWA Cross-border initiative | Mozambique, Swaziland, South Africa | Malaria | Malaria control in South Africa and Swaziland through zone of malaria control with Mozambique |
| **ASIA** | | | |
| Australian Federation of AIDS Organizations (AFAO) | China, Indonesia, Malaysia, Philippines, Thailand | HIV | Key populations and civil society support for transitioning countries |
| India HIV/AIDS Alliance * | Philippines, Thailand, Vietnam, Indonesia, India, Cambodia, Nepal | HIV | Increasing access to harm reduction services for people who inject drugs |
| Youth Leadership, Education, Advocacy and Development (Youth LEAD) | Cambodia, Indonesia, Nepal, Pakistan, Philippines, Viet Nam | HIV | Strengthening young key populations advocacy |
| **MIDDLE EAST AND NORTH AFRICA** | | | |
| Middle East and North Africa Harm Reduction Association (MENAHRA) and Regional Arab Network Against AIDS (RANAA) * | Afghanistan, Egypt, Iran (Islamic Republic), Jordan, Lebanon, Libya, Morocco, Pakistan, Sudan, Tunisia | HIV | Harm reduction for key populations |
| **LATIN AMERICA AND THE CARIBBEAN** | | | |
| Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) * | Belize, Cuba, Dominican Republic, Guyana, Haiti, Jamaica, Suriname, Trinidad and Tobago | HIV | Improving policy environment and reducing legal barriers and stigma for key populations |
| Regional Coordinating Mechanism - Mesoamerica | Belize, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Panama | HIV | Expanding access and utilization of HIV prevention, testing, and care among mobile and migrant populations |
| Organismo Andino de Salud-Convenio Hipólito Unanue (ORAS-CONHU) | Argentina, Belize, Bolivia, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Uruguay, Venezuela | TB | Strengthening and expanding the capacities of the national laboratories networks and the supranational reference laboratories for tuberculosis in the Americas |

| Applicant | Countries | Comp. | Description |
|---|---|---|---|
| Pan-Caribbean Partnership Against HIV/AIDS (PANCAP) | Antigua & Barbuda, The Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts & Nevis, Saint Lucia, St. Vincent & The Grenadines, Suriname, Trinidad & Tobago | HIV | Removing legal and human rights barriers to HIV, sexual, and reproductive health services for key populations |
| **EASTERN EUROPE AND CENTRAL ASIA** | | | |
| Eurasian Coalition on Male Health (ECOM) | Armenia, Belarus, Georgia, Kyrgyzstan, Macedonia (FYR), Azerbaijan, Estonia, Kazakhstan, Moldova, Russian Federation, Tajikistan, Ukraine | HIV | Increasing HIV prevention, testing, treatment, care, and support for MSM and transgender people |
| Alliance for Public Health (APH) * | Belarus, Bosnia & Herzegovina, Bulgaria. Georgia, Kazakhstan, Kyrgyzstan, Moldova, Romania, Russian Federation, Ukraine | TB + HIV | Achievement of 90-90-90 for key populations in select cities |

*Concept notes marked with as asterisk (*) are the subject of case studies in a forthcoming paper from ICASO and the International HIV/AIDS Alliance.*

*Editor's note: This article was altered after GFO 289 was first published to correct the list of countries shown in the table for the application from the International Treatment Preparedness Coalition - West Africa (ITPC-WA). See also the Erratum we published here concerning the status of the applications.*

## Key findings

The following are the main findings from an analysis conducted recently by ICASO and the International HIV/AIDS Alliance.

**Invitations following expressions of interest offered predictability.** The EOI process was used more effectively for this window than for the first. Applicants that submitted EOIs were invited to develop a concept note (with a maximum funding amount indicated); encouraged to partner with other applicants; or encouraged to explore other opportunities. By making initial assessments of the proposals through the EOI process, identifying the strongest ones, and indicating that they would most likely be funded, and at what level, The Global Fund offered an important measure of predictability that was not always present in the first window. Notably, all but one of the reviewed RCNs proposed a program at near or the maximum available. This was clearly a useful guidepost.

**CCM endorsements demand extensive effort, but offer little benefit.** Obtaining country coordinating mechanism (CCM) endorsements was a labor- and resource-intensive process for nearly all applicants. Bangyuan Wang, who was involved with the India HIV/AIDS Alliance proposal, described obtaining endorsements as "the most challenging part of the process." Nonetheless, it is a clear requirement that the CCMs of all countries involved provide written endorsement of the RCN. (In the absence of a CCM, the endorsement had to be obtained from the national disease program.) The purpose of CCM endorsements is ostensibly to demonstrate mutual awareness and coordination of programming between the country and regional levels. However, because CCM endorsement is largely a formality, it does not really achieve this purpose. In addition, in many cases, the regional programs exist

precisely to address issues that the CCMs or country programs have neglected to address, which implies that there may be resistance at country-level to the proposed regional program.

In several cases, the endorsement of certain CCMs could not be obtained, for reasons ranging from not having enough time to review the proposal and send the letter of endorsement by the RCN submission deadline, to CCM members being actively opposed to the proposed program. The Global Fund accepted RCNs with incomplete endorsements if applicants could demonstrate that adequate effort had been made to obtain the endorsement or that a CCM intended to indicate support. This flexibility on the part of The Global Fund is commendable, but it suggests that the endorsements may not be as important to the viability of regional programs as is implied by the onerous requirements.

**The actions of the Technical Review Panel sometimes appear to be unilateral.** Despite the predictability offered by the improved EOI process, there were still surprises. For example, in the case of the concept note submitted by the Alliance for Public Health in the EECA, the TRP "recommended" that that the proposed budget be cut in half. The TRP provided a rationale along with its recommendation, but the APH did not perceive the whole process as a negotiation.

The two organizations in the MENA region that submitted a proposal – RANAA and MENAHRA – also received a difficult response from TRP, which de-prioritized some of the programming that they considered high-priority. "We should have had an opportunity to defend the program after the TRP weighed in," remarked RANAA Executive Director Golda Eid.

After the TRP recommended cutting some of the more innovative components of the concept note from the Caribbean Vulnerable Communities Coalition, Dr. John Waters, the program manager, noted that while some TRP feedback was quite helpful, other feedback was shortsighted.

Sometimes, what the applicants perceived as the priorities of the proposed programs was not shared by the TRP. What the TRP deems to be the priorities seems to generally win the day, however, with the applicants having no opportunity to respond (despite their unique expertise on regional issues).

**Communication between applicants and The Global Fund Secretariat is unsystematic.** There does not appear to be a home, or hub, for regional proposals or programs at The Global Fund Secretariat. Communication between applicants and the secretariat often take place in an ad-hoc fashion, with applicants' primary contact being fund portfolio managers in some cases, the Access to Funding Department in others, and even the Community, Rights, and Gender Department in some instances. Beyond having different points of entry, applicants received varied levels of attention and support. For example, some RCNs were reviewed by Secretariat staff at several stages throughout development, while others were not.

**The regional concept note template still isn't quite tailored for regional programs.** The regional concept note template is still mostly the same as the country template, especially with regard to the narrative component. There was one change made apparently to alleviate

some of the most difficult challenges experienced by regional applicants: The work plan tracking measures template was made the default modular template for regional applicants, with some targeted instructions. However, this change was rolled out to applicants in a haphazard manner. Some applicants received the adapted form early in the development process, while others were not made aware of the new template until after they submitted the first draft of their concept note. It appears that while there was awareness of the imperfections of the RCN template, there was no system to efficiently deliver an improved one. This experience further demonstrates a lack of coordination at the Secretariat regarding regional proposals.

*ICASO and the International HIV/AIDS Alliance will be issuing a paper summarizing its findings.*

*This is Charlie Baran's first article as a GFO correspondent. Charlie is an independent advocate and consultant, based in Los Angeles, California. His work focuses on promoting representation and leadership of key populations and civil society in health and development programs. He can be contacted at charlie.baran@gmail.com or charliebaran.com.*

TOP

---

## 4. NEWS: Replenishment round-up: New pledges from Japan and New Zealand

*Events scheduled for the High Level Meeting on Ending AIDS*

Anna Maalsen 7 June 2016

The Global Fund's replenishment campaign cranked up a notch in May with the announcement by Prime Minister Shinzo Abe of Japan of a USD 800 million pledge to The Global Fund's Fifth Replenishment ahead of G7 Summit which was held on 26–27 May in Japan.

Japan's pledge was part of a larger USD 1.1 billion package of new funding dedicated to five multi-lateral global health initiatives aimed at responding to infectious diseases, public health emergencies, and the achievement of universal health coverage and the Sustainable Development Goals.

Whilst the USD 800 million is the same amount as pledged in the Fourth Replenishment campaign (see Aidspan's Global Fund Pledges and Contribution table here), given current foreign exchange fluctuations, observers pointed to the fact that in terms of yen, the Japanese currency, the Fifth Replenishment pledge actually translates into a 46% increase over the pledge made in the Fourth Replenishment campaign.

Japanese civil society organizations welcomed the announcement, but urged the government to ensure that the unpaid commitment of USD 140 million from its Fourth Replenishment pledge is disbursed prior to the end of 2016 and remains separate from the new pledge. They also called for the new pledge to be paid in total during the 2017-2019 period.

Despite Japan's announcement, and the priority that was placed on global health initiatives, such as The Global Fund, and their contribution to the overall sustainable development agenda as part of the G7 Leaders Summit, no new money was raised for these causes at the summit.

Japan's pledge followed an announcement from Canada's Prime Minister, Justin Trudeau, of a CAD 785 million pledge for the 2017-2019 period (see GFO article). When Canada's Minister for International Development and La Francophonie, Marie-Claude Bibeau, addressed the World Health Assembly in Geneva, Switzerland on 25 May, she invited world leaders to attend the Fifth Replenishment Conference in Montreal on 16 September 2016.

Minister Bibeau called for "continued collaboration and renewed commitment to end the HIV/AIDS, TB, and malaria epidemics for good by 2030" and said that this can be done "through supporting the important work of The Global Fund to Fight AIDS, Tuberculosis and Malaria…" She also made it clear that Canada would be giving its highest priority in its international assistance policy to the "protection and promotion of the health and rights of women and girls, especially their sexual and reproductive health and rights."

(Later in May, Canada announced an investment of CAD 85 million for the Stop TB Partnership's TB REACH initiative.)

Back in April, New Zealand announced a NZ$ 1 million pledge for the Fifth Replenishment. This pledge comes after a long absence by New Zealand; its last contribution was made during the 2008-2010 replenishment period. It is a positive signal of support for The Global Fund by smaller donor countries. New Zealand's ambassador to the World Trade Organization, Vangelis Vitalis, said, "Lifting the burden of HIV, tuberculosis and malaria helps build prosperity and security, both in the Pacific and around the world. New Zealand is pleased to play its part in the Global Fund partnership."

### High Level Meeting on HIV

This week, leaders of the global HIV response are gathering in New York for the High Level Meeting (HLM) on Ending AIDS from 8-10 June. Advocacy groups have been working hard behind the scenes to ensure that the push to fast track HIV investments includes a successful Fifth Replenishment for The Global Fund.

The Global Fund Advocates Network (GFAN) was scheduled to host a side meeting on 7 June, with the Director of External Relations of The Global Fund, Christoph Benn, to discuss the Fifth Replenishment and Global Fund–related advocacy at the HLM.

The Global Fund's Executive Director, Mark Dybul will be also attending a special side event on "Ensuring a Sustainable HIV Response in Middle Income Countries" being hosted by the Permanent Mission of the Kingdom of the Netherlands, and organized by Aids Fonds-STOP AIDS NOW!, the International HIV/AIDS Alliance, STOPAIDS UK, the Open Society Foundations, and the Robert Carr Civil Society Networks Fund.

ICASO has prepared a comprehensive list of how to get involved in the HLM here. In addition, GFAN has prepared a summary of the key activities related to GFAN or The Global Fund at the HLM. (Note if the link for the summary does not work, a copy of the summary is available from the author at anna_maalsen@msn.com.)

**Other developments**

GFAN is supporting its partners Osservatorio AIDS and ACTION Italy through an open letter to letter to Italian PM Matteo Renzi requesting that Italy double its contribution to The Global Fund from € 100 million to € 200 million. Any organizations or individuals wishing to support this effort can access the sign-on letter here.

Finally, the AIDS Healthcare Foundation is spearheading a "Fund the Fund" campaign through an online petition.

TOP

---

## 5. NEWS: Advocacy brief for UN High Level Meeting says The Global Fund and key populations are delivering results

Gemma Oberth 8 June 2016

The Global Fund Advocates Network (GFAN) has released an advocacy brief aimed at stakeholders who are involved in the 2016 High Level Meeting on Ending AIDS. The meeting is taking place this week, from 8-10 June in New York, where country delegations from around the world will adopt a new Political Declaration on HIV/AIDS.

The brief is an advance summary of a forthcoming publication by the Global Fund Advocates Network and ICASO, in partnership with the Free Space Process, which examines the evidence around the vital role that key populations and vulnerable communities play in advancing results through Global Fund investments. The paper has five overarching advocacy messages which impress upon the need for a fully-funded Global Fund:

**1. Investment in key populations is needed now more than ever.**

The brief begins by stating that investment in key and vulnerable populations is a fundamental factor to ending AIDS, TB, and malaria. It asserts that without scaled-up, evidence-based programs for those most marginalized and vulnerable, it will not be possible to meet the United Nations Sustainable Development Goals (SDG), nor the goals set out in the UNAIDS Strategy 2016-2021, the Stop TB Partnership Strategy 2016-2020, and the Global Technical Strategy for Malaria 2016-2030. Though the following information is not contained in the brief: A recently published paper on what is required to end AIDS by 2030 (see Stover et al., 2016) shows that resource needs are concentrated in just a few areas. Two-thirds of what is needed is for just four interventions, one of which is services for key populations (9%). The remaining three are ART (39%), program enablers (10%), and condoms (7%).

**2. The Global Fund invests in rights- and evidence-based interventions for key and vulnerable populations.**

Preliminary results from an ongoing resource tracking initiative led by the Community, Rights, and Gender (CRG) department at the Global Fund Secretariat indicate that approximately one in 10 dollars (in USD) of all funds allocated to HIV and joint HIV/TB programs has been directed towards programs for key populations. However, the brief cautions that this amount varies depending on a country's willingness or ability to prioritize these investments in funding requests.

**3. The Global Fund plays a catalytic role in improving national responses and leveraging domestic financing for key and vulnerable populations.**

The brief boldly argues that no other agency is as effective as The Global Fund in leveraging additional investments and technical support to catalyze scale-up of high quality interventions for key populations. It provides the example of Costa Rica, where The Global Fund has leveraged a $11.2 million commitment from government towards a social protection board funding mechanism for local HIV NGOs to specifically prioritize support for organizations serving MSM and transgender women. The brief also cites a case study from Botswana, where strategic litigation supported by The Global Fund led to a ruling that the government must provide free antiretroviral therapy to non-citizen prisoners.

**4. The Global Fund amplifies the voices and leadership of key and vulnerable populations.**

For this section, the brief shares some powerful testimonials from key populations themselves. EriKa Castellanos, a transgender woman living with HIV says, "Having the Global Fund in Belize has meant that the voices of key populations are being taken into account through the Belize country coordinating mechanism (CCM). This platform allows debate for the first time of some of the drivers of the epidemic." Castellanos is the Executive Director of the Collaborative Network for Persons Living with HIV (CNET+) in Belize and a Global Fund champion as a member of the GFAN Speakers Bureau.

The views of Peninah Mwangi, a CCM member representing sex workers in Kenya, are also shared. "The Global Fund has empowered communities," she says. "The implication of trusting and directly supporting communities to run a program as sub-recipients is huge. Owning the epidemic has been taken literally, with positive response. We plan, strategize, and invent at a community level to ensure that we achieve our targets and impact our communities."

**5. The Global Fund places key populations at the heart of its work, providing a "package" of supportive strategies, policies, and processes.**

Lastly, the brief emphasizes that The Global Fund does not just talk about the importance of key and vulnerable populations, but also concretely demonstrates its commitment to these groups through a comprehensive package of strategies, policies, and processes. The brief makes mention of the Global Fund's $15 million CRG Special Initiative, which delivers

quality peer-led technical assistance to improve gender and human rights elements in country dialogue, concept notes, and grant negotiations. The CRG SI has also supported long-term mentorship to national key populations networks through a partnership with the Robert Carr Networks Fund, and ensured access to information and linkage to further support through the initiative's six regional platforms for communication and coordination.

"This research, brief, and upcoming paper were in part developed to push back on the overall exclusion of these communities within the response: something that civil society has to fight again at this week's UN High Level Meeting on AIDS," says Peter van Rooijen, Executive Director of International Civil Society Support (ICSS), host of the GFAN Secretariat. "As we move forward to the 5th Replenishment of The Global Fund this September in Canada, all governments and donors should increase their support to the Fund which places key and vulnerable populations at the heart of the response."

*Note: GFO will report on the full publication from GFAN, ICASO and the Free Space Process when it is released in the coming weeks.*

TOP

---

## 6. NEWS: Georgian NGO responds to large increase in HIV among MSM

*TA provided by The Global Fund's CRG initiative*

Tinatin Zardiashvili 7 June 2016

Under its Community, Rights, and Gender special initiative, The Global Fund is providing technical assistance (TA) to assist a community-based organization, LGBT Georgia, to respond to an alarming increase in HIV incidence among men who have sex with men.

According to a surveillance survey regularly performed by Curatio International Foundation, with support from The Global Fund, HIV incidence among MSM in Georgia went from 7% in 2010 to 13% in 2013. And in Tbilisi, the capital, the incidence rose to 25% in December 2015.

The request was initiated by the principal recipient for Georgia's existing HIV grant, the National Center for Disease Control and Public Health. The TA is being provided for three months by experts from Eurasian Coalition of Male Health and the Asia-Pacific Coalition for Male Sexual Health.

The TA has three elements: (1) training community and medical personal in preventive methods; (2) conducting a needs assessment of MSM services across Georgia; and (3) undertaking organizational strengthening of LGBT Georgia.

The first element, training, has already been implemented. A training session took place on 10-11 May with the goal of sensitizing participants to the pre-exposure prophylaxis method– specifically, what is it, why it should be used, and how best to organize the provision of

PrEP. On the first day, community representatives were trained; and on the second day, medical personnel. Training participants discussed various issues, including confidentiality and where the PrEP should be provided. The MSM community expressed a preference to have the service provided in a community-based setting as opposed to medical facilities.

The second element, the needs assessment, has also started. It is being done by local experts hired by ECOM. The needs assessment will explore all existing services and gaps, including PrEP. The results of the assessment will inform the pilot PrEP program that is part of the HIV grant. The program will recruit 100 participants in 2017 and another 100 persons in 2018. (The plan is to use PrEP not only for MSM, but also among sex workers and people who inject drugs, which are the populations most affected by HIV.)

The third element, organizational development, will start in the next few weeks. A strategic planning workshop will be held to identify gaps and solutions. One of the important outcomes of the workshop will be an organizational development plan for LGBT Georgia.

Capacity building of MSM organizations in Georgia is particularly important. Although the NGO sector is generally well developed, the networks of PWIDs and SWs are stronger than their MSM counterparts. MSM community-based organizations are still very new, and stigma against the MSM population is extremely high. But the legal environment is less harsh (MSM are not criminalized, for example), so there is some hope that the MSM service gap can be bridged.

The PR and National AIDS Center understand that the communities must play a central role in the delivery of PrEP. According to Nikoloz Chkhartishvili, deputy director of the National Aids Center and program manager for the HIV grant, "The role of the communities in PrEP piloting is very high, as community-based organizations are expected to mobilize and motivate participants to use the service."

TOP

---

## 7. NEWS: Funding of $164 million approved for 13 grants in 11 countries

*The largest award went to a Niger malaria grant*

**Sierra Leone received $11 million in incentive funding for its malaria grant**

David Garmaise 7 June 2016

In May 2016, the Global Fund Board approved $164 million in funding for 13 grants emanating from concept notes submitted by 11 countries. Of the $164 million, $114 million represented new money; the balance was existing funding that had been approved prior to the new funding model but was nevertheless included in the NFM allocations to countries. The Board was acting on recommendations from the Grant Approvals Committee and the Technical Review Panel.

In addition, the Fund placed interventions worth $55 million in the registry of unfunded quality demand. See the table for details.

**Table: Funding for country grants approved by the Global Fund, March 2016 ($ million)**

| Country (component) | Grant name | Principal recipient | Approved funding | | | Added to UQD register |
|---|---|---|---|---|---|---|
| | | | Existing | New | Total | |
| Colombia (HIV) | COL-H-FONADE | FONADE | 4.5 m | 3.0 m | 7.5 m | 0.5 m |
| Comoros (HIV) | COM-H-DMLS | Ministry of Health | 1.0 m | 5.0 m | 6.0 m | NIL |
| Congo (TB/HIV) | COG-H-CRF | French Red Cross | 7.7 m | 0.0 m | 7.7 m | NIL |
| | COG-H-SEPCNLS | SEPCNLS | 0.8 m | 5.9 m | 6.7 m | |
| | COG-T-MSP | Min. of Health and Pop. | 0.4 m | 2.8 m | 3.2 m | |
| Georgia (HIV) | GEO-H-NCDC | Nat. C. for Dis. Control | 14.0 m | 4.4 m | 18.4 m | 0.9 m |
| Guatemala (TB) | GTM-T-MSPAS | Min. of Health and S.A. | 0.7 m | 5.8 m | 6.5 m | NIL |
| Kyrgyzstan (TB/HIV) | KGC-C-UNDP | UNDP | 11.8 m | 11.5 m[1] | 23.3 m | NIL |
| Mongolia (TB) | IND-S-MOH | Min. of Health and Sport | 2.1 m | 3.4 m | 5.5 m | 3.5 m |
| Nicaragua (TB) | NIC-T-INSS | Instituto N. de S.S. | 1.0 m | 6.9 m | 7.9 m | NIL |
| Niger (malaria) | NER-M-CRS | Catholic Relief Services | 5.5 m | 32.8 m[2] | 38.3 m | 47.3 m |
| S. Leone (HSS) | SLE-Z-MOHS | Min. of Health and Sanit. | 0.0 m | 27.9 m[3] | 27.9 m | 3.5 m |
| Turkmenistan (TB) | TKM-T-UNDP | UNDP | 1.2 m | 4.1 m | 5.3 m | 0.5 m |
| **TOTALS** | | | **50.7 m** | **113.5 m** | **164.2 m** | **56.2 m** |

The grants to Comoros, Congo, and Niger were in euros which were converted to dollars at the rate of 1.1184.

[1] The new funding for Kyrgyzstan (TB/HIV) includes $1.1 million in incentive funding.
[2] The new funding for Niger (malaria) includes $2.5 million in incentive funding.
[3] The new funding for Sierra Leone (HSS) includes $11.0 million in incentive funding.

The largest awards went to Niger ($38.3 million for malaria), Sierra Leone ($27.9 million for HSS), Kyrgyzstan ($23.3 million for TB/HIV), and Georgia ($18.4 million for HIV).

The following is a summary of the GAC's comments on some of the grants awarded funding.

### Niger (malaria)

The goal of the program to be funded by the grant to Niger is to reduce malaria incidence and mortality by 75% from 2013 to 2018.

The grant includes provision for staff incentive payments totaling 1.7% of the budget. Similar incentives were paid under the previous malaria grant. In the context of low government wages and the high workload expected from government staff involved in the implementation of the grant, the GAC considered these incentives to be necessary to ensure the successful implementation of grant activities. However, its also called for a gradual and well-planned phase-out of incentive payments.

As a result of an investigation conducted by the Office of the Inspector General in December 2014, which found unsupported and inadequately supported expenditures as well as procurement irregularities, the following risk mitigation measures were put in place:

- the installation of an international fiscal agent;
- the implementation of the zero cash policy;
- procuring health products through the pooled procurement mechanism;
- outsourcing some non-health procurements through international nongovernmental organizations; and
- increasing the scope of work of the local fund agent (LFA) for tender reviews.

However, the GAC noted that while these measures have greatly mitigated the risks linked to procurement and financial processes, they have also slowed implementation and reduced absorption levels. The Secretariat is currently working with its risk management team, the fiscal agent and the LFA to revise and gradually adapt these measures to the current country context, in order to improve absorption and increase program impact.

**Sierra Leone (HSS)**

The $29.9 million in funding approved for Sierra Leone included incentive funding of $11 million. This represents an exception to the policy that HSS grants are not eligible for incentive funding. The GAC said this action was taken because The Global Fund recognized that significant additional investments for HSS could greatly contribute to the recovery of the TB and HIV disease programs, as well as the health systems, following the devastation of the Ebola outbreak.

The goal of the program to which The Global Fund is contributing is to build functional and resilient national and district systems for heath. Under the grant, 13,000 community health workers will be trained and incentivized to provide an essential package of services upgraded to include HIV, TB, and malaria. Money will also be provided for the distribution of medical supplies and for building a central warehouse.

The GAC report identified a number of risks associated with this grant as well as the measures that will be undertaken to mitigate these risks.

**Georgia (HIV)**

The goal of the program being supported by the grant to Georgia is to reverse the HIV epidemic through strengthened interventions targeting key affected populations, and improvements in health outcomes for people living with HIV. One of the objectives is to ensure a strong response through an enhanced commitment from government, an enabling legislative and operational environment, and the greater involvement of civil society.

According to the GAC, strategies to support the program's goal and objectives include: (a) effective transition planning and advocacy activities, with high-level involvement of civil

society representatives and community groups; and (b) improving the quality and increasing the scale of preventive interventions focused on key populations.

The GAC said that the government has increased domestic funding and is now funding all first-line antiretrovirals; prevention of mother-to-child transmission, including HIV testing; post-exposure prophylaxis for health care workers; and opioid substitution therapy services. During the implementation period of this grant, Georgia also plans to assume responsibility for fully funding all ARVs, and for covering the costs of clinical monitoring and treatment adherence measures by healthcare workers; remaining opioid substitution therapy activities; community-based voluntary counselling and testing; and HIV surveillance among key populations.

**Colombia (HIV)**

In Colombia, the HIV epidemic is concentrated among men who have sex with men, transgender females, people who inject drugs, people who live on the street, and sex workers.

The GAC says that the focus of the program supported by this grant is to enhance the sustainability of the "sub-national" response. This will include:

- strengthening the coordination of sub-national actors involved in the HIV response;
- expanding community outreach efforts of civil society organizations for key populations; and
- promoting and facilitating the contracting of civil society organizations by the Colombian health system and sub-national authorities.

**Congo (TB/HIV)**

The three principal recipients for this grant are the French Red Cross, the Permanent Executive Secretariat of the National Council for the Fight Against AIDS (SEP/CNLS), and the Ministry of Health and Population.

The Government of Congo co-finances the HIV program by procuring ARVs for adults. There have been instances in the past where the government has not obtained the drugs, resulting in recurrent stock-outs and sub-satisfactory grant performance. The GAC said that high-level advocacy resulted in ARVs and anti-TB drugs being earmarked in the national budget for 2016. Nevertheless, the Secretariat will continue to closely monitor the fulfillment of the government's commitment.

Additional risks identified by the Secretariat include weaknesses in the capacity of PRs, as well as poor financial reporting and the absence of asset verification during grant implementation. To address these risks, the Secretariat will review all positions within the PRs to ensure that the "most fit" candidates are hired for the program; new financial management software will be installed; the PRs will conduct an asset verification exercise; and the number of sub-recipients in the grant administered by the French Red Cross will be reduced from 22 to 11 to make the workload of the PR more manageable.

### Shortened grant

The Board also approved incremental funding in the amount of $32 million for the Sudan malaria grant to allow for services to be provided through to 31 December 2017, and to sustain the scope and scale of essential services in malaria vector control in 2017. The grant had been funded only to 30 June 2017.

*Information for this article comes from the May 2016 report of the Secretariat's Grant Approvals Committee to the Board (GF-B35-ER01). This document is not available on the Fund's website.*

TOP

---

This is issue #289 of the GLOBAL FUND OBSERVER (GFO) Newsletter. Please send all suggestions for news items, commentaries or any other feedback to the GFO Editor at david.garmaise@aidspan.org. To subscribe to GFO, go to www.aidspan.org.

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

Aidspan (www.aidspan.org) is a Kenya-based international NGO that serves as an independent watchdog of the Global Fund, aiming to benefit all countries wishing to obtain and make effective use of Global Fund resources. Aidspan finances its work through grants from foundations and bilateral donors. Aidspan does not accept Global Fund money, perform paid consulting work, or charge for any of its products. The Board and staff of the Fund have no influence on, and bear no responsibility for, the content of GFO or of any other Aidspan publication.

GFO Newsletter is now available in English and French. Some articles are also available in Russian.

GFO Editor: David Garmaise (david.garmaise@aidspan.org).

Reproduction of articles in the Newsletter is permitted if the following is stated: "Reproduced from the Global Fund Observer Newsletter, a service of Aidspan."

**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/node/934.

Click here to unsubscribe.

GFO archives are available at www.aidspan.org/page/back-issues.

Copyright (c) 2016 Aidspan. All rights reserved.

TOP