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NEWSLETTER

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Plan does not specify which services the government is taking over or when

Tinatin Zardiashvili and David Garmaise 8 August 2017

Georgia has developed a transition plan in response to gradual reductions over the years to its allocations from the Global Fund. The goal of the Georgia Transition Plan is to ensure a smooth transitioning to full domestic funding of the HIV and TB programs by 2022 without compromising services. However, the plan does not specify which services the government is taking over or when.

The Georgian CCM provided Aidspan with a copy of the transition plan. This article describes the contents of the plan. It also provides some analysis (see especially the section at the end of the article). This is the first time that Aidspan has written about the contents of a transition plan.

In addition to a 48-page narrative document, the Georgia Transition Plan includes three annexes: (1) a responsibilities matrix and timeline; (2) an M&E framework; and (3) a budget.

In preparing the plan, Georgia has chosen to assume that the Global Fund will pull out entirely by 2022, which is the year that Georgia's grants from its 2017-2019 allocation are expected to end. Georgia has made this assumption even though the country is not on the Fund's list of components expected to transition from Global Fund support by 2025.

> *Editor's note: Georgia received an allocation for 2017-2019 for HIV and TB. If Georgia were to be informed sometime in the next couple of years that the Global Fund was planning to withdraw completely, the country would still be entitled to receive "transition funding" for the 2020-2022 allocation period. Under current rules, a component that has been identified for transition is entitled to receive one last allocation from the Global Fund. However, this allocation is supposed to be used solely or primarily to defray the costs of implementing a transition plan.*

In 2015, Georgia conducted a transition readiness assessment (TRA) (see GFO article). The transition plan builds on the TRA. The plan lists all of the problems identified in the TRA and covers those that are not being addressed either by the Global Fund or the national HIV and TB programs. The CCM advises that the Georgia Transition Plan should be read together with the documents describing the national TB and HIV programs and the country's most recent requests for funding to the Global Fund.

(Although the official name of the plan is “Georgia Transition Plan,” many stakeholders refer to it as the “Georgia Transition and Sustainability Plan” or “TSP.”)

The Transition Plan describes (a) the problems that have to be addressed in order to ensure a successful transition; and (b) the activities that will be implemented to resolve the problems and gaps.

Preparation of the Georgia Transition Plan was initiated by the country coordinating mechanism (CCM) and the National Center for Disease Control and Public Health, the principal recipient (PR) of the Global Fund grants in Georgia, with funding provided by the Global Fund. The plan was developed by a team of independent consultants (Curatio International Foundation). According to the transition plan document, all stakeholders were actively involved in the development of the plan, including the Policy and Advocacy Council (PAAC), the body specifically established to assist the CCM with the transition of the HIV and TB programs. The process of preparing the plan was agreed with the Global Fund’s fund portfolio manager. The Global Fund Secretariat commented on a draft of the plan, and the final plan was endorsed by the CCM.

The plan is structured around two group of problems, those that have to do with the external environment – defined as not directly related to the health system but still significantly affecting its development; and those that are related to the internal environment, i.e. directly connected to the health system. With respect to the latter, the transition plan describes problems in the following areas: financial resources, human resources, health information systems, governance, reporting, services, procurement and organizational capacities.

Below we provide information on some of the problems identified in these areas, and some of the activities that the plan says will be implemented to address the problems.

External environment

According to the Georgia Transition Plan, civil society organizations (CSOs) are currently restricted in their ability to participate in government tenders. For example, most service provider CSOs find it difficult to meet the requirements of the Public Procurement Law to present a bank guarantee worth 1-2% of the total budget of a tender proposal. The plan said that there may also be other regulations that hinder the participation of civil society. To address this problem, the plan calls for the procurement law and relevant regulations to be reviewed to identify the barriers to CSO participation in the state tenders; and for measures to build the capacity of CSOs and their networks and coalitions to satisfy the state procurement requirements. The capacity building should include training and technical assistance in management and resource mobilization, the plan stated.

The transition plan declares that "it is … important for the state to be able to sign contracts with NGOs as [the] non-governmental sector is a very important player in effective implementation of preventive measures." The plan calls for the development of a detailed operational manual describing the rules and procedures for contracting CSOs for health service delivery.

According to the plan, restrictive drug policy remains a significant barrier to successful implementation of the HIV program. The plan says that this problem has to be resolved before the Global Fund financing ends. The plan calls for increased coordination among key stakeholders, relevant government bodies, parliamentary committees, civil society and the National Platform on Drug Policy Reform (see GFO article) to change the country's drug legislation by developing and enforcing a new four-pillar drug policy, anti-drug strategy and action plan.

Internal Environment

Financial resources

Not surprisingly, the biggest problem is the increasing financial gap being created by the gradual reduction of the Global Fund support. For example, despite the existence of defined state obligations, the implementation of Georgia's national TB strategy (2016-2018) is running "in the red"; the funding gap is estimated to be above 20%.

In addition, the transition plan said, the financial obligations of the Ministry of Labor, Health and Social Affairs (MoLHSA), which manages both the HIV and TB strategies, is likely to exceed its budget. The plan calls for the timely identification of internal and external opportunities to avoid interruption of the programs due to financial gaps.

The plan includes several activities designed to increase efficiency. One example of this is the introduction of a result-based financing (RBF) system for the TB program. Georgia believes that this is a suitable activity for inclusion in the transition plan because the government would have clear guidance on how to spend its money wisely (and potentially spend less, and spend for results).

Human resources

A critical problem for both the HIV and TB programs is that health care staff don't have sufficient skills. To address this problem, the transition plan calls for the development of a policy that defines the professional competences required – for medical and other staff, as well as for workers in CSOs. It also calls for institutionalizing TB and HIV training programs and integrating them into the relevant formal education system (undergraduate and postgraduate).

Health information systems (HIS)

According to the transition plan, HIV data collection is not standardized because it is not segregated by age and gender; the HIV and TB information systems are not fully integrated into Georgia's national information system; and statistical data are not regularly analyzed and used for decision-making. To address these problems, the plan calls for monitoring and evaluating existing HIS strengthening interventions as well as current processes to fully

integrate advanced surveillance, monitoring and reporting systems. It also calls for staff to be trained on the use of the HIS.

Governance

The Transition Plan states that the national HIV and TB strategy documents do not have "adequate statutory force, which means that priorities may change with [a change in] government." The plan calls for both the HIV and TB national strategies to have "adequate statutory force … which would make their implementation mandatory." (Aidspan has been informed that after the transition plan was completed, the cabinet endorsed both strategies.)

In addition, regarding the TB program specifically, the plan said that program management functions and responsibilities are not clearly defined, which causes program fragmentation and makes achieving sustainability more difficult. The plan calls for strengthening the organizational capacity of the TB program by adopting a legal document that clearly defines functions and responsibilities for program management. This could take the form of a Government of Georgia resolution or, possibly, changes to the TB Law.

The plan states that although the CCM has been the major body coordinating the national response for both HIV and TB, it is not well placed within the government hierarchy, and thus lacks legal power to assure effective coordination across different sectors. According to the transition plan, there is unanimous consensus that the CCM should continue its operations after the Global Fund withdraws its support. During the transition phase, the plan states, various options will be discussed concerning how the CCM should evolve; the optimal option will be selected; and a plan will be developed to implement the selected option.

Reporting

The transition plan said that currently there are no official channels for dissemination of the HIV or TB program information and financial data. Detailed information about costs are not available, which restricts the ability of CSOs to carry out advocacy activities and the ability of different stakeholders to monitor the programs. To address these problems, the plan calls for the government to establish a system of health accounts during the transition that will allow for publicly available HIV and TB expenditure reports to be produced and for spending analyses to be conducted annually.

Services

The transition plan states that currently, with respect to HIV, there are no approved standards for HIV-preventive services for the key affected population groups as well as for harm reduction programs. Thus, it is difficult to define a unit cost, which is needed to calculate by how much the national government's budgets need to increase to take over responsibility for funding these services and programs. The plan says that "advocacy is planned" for the approval and implementation of national standards for HIV prevention and harm reduction. It also calls for training for CSOs on the approved standards. (The assumption is that CSOs are best placed to ensure the practical application of these standards.)

Concerning the TB program, the transition plan calls for a gradual shift towards a people-centered TB case model to avoid unnecessary hospitalization and improve efficiency of the system.

Procurement

Currently, the procurement and supply of health products for HIV prevention and treatment in Georgia is managed by the National Center for Disease Control and Public Health (NCDC). Antiretrovirals are purchased through the Global Fund's pooled procurement mechanism (PPM). The procurement and supply of health products for TB treatment is also managed by the NCDC. First-line drugs are procured through the state's procurement mechanism, while second-line drugs are procured through the PPM.

No decision has been taken yet concerning whether the NCDC will continue to manage the procurement and supply chain function after the Global Fund withdraws. Shifting responsibility for this function to the Social Service Agency (SSA) is possible because the SSA procures health commodities for other national health programs. The transition plan calls for selecting the agency that will be responsible for procurement and supply chain management; and conducting capacity building of the agency selected (if a new entity will take over from the NCDC).

Organizational capacities

The transition plan states that because the national TB Program does not have a formal management structure, program continuity and sustainability risks are high. In November 2014, the Ministry of Labor, Health and Social Affairs (MoLHSA) created a new department, the National Tuberculosis Council (NTC), to be responsible for TB program management. The transition plan says that in order to improve management and coordination of the national TB Program, the organizational capacity of the secretariat of the NTC will need strengthening. Thus, the plan calls for capacity building activities to enhance the ability of the NTC secretariat to provide operational and secretarial support to the NTC.

Cost

Georgia estimates that the cost of implementing its transition plan is $2.4 million over five years (2017-2021). According to the plan, a potential funding source was identified for the operational expenses for the transition's plan proposed M&E unit starting from 2018 ($96,000 over the period from 2018-2021); and external funding sources have also been identified for the activities under the objective "Create conducive legal environment for HIV national response" (cost: $29,200 over the same period). All other funding is expected to be provided by the Global Fund in the form of a transition grant.

Reaction

Because they found the transition plan quite complicated and difficult for communities to understand, CSOs in Georgia developed a user-friendly version of the plan (with funding from the Community, Rights and Gender department of the Global Fund Secretariat).

On 1-2 June 2017, the Eurasian Harm Reduction Network (EHRN) organized a workshop to review and discuss the transition plan, and develop strategies to monitor the implementation of the plan. The report of this workshop said that the transition plan cannot be viewed in isolation, but rather should be considered in conjunction with the national strategic plans for TB and HIV, as well as Georgia's most recent funding requests to the Global Fund for TB and HIV (for the country's 2014-2016 allocation.) The report said that monitoring the implementation of the transition plan requires a deep understanding of all of these documents.

The report said that the user-friendly version of the plan is a useful monitoring tool, not only for communities, but also for the program implementers. Finally, the report stated that if the CCM did not continue to function beyond the withdrawal of Global Fund support, it would be difficult to maintain the involvement of the communities in the process.

David Subeliani, one of leaders of the White Noise Movement, which advocates for drug decriminalization in Georgia, told Aidspan that the transition plan does not guarantee that services for the key affected populations will be sustained. "Communities will have to continue their advocacy for increased domestic funding," he said. I doubt that they would be able to do so without support from the Global Fund."

Dr. Ketevan ChkhatarashviIi, the president of Curatio International Foundation (CIF), told Aidspan that she was concerned that CSOs are interested in monitoring only selected indicators of the transition plan, i.e. those which are closer to the interest of the communities they represent. "Unfortunately, most CSOs do not see a complex picture and the linkages between the approved concept note" – for Georgia's funding from the Global Fund for the implementation period 1 July 2016 to 30 June 2019 – "the NSPs and the transition plan. Ideally, these three things should be monitored as a one whole process, because each of them covers activities that are essential for smooth transition process."

Tamar Gabunia, Vice-Chair of the Georgia CCM, told Aidspan that the Georgia Transition Plan has been developed through a long stakeholder consultation process. "The plan does not duplicate activities covered by the national TB and HIV strategies, but is concerned with health systems strengthening to prepare a solid foundation for anticipated transition."

"Although, the plan itself cannot address existing legislative barriers to sustainable implementation of HIV preventive services by CSOs," Gabunia said, "it calls for high-level advocacy to achieve necessary legal amendments for maintaining access to harm reduction and other essential HIV preventive services."

Gabunia added that "the implementation of the TSP should be closely monitored by CSOs and community representatives. A mechanism will be established to facilitate monitoring – a mechanism that will not only help to identify implementation problems but also provide an appropriate response," she said.

Aidspan comment

This was Aidspan's first opportunity to review a transition plan. We have several observations:

1. In the absence of guidelines (or a template or model plan) from the Global Fund concerning what should be included in a transition plan, countries are left to their own devices to figure out what their plan should contain.

2. As others have noted, the Georgia Transition Plan is complicated and not easy to understand. One of the reasons it is not easy to understand is that to obtain a complete picture of what Georgia is planning for the transition, one has to read not only the Georgia Transition Plan, but also the country's national strategic plans for TB and HIV, and Georgia's most recent funding requests. We understand this, but we can't help feeling that a transition plan should be able to stand on its own.

3. Georgia's most recent funding requests are the concept notes that were approved in 2016 with funding from the 2014-2016 allocations. There is a problem with relying on the concept notes for a description of the programs being implemented. After they are submitted, the concept notes are reviewed by the Technical Review Panel and the Grant Approvals Committee. Clarifications are sought which result in changes to the programs described in the concept notes. This is followed by the grant-making stage, during which more changes are made to the proposed program. The final approved program can look quite different from the original concept note. But there is no one document that describes the final program.

4. We expected to see a list of the services for which the government is assuming responsibility, and a timetable for when this will happen. But there is almost none of this in the Georgia Transition Plan.

5. We don't assume that the government will necessarily take over all programs that were financed by the Global Fund. The government may wish to adapt some of the programs, and may even drop some altogether if they don't fit with national priorities. (See Aidspan's coverage of a paper by Gemma Oberth and Alan Whiteside on program sustainability.)

6. We would have expected to see a section of the transition plan describing how the government is going to pay for the costs of antiretroviral treatment. However, Aidspan understands that Georgia's National HIV Strategy already commits the government to covering the full costs of ARVs. This explains why there is nothing in the transition plan about ARVs. It also underscores what stakeholders are saying about needing to consider not only what is in the plan but also what is in the national strategy and the latest Global Fund requests for funding.

7. There were many items in the Georgia Transition Plan that did not appear to have anything to do with transition. For example, the plan calls for several activities to be

implemented to strengthen the national TB program. This is something that Georgia should be doing, transition or no transition. However, while such items may not be directly related to transition, stakeholders in Georgia may consider that they are necessary for longer-term sustainability of the country's TB and HIV programs.

8. Some actions that do not appear to be directly related to transition can nevertheless make transition easier. For example, the Georgia Transition Plan calls for a gradual shift towards a people-centered TB case model to avoid unnecessary hospitalization and to improve efficiency of the system. This action will bring costs down which, in turn, will make it easier for the government to take over provision of these services.

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2. NEWS: Global Fund announces plans for $260 million allocated to multi-country approaches

A combination of pre-identified applicants and competitive applications will be used

David Garmaise 8 August 2017

The Global Fund has unveiled its plans for the $260 million earmarked for multi-country approaches in the 2017-2019 allocations. The multi-country funding is part of a larger pot of money ($800 million) set aside for catalytic investments. In addition to the multi-country approaches, the catalytic investments include matching funds and strategic initiatives (see GFO articles here and here).

(When the catalytic funding was first announced, multi-country approaches were allocated $272 million. The total included $12 million to fund projects related to procurement and supply management (PSM). The PSM funding was subsequently shifted to strategic initiatives. The revised breakout of the $800 million in catalytic investments, therefore, is as follows: matching funds $356 million; multi-country initiatives $260 million; and strategic initiatives $184 million.)

The purpose of the multi-country funding is to address a limited number of priority issues that cannot be addressed through country allocations alone and that affect several countries in a given region. The Global Fund recently posted on its website a general description of how this money will be spent, along with an FAQ document and a guidance note.

One multi-country project has already reached the grant-making stage: the second phase of the Regional Artemisinin-resistance Initiative (RAI) in the Mekong Region of Southeast Asia. By far the largest single project, the RAI will receive $119 million (46% of the total budget).

For the multi-country funding, the Global Fund identified a key strategic priority for each disease. See Table 1 for a list of the strategic priorities and each one's share of the multi-country funding.

Table 1: Strategic priorities for multi-country funding

Component	Strategic priority	Funding ($US million)
Malaria	Malaria elimination in low burden countries	$145 m
TB	Finding the missed people with TB	$65 m
HIV	Sustainability of services for key populations	$50 m
	Total	**$260 m**

Within each strategic priority are *specific priority areas*. The Global Fund is using a combination of pre-identified applicants and a competitive application process to address the specific priority areas.

Pre-identified applicants

For four of the priority areas (two each for malaria and TB), the Fund will invite a pre-identified applicant to develop a funding request that addresses the defined objectives and regional focus. See Table 2 for details.

Table 2: Priority areas for pre-identified applicants

Com-ponent	Priority area	Funding ceiling ($US million)	Expected date of submission	Expected no. of grants
Malaria	Elimination of malaria in Mesoamerica and Hispaniola [1]	$6.0 m	August 2017	1
	Elimination of malaria multidrug resistance (Regional Artemisinin-resistance Initiative) [2]	$119.0 m	Completed	1
TB	TB in mining [3]	$22.5 m	August 2017	1
	Supranational labs in Eastern and Southern Africa	$4.5 m	April 2018	1
	Total	**$152.0 m**		

[1] Covers Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Dominican Republic and Haiti.

[2] Covers Myanmar, Thailand, Laos, Cambodia and Vietnam.

[3] Covers at least Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

The Global Fund said that the pre-identified applicants will be defined in regional dialogue processes involving key stakeholders, led by the Secretariat. These applicants will be organizations that are fairly prominent in the region. They could include current regional grant recipients.

Competitive applications

For another nine priority areas (five for TB and four for HIV), the Fund will publish requests for proposals and will invite eligible applicants to respond. See Table 3 for details.

In general, suitable civil society, and community-based organizations, international organizations, regional networks, and regional co-ordination mechanisms are eligible to apply for funding under multi-country priorities.

Table 3: Priority areas for competitive applications

Com-ponent	Priority area	Funding ceiling ($US million)	Date RFP to be published	Expected date of submission	Expected no. of grants
TB	Improving the quality of care and prevention for multidrug-resistant TB in Eastern Europe	$5.0 m	Q4 2017	April 2018	1
	Support Latin American and Caribbean countries transitioning from Global Fund TB financing	$4.5 m	Q4 2017	April 2018	1
	Interventions among refugees in Eastern Africa	$7.5 m	Q4 2017	April 2018	1
	Supranational laboratory in Western and Central Africa	$6.0 m	Q4 2017	April 2018	1
	TB/MDR-TB interventions among mobile population in Asia	$15.0 m	Q4 2017	April 2018	2
HIV	Sustainability of services for key populations in Latin American and Caribbean region	$17.0 m	Q4 2017	April 2018	2-3
	Sustainability of services for key populations in Eastern Europe and Central Asia region	$13.0 m	Q3 2017	Feb. 2018	1-2
	Sustainability of services for key populations in South East Asia region	$12.5 m	Q4 2017	April 2018	1
	Sustainability of services for key populations in Middle East and North Africa region	$7.5 m	Q4 2017	April 2018	1
Total		**$88.0 m**			

For priority areas with a competitive application process, requests for proposal (RFPs) will be published on the Global Fund website four to six months prior to the expected submission window in order to allow for a robust regional dialogue.

With respect to the priority area for TB/MDR-TB interventions among mobile populations in Asia, the aims are to strengthen service delivery intervention for early diagnosis and effective treatment of TB and MDR-TB among cross-border migrants, including pre-departure and arrival screening; and to strengthen laboratory capacities, patient referral and follow-up for treatment completion and community engagement. This priority area has two streams. The first one focuses on covering countries hosting and repatriating Afghan refugees (mainly Afghanistan, Pakistan and Iran). The ceiling for this stream is $5.0 million. The second one focuses on addressing the increasing problem of TB/MDR-TB related to cross-border and migration in the Greater Mekong sub-region, which encompasses Cambodia, Laos, Myanmar, Thailand and Vietnam. The grant is also open to other relevant countries. The ceiling for this stream is $10 million.

The HIV priority areas focus on sustainability of services for key populations, and involve supporting the development, innovative delivery of services and sustainability of community-led service delivery and monitoring through: (a) supporting regional advocacy; (b) addressing legal barriers to access to services; and (c) laying the groundwork for continuity of services as part of a transition process.

The Global Fund said that a consultation process to identify gaps and lessons learned from national and regional investments will be conducted in each region. It is expected that these consultations will result in suggestions for appropriate interventions to meet the strategic priority of sustainability of services for key populations.

Elimination of malaria in Southern Africa

There is one additional priority area – the elimination of malaria in Southern Africa – where the Global Fund has not yet decided whether to pre-identify an applicant or go with a competitive process. The decision will be made in the fourth quarter of this year. The aim of this priority is to support the global technical strategy goal of eliminating malaria in low burden countries in Southern Africa: four front-line countries (South Africa, Botswana, Swaziland and Namibia) and four second-line countries (Angola, Mozambique, Zambia and Zimbabwe). The funding ceiling for this priority area is $20 million.

Other information

All multi-country grants will be for three-year period.

The Technical Review Panel will assess all funding requests that are deemed eligible and will recommend which ones should proceed to grant-making.

As is the case for country funding requests, regional applicants are encouraged to prepare a prioritized above-allocation request. This ensures that multi-country programs will have "pre-approved" interventions to integrate into grants when savings or efficiencies are found during grant-making or if other funding becomes available. At the same time, however, the Fund encourages multi-country applicants to take into account the "limitations" of funding available for multi-country priorities.

The guidance note provides a list of people to contact in the Secretariat for more information on each of the priority areas.

During the 2014-2016 funding cycle, the Global Fund distinguished between multi-country grants (typically groups of small island economies funded through country allocations) and regional grants (which brought together a number of countries and were funded through a separate pool of funds). For the 2017-2019 cycle, the term "multi-country" is now used to refer to both types of grants. However, funding for the small island economies type of multi-country grants comes from the country allocations themselves and so is not included in the $260 million allocated to multi-country priorities.

Current regional programs

What will happen to current regional programs? There are currently 34 such programs supported by the Global Fund. Many of the programs are not scheduled to end until 2018 or 2019, but some will end in 2017. Presumably, many of these programs will simply lapse. However, as noted above, some of the pre-identified applicants could be organizations that are currently implementing regional programs. In addition, organizations that are currently implementing regional programs will have the opportunity of responding to requests for proposals for those priority areas that are being addressed through competitive applications.

TOP

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3. NEWS: Significant improvement needed in Global Fund grants to South Africa, OIG finds

Start-up delays and coordination challenges have hampered implementation

Gemma Oberth 8 August 2017

On 19 July 2017, the Global Fund published an audit report by the Office of the Inspector General (OIG) on grants to the Republic of South Africa. The country is part of the Fund's High Impact Africa 1 portfolio and has $312 million in signed grants for the implementation period April 2016 to March 2019. South Africa has an estimated adult HIV prevalence of 19.1% and is home to 7.1 million people living with HIV – the highest number in the world. South Africa's TB incidence is 454/100,000 population, ranking it among the six countries which account for 60% of all new cases (India, Indonesia, China, Nigeria, Pakistan and South Africa).

Importantly, the audit did not identify any misuse of funds or fraud.

The audit found that significant improvement is needed in the overall delivery of the program, citing weak data and monitoring systems as well as coordination among the principal recipients (PRs) as key risks. South Africa's HIV and TB grants are currently being implemented by eight PRs, three from government and five from civil society (see GFO article). The timing of the audit and new implementation arrangements help explain the OIG's top-line finding. The audit was performed just nine months into grant implementation, with three of the PRs being new. Indeed, the OIG asserts that it is premature to conclude on the effectiveness of the current grant program, noting that its rating only concerns the design of the program activities and the implementation approach.

Specifically, the report points out that programs are not always being implemented in line with the concept note, which the Technical Review Panel deemed sound and high-impact. For example, at the time of the audit, one PR had reallocated $2.7 million originally earmarked for supplementary nutrition to travel and other related costs. Approval was not sought from South Africa's country coordinating mechanism (CCM), nor were alternative

arrangements made for the 18,000 TB patients who require supplementary nutrition to support their adherence and retention on treatment.

Similarly, the OIG report notes that several PRs have reduced geographic coverage targets from those specified in the concept note, also without seeking CCM approval. The adherence program was reduced from 31 to 21 districts and the stigma program was reduced from 18 to six districts.

According to the CCM Secretariat, changes in district coverage for the stigma program were due to the fact that specific costs of the program were not available at the time of grant-making. For the adherence program, the exact implementation support required by health facilities was not yet clear during grant-making because the national adherence guidelines and related standard operating procedures had only just been completed. As a result, targets for implementation were yet to be set by the districts, affecting the selection of sites for the Global Fund grant.

Other key findings on the TB program include delayed implementation of program activities, such as reaching inmates with a comprehensive package, identifying services providers for community mobilization, and training lay counsellors to provide adherence support. Further, the OIG notes that the training of nurses to be able to initiate multidrug-resistant TB treatment had not started at the time of the audit (December 2016), although the country has since confirmed that 88 nurses were trained between January and March 2017.

As part of its planned actions in response to the audit, the South African CCM intends to define thresholds, or "trigger points," which will clearly articulate when changes to budgets or targets must be brought before the CCM for approval.

"Having clearly defined information sharing and approval requirements will help the CCM perform its oversight role more effectively," says Nevilene Slingers, Executive Manager for Donor Coordination at the South African National Aids Council (SANAC) and head of the CCM Secretariat. Slingers also told Aidspan that from 18-20 July 2017, the South African CCM completed a formal CCM orientation, taking its members through the Global Fund's new mandatory training package (see GFO article).

"This training has helped to address some of the ambiguity around CCM roles and responsibilities that the OIG raised," said Slingers.

The OIG also notes significant delays in several program areas, threatening the country's ability to meet its grant performance targets. For instance, aspects of a geospatial mapping exercise to define responses in HIV "hotspots" are delayed by at least six months. SANAC's business case for establishing a social impact bond for sex workers, an innovative finance

mechanism designed to raise additional funding, has not yet been approved by the relevant government department. Data from the TB prevalence survey is unlikely to be available in time to guide implementation of the current grant.

Implementation delays may affect more than the ability to reach targets because of the Global Fund's new "no carry over" rule for unused funds. Any money that is not spent within the grant timeframe must be returned to the Secretariat. Previously, countries were able to roll over savings into the next implementation period.

To mitigate challenges, the OIG suggests there is a need for integrated national plans on the part of the government and development partners to guide the design and geographic prioritization of activities targeting key and vulnerable populations. South Africa already has a National Sex Worker HIV Plan (2016-2019). Since the OIG audit, the country has also published a National HIV Framework for Lesbian, Gay, Bisexual, Transgender and Intersex populations (2017-2022) – touted as a world first.

The Global Fund Secretariat is committed to supporting the country in accelerating implementation. As an example, the OIG report notes the Secretariat's agreed management action to support the updating of the business case for the social impact bond to address issues and risks identified by the Department of Science and Technology.

Difficulties in measuring grant performance is another issue flagged by the OIG, citing weak monitoring tools and a multiplicity of uncoordinated data systems as part of the problem. Given that many of the interventions in South Africa's grant are new, good quality data to assess their impact is particularly important. The OIG notes that the absence of a monitoring and evaluation plan under the 2012-2016 National Strategic Plan (NSP) for HIV/TB/STI is an underlying cause, though this is outside of the control of the Global Fund program. For the country's current NSP (2017-2021), a monitoring and evaluation plan is now being developed.

Coordination challenges

Along with delays, the OIG indicates that coordination challenges at multiple levels pose risks to effective program delivery. Coordination between national and provincial AIDS councils, among various government departments, across multiple funding partners and among the multitude of Global Fund implementers are all noted to affect grant synergy.

"As a PR, we are acutely aware of the coordination challenges in the current Global Fund grants, particularly for the young women and girls program," said Marieta de Vos, Program Director with the Networking HIV & AIDS Community of Southern Africa (NACOSA). Interventions targeting young women and girls are being implemented by six different PRs, creating extra layers of complexity for delivering a standardized package of care, de Vos told Aidspan.

"There are also continued efforts needed to ensure complementarity between the national young women and girls campaign – "She Conquers" – the Global Fund program, PEPFAR's

DREAMS, and other investments from partners like KfW and Elma Philanthropies, as well as the relevant government departments" said de Vos.

In April 2017, the Office of the Presidency convened a high-level meeting to address some of the coordination issues with national young women and girls programming. Those present in the meeting agreed to conduct an activity mapping of donors and service providers reaching this population and to engage with provinces and districts to ensure alignment between national policy and provincial implementation. This high-level group will continue to meet, alongside the quarterly coordination meetings for the Global Fund young women and girls program.

Agreed management actions

The OIG report also spells out a number of management actions agreed to by the Global Fund Secretariat to support improved grant implementation. Specifically, the Secretariat has committed to:

- develop revised budgets and implementation arrangements for the remaining duration of the grants to improve the availability and quality of TB and drug-resistant TB services;
- support the PRs in the development of quality standards for adolescent girls and young women and in revisiting the work plans;
- roll out a revised consolidated performance framework for interventions related to adolescents and young people in and out of school; and
- strengthen oversight by the CCM.

Despite the above-mentioned challenges, the OIG report highlights some key achievements and good practice emerging out of the Global Fund's grants to South Africa. The OIG notes that the Global Fund program is evidence-based, aligned to the country's national strategic plan, and strategically targeted at reaching key and vulnerable populations, including sex workers, men who have sex with men and adolescent girls and young women. The OIG also lauds the South African government's strong financial commitment to the response: Domestic funding accounts for 80% of total HIV resources in the country. South Africa relies on the Global Fund for just 5% of its HIV and TB response.

"South Africa is a world leader in the fight against the diseases and the Global Fund provides catalytic investments in critically important areas," said Seth Faison, Head of Communications at the Global Fund. "Many of these programs are new and require strong leadership and effective coordination. As in all new interventions, changes are made as lessons are learned."

Faison told Aidspan that the Global Fund is already working with partners to address coordination and governance as well as programmatic assurance challenges identified by the OIG.

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4. NEWS: Global Fund is making progress in improving consultant management processes: OIG

Use of consultants in 2016 cut almost in half compared to 2015

David Garmaise 8 August 2017

The Secretariat has made progress in improving consultant management processes, particularly over the last year and half. Consultant costs, as a percentage of total staff costs, have gone down from 35% in 2015 to 19% in 2016. Processes and compliance have improved. The Secretariat is aware of several outstanding weaknesses and has various ongoing initiatives to remediate them.

These were among the findings of an audit on the planning and management of consultants conducted by the Office of the Inspector General (OIG). A report on the audit was released on 2 August 2017.

In 2016, the OIG said, the Secretariat initiated consultant procurement planning and zero-based budgeting. The first annual consultants' procurement plan was completed in 2017. However, the OIG noted that the Global Fund has not yet developed robust strategic workforce planning processes; and that the pros and cons of engaging employees as opposed to long-term consultants are generally not analyzed. Currently, about 60% of the individual consultants are contracted for a period of more than one year. In some cases, the OIG said, long-term consultants were used after staff positions were denied due to an upper limit on staff costs.

The consultant planning and management cycle involves different units of the Secretariat, such as human resource management, budgeting and legal. The processes and controls for consultant management vary considerably across these units. The OIG said that a lack of clearly defined roles and accountability has limited the effectiveness of controls related to consultant management. It added that there is a need for increased institutional guidance and standardized controls.

The financial system used for managing consultant expenditures has strong controls, the OIG reported. However, this system is not designed to cover additional management information needs, which are therefore being addressed through manual processes. On the human resources side, the OIG said, a system is not yet in place to provide easy and reliable access to key information on consultants for effective strategic planning and operational decision-making. The OIG noted that software improvements are currently being designed which will address these gaps.

With respect to contracting and performance management of consultants, the OIG stated that ongoing initiatives have led to adequate on-boarding guidance for consultants, improved integrity checks, and generally well-defined scope of work. However, the OIG said, improvements are needed in the areas of compliance with contractual requirements, reference checks of consultants, and tracking and recording of performance.

In summary, the table below lists the four aspects of consultant management examined by the OIG in this audit, and the OIG's rating for each one.

Table: Aspects of consultant management, showing the rating for each

No.	Aspect	Rating
1.	Planning the use of consultants and alignment with strategic business needs	Partially effective
2.	Processes to ensure that consultants engaged are aligned with defined business requirements	Partially effective
3.	Contracting and performance management of consultants	Partially effective
4.	Internal processes, roles and accountabilities	Need significant improvement

There are four tiers in the OIG's rating scheme: "effective"; "partially effective"; "needs significant improvement"; and "ineffective."

Agreed management actions

In response to the OIG's findings, the Secretariat agreed to incorporate detailed guidance to its various units on the use of consultants; to define roles and responsibilities for key aspects of consultant management; and to enhance controls on contractual compliance, reference checking and performance tracking. The Secretariat will also analyze the costs, benefits and risks for existing long-term consultants against staffing options.

Previously identified issues

The OIG audit report on the Global Fund Procurement and Supply Chain Management in 2015 (GF-OIG-15-008) covered the recruitment and selection of consultants. Significant gaps were identified; for example, 74% of non-health procurements sampled, including consultants, were selected using the "exception to competition" option. The audit also confirmed earlier findings from a European Commission audit of the Global Fund, about material weaknesses in procurement-related systems, controls, rules and procedures.

Subsequent OIG reports (GF-OIG-16-016 and GF-OIG-16-026) covering consultant selection highlighted similar weaknesses. Other selection weaknesses were also noted, including missing critical bid evaluation details in the bidding documents; arbitrary use of different evaluation methods in selection which were not pre-defined; failure to prepare technical evaluation reports; evaluation committee members not declaring potential conflicts of interest; and non-competitive determination of consulting fee rates.

In response to these various findings on the selection processes, the Secretariat is currently revising all procurement regulations under an ongoing Procurement Improvement Plan, a joint initiative of the finance and sourcing teams. This plan is incorporating strengthened controls in the consultant selection processes, including stricter rules on the use of "exceptions to competition," approval thresholds, and conflict of interest declarations. The improvements also include clear definitions of compliance roles, accountabilities and reporting mechanisms. The revisions are captured in the agreed management actions from the earlier OIG reports, with target dates of June 2017.

All OIG reports are available on the audit and investigations page of the OIG section of the Global Fund's website.

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5. ANALYSIS: Unitaid: key innovation partner of the Global Fund

A closer look at an organization that helps build the evidence for scale-up of the most impactful interventions for HIV, TB and malaria

Charlie Baran 8 August 2017

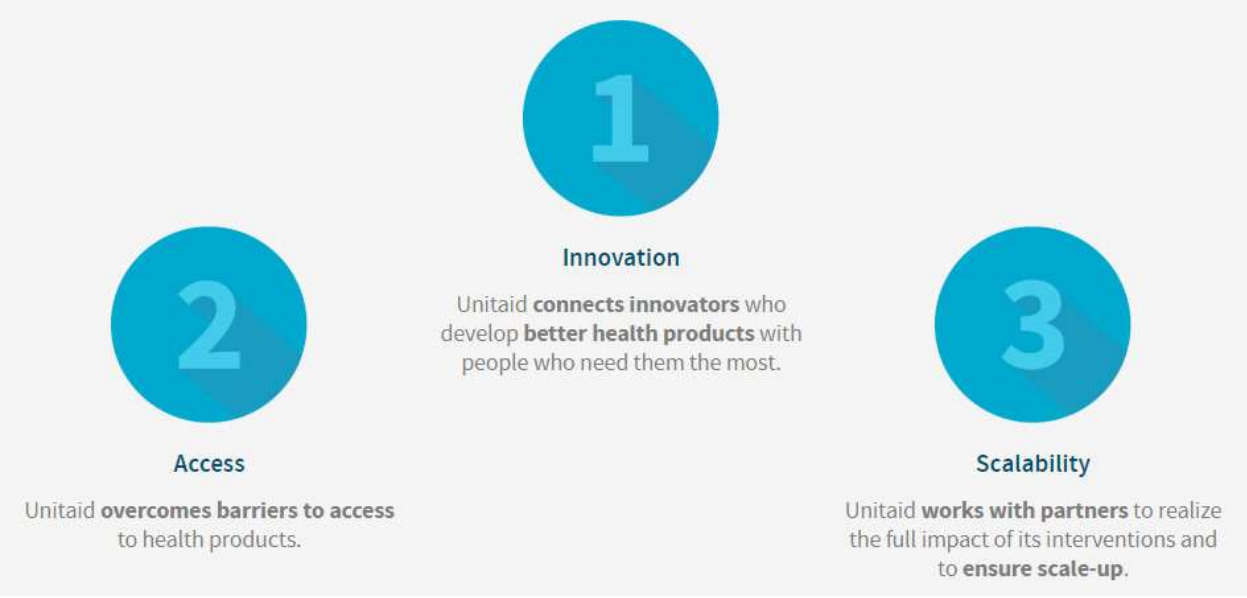

Image: Unitaid's strategic objectives

In two previous articles this year (see Part 1 and Part 2), GFO analyzed some of the similarities and differences among four of the largest multilateral global health financing mechanisms: the Global Fund, Gavi, the vaccine alliance, the Global Financing Facility in Support of Every Woman Every Child, and Unitaid. In those articles, we discussed where there are some notable overlaps among donors and recipients of the mechanisms, where there is alignment across strategic objectives, and how they distinguish themselves from each other in approach, scope and engagement with civil society and impacted communities.

Building on this reporting, GFO offers this focused profile of Unitaid, which has deep synergies with the Global Fund. There are good reasons for Global Fund stakeholders – particularly those involved with funding request development and implementation planning – to be aware of how Unitaid works and what that can mean for HIV, TB and malaria programs at country level.

As described in it the opening of its 2017-2021 Strategy, "Unitaid's mission…is to maximize the effectiveness of the global health response by catalyzing equitable access to better health products." A three-pronged approach operationalizes this mission: *Innovation, Access, and Scalability*. Using a much smaller budget (average $250 million per year) than the Fund or Gavi, Unitaid can be thought of as more laboratory and less implementer. Where the Global Fund supports programs through which products and services are delivered to large populations, Unitaid supports smaller-scale initiatives to see how new and innovative health products and delivery approaches can overcome barriers and achieve the most impact.

"We are small but highly maneuverable and operate like a speed boat," said Unitaid's Executive Director, Lelio Marmora. "That allows us to explore uncharted waters and act as pathfinders for the Global Fund and other big entities that are more like aircraft carriers in scale." To oversimplify: Unitaid tests, the Fund delivers.

One word that can be used to describe Unitaid is *catalytic*. "We can take bigger risks than others can," said Sanne Fournier-Wendes, Senior Advisor to the Executive Director at Unitaid. Unitaid can try out promising but untested ideas, or help generate the evidence to inform World Health Organization (WHO) guidelines or national programs which are then referenced by the Fund or others. The Global Fund, on the other hand, is not built for risk-taking; the Fund channels money to proven interventions for maximum impact. As such, the Fund's success relies heavily on innovators like Unitaid, particularly in those treatment and prevention areas which are less "tried and true."

Key programs

Unitaid currently has 40 active grants, with investments totaling about $800 million, which aim to "identify cutting edge innovations in [HIV, TB and malaria] and beyond," said Fournier-Wendes. Unitaid's recent open calls for proposals reflect some of their top priorities, including multidrug resistant TB (MDR-TB), access to malaria treatments, HIV self-testing, and low-cost licensing and generic pharmaceutical production through TRIPS (trade related aspects of intellectual property rights) flexibilities.

endTB project

One of the most challenging aspects of the response to TB – for public health officials and patients alike – is MDR-TB. The common treatment regimens for MDR-TB are completely inadequate: They are long (up to two years), they are toxic (causing severe and lasting side effects), and they are often ineffective.

"The endTB project aims to find better, shorter and less toxic treatments for MDR-TB," said Eva Nathanson, who oversees Unitaid's TB and malaria portfolios. The endTB project – a

clever acronym for *Expand New Drug Markets for TB* – aims to ensure access to two new TB drugs for countries who need them but cannot afford them. The two drugs, bedaquiline (developed by Janssen) and delaminid (developed by Otsuka), are the first new TB drugs to come to market in 50 years. According to Unitaid, which works with Partners in Health on the project, "the treatment regimens for the new drugs are shorter than the existing MDR-TB regimens and are presumed to be more effective and less toxic."

While Unitaid and endTB are not behind the development of these drugs, they are at the forefront of understanding the market for the drugs, and the development of optimal treatment regimens, particularly in resource-limited environments. The project is currently working in 17 low- and middle-income countries, all of which have active TB grants from the Global Fund, where about 1,500 MDR-TB patients have been enrolled in an observational study looking at feasibility of the two regimens. The 17 countries are Armenia, Bangladesh, Belarus, DPRK (North Korea), Ethiopia, Georgia, Haiti, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Myanmar, Pakistan, Peru, South Africa and Viet Nam.

"The preliminary outcomes are promising, said Nathanson. "We have just witnessed remarkable progress in two countries, Lesotho and Georgia, where patients, care-givers and health care personnel are thrilled by the improved treatment outcomes and less toxic treatment for patients." The next phase will be a clinical trial in six countries looking at the performance of these treatments against conventional TB treatment.

As Nathanson sees it, an important outcome of the endTB project – should the findings indicate that the new treatments are superior and deliverable – would be new WHO guidelines for MDR-TB treatment. These guidelines would then form the basis of TB program planning in Global Fund recipient countries and beyond. In addition, Unitaid communicates directly with the Fund's Technical Review Panel to keep them up to speed on developments and product lists. Unitaid personnel also occasionally join Global Fund country teams on missions to better understand how Unitaid project results are applied, and what local priorities and challenges are. Thus the project is being implemented with an eye towards feasibility in Global Fund-supported contexts, both from a technical review and procurement angle as well as grant implementation at country-level.

ACCESS-SMC project

"The ACCESS-SMC project has been vital to gaining evidence on the effectiveness of malaria prevention among children," said Nathanson. The project has so far proven the feasibility, safety and effectiveness of seasonal malaria chemoprevention in the countries of West Africa and the Sahel where malaria transmission is strongly linked to distinct rainy seasons. (The Sahel, a transitional region between the Sahara in the north and the savannahs to the south, spans a number of African countries.) The ACCESS-SMC project ensured that 6.4 million vulnerable children across the Sahel received malaria prophylaxis in 2016.

ACCESS-SMC, in which Unitaid is partnering the Malaria Consortium, is another example of Unitaid's catalytic approach. There were indications that seasonal malaria chemoprevention (SMC) could have a substantial positive impact for children in areas where there is seasonal malaria risk, rather than year-round, such as in the Sahel region. But funders

were hesitant to invest in SMC because it was an unproven intervention. Unitaid was able to take the risk and implement large scale roll-out of SMC in Sahel and demonstrate that the intervention was feasible, safe and effective, thus opening the door for longer-term financing to bring SMC to more children. "Out of seven SMC project countries, four (Gambia, Guinea, Mali and Niger) have secured Global Fund financing for SMC in 2017," said Nathanson, indicating that pediatric malaria prevention is headed for scale-up around the region in the near future.

How the Fund and Unitaid interact

Unitaid and the Global Fund have an exceptionally synergistic relationship. "We work very closely with the Global Fund at all levels," said Fournier-Wendes. In many cases, Unitaid tests new products or delivery approaches and the Global Fund scales up those that demonstrate impact. In practical terms, they are working with much of the same variables: Both focus largely on the same three diseases, and are working in many of the same countries; six of the Fund's top ten recipients are also in Unitaid's top ten. At the country-level, Unitaid requests its grantees work with CCMs to encourage countries to include successful products in funding requests and national strategies.

One strategic area in which the Fund and Unitaid work very closely is market-shaping. "Market-shaping" generally refers to the intervention of non-market actors, such as NGOs or funders, to help clear or mitigate hurdles to the introduction, distribution or acceptance of new products. In 2014, the organizations signed a collaboration agreement regarding a shared market-shaping agenda, which has been updated since. Their market-shaping also relies on the upstream/downstream roles the organizations inhabit, with Unitaid focusing on demonstrating feasibility or demand-generation for products and approaches, and the Fund providing the resources to bring interventions to scale. The Fund's immense purchasing power is then further leveraged for affordability for recipient countries, such as through wambo.org, the Fund's online procurement platform for PRs, in which Unitaid is also a co-investor.

STAR program

The ongoing STAR program ("Stimulating and shaping the market for HIV self-testing in Africa") is a key example of how Unitaid and the Fund work synergistically, both in implementation research and market-shaping. According to the program's webpage, the first phase of the STAR grant, which is implemented by Population Services International, "aims to evaluate the acceptability, feasibility, and impact of HIV self-testing among different populations in Malawi, Zambia and Zimbabwe, and generate information about how products for HIVST [HIV self-testing] can be distributed effectively, ethically, and efficiently." The first phase of the program, which focused on providing proof of concept for HIVST in low- and middle-income settings, is wrapping up now.

According to the program's manager, Heather Ingold, the results of STAR Phase 1 have been "very encouraging," showing that tests can be accurately used by lay people, that demand is high, and that no social harms have been reported. The first phase of STAR found that HIVST reaches populations not already accessing services (44-52% are men, 32-48% are

adolescents and 21-31% are first time testers) and that HIVST increases the overall uptake of HIV testing. "We're seeing people who self-test link to care earlier, and [we are seeing] that HIVST increases linkage to voluntary medical male circumcision (VMMC) for HIV-negative men, Ingold said."

This first phase has already produced results for Global Fund grantees: three self-test products have received eligibility certification from the Unitaid /Global Fund Expert Review Panel for Diagnostics, which means that they are able to be procured with Global Fund grant monies. The Phase 1 results also led to the WHO issuing normative guidance for HIVST in 2016, which has in turn helped to expand the number of countries which are including HIVST as part of their approach to HIV testing, prevention, and linkage to care. According to a report released on 25 July 2017 by Unitaid and WHO, 40 countries now included HIVST in their national strategies.

Phase 2 of this project has further implications for countries with Global Fund grants because it will help resolve two critical application issues, according to Ingold: "The total cost of test delivery needs to be further optimized, in addition to reducing the cost of the commodity; and a clear investment case must be built, including evidence of cost-effectiveness and impact of HIVST in closing the testing gap and on linking newly identified cases to treatment and care – as well as linking those found negative to combination prevention services."

Phase 2 of the STAR program includes the addition of South Africa, Lesotho and Swaziland alongside continued work in the Phase 1 countries, Malawi, Zambia and Zimbabwe. More information on HIV self-testing is available at hivst.org.

Unitaid also has active market-shaping projects on the treatment side of the HIV response. Most recently, Unitaid partnered with the Government of Kenya to announce that a previously unavailable antiretroviral drug, dolutegravir (DTG), is being introduced as a new first-line option for people living with HIV in Kenya. According to the press release, "DTG has been the drug of choice for the last two years for people living with HIV in high-income countries," due to its low toxicity and simple one-pill-daily regimen.

Unitaid is also supporting four clinical trials involving DTG to gather the evidence required to expand the use of DTG to patient populations in low-income countries. Without the intervention of Unitaid to support initial roll-out and associated data collection on feasibility of the regimen in Kenya, Kenyans living with HIV would wait up to several more years to access the improved ARV therapy, which has fewer side effects and is better tolerated than other regimens. As part of the initiative, Unitaid is also helping to introduce DTG in Uganda and Nigeria this year. Pending the results of clinical trials which will inform WHO treatment guidelines, it will likely become a major product procured with Global Fund grants moving forward.

Finally, there are even strong connections between the Fund and Unitaid from a human resources and facilities standpoint. The Executive Director, Lelio Marmora, and a number of other staff at Unitaid spent earlier parts of their careers at the Fund. Prior to joining Unitaid, Mr. Marmora oversaw the Africa and Middle East department at the Fund. Today both

organizations are on the same campus in suburban Geneva. And they will both be moving to the new Geneva health campus with Gavi and the Stop TB Partnership in 2018.

Unitaid is a resource for the Global Fund, other funders – including PEPFAR – and disease-response planners and implementers. As Global Fund country teams and country-level stakeholders develop funding requests and reprogram grants, they would be well-served to keep abreast of Unitaid's work and results, particularly innovations in the pipeline, so as to be able to incorporate some of the most relevant and optimized HIV, TB and malaria treatment, prophylaxis, and diagnostic products and approaches. Because the products and approaches are pursued with Global Fund implementation in mind, implementers may find Unitaid results some of the most practical and applicable around.

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6. NEWS: Programs supported by the Global Fund continue to show impressive results

Gains reflect increased uptake and better reporting

David Garmaise 8 August 2017

The Global Fund continues to show impressive gains with respect to the number of people receiving key HIV, TB and malaria services as a result of programs supported by the Fund. Some of the gains reflect increased uptake of services, while other gains are the result of better reporting.

On 20 July, the Global Fund released a fact sheet on its results for the period ending in December 2016. There is a six-month lag in reporting due to the time it takes to collect and verify the data.

In the six months ending December 2016, an additional 953,000 people were put on antiretroviral therapy (ARV) by programs supported by the Global Fund, an increase of 9.5%. Four countries account for about half of the six-month increase: Nigeria (22%), Tanzania (11%), Uganda (10%) and Myanmar (10%). In addition, the full national result from Kenya is now included in Global Fund reporting; previously, the Global Fund captured just 50% of the national result.

Over that same period, 826,000 new smear-positive TB cases were detected and treated, an increase of 5%. India and Indonesia accounted for 60% of the increase. Also in the second half of 2016, about 82 million mosquito nets were distributed for the prevention of malaria, an increase of 11.5%. The highest number of nets was distributed in Tanzania, the Democratic Republic of Congo, Guinea and India. Together, they accounted for 70% of the increase from June 2016.

Year-over-year results

The results for all of 2016 are shown in the table.

Table: Global Fund results for key services as of end 2016 showing comparison with 2015 results

Indicator	End-2015 results	End-2016 results	Gain	% increase
HIV				
ARVs	9,220,000	11,000,000	1,780,000	19.3%
PMTCT	3,600,000	4,250,000	650,000	18.1%
Counseling & Testing	509,000,000	579,000,000	70,000,000	13.8%
Basic care & support for OVC	7,860,000	8,000,000	140,000	1.8%
Condoms distributed	5.27 billion	5.32 billion	50,000,000	0.9%
TB				
Smear+ cases detected and treated	15,100,000	17,400,000	2,300,000	15.2%
Cases successfully treated	11,700,000	14,800,000	3,100,000	26.5%
Treatment for MDR-TB	267,000	373,000	106,000	39.7%
Malaria				
ITNs distributed	659,000,000	795,000,000	136,000,000	20.6%
Structures covered by IRS	63,900,000	73,900,000	10,000,000	15.6%
Cases of malaria treated	582,000,000	668,000,000	86,000,000	14.8%

The fact sheet includes an explanation of how the results were calculated and verified, as well as information on the criteria for reporting on national results. The fact sheet states that Namibia and Swaziland were excluded from the end-2016 ARV results as they did not meet the criteria for reporting national results. The fact sheet also states that the Global Fund reports 10% of the national number of people on ARV in South Africa because it provides 10% of the country's ARV drugs.

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7. NEWS: Four INGOs implementing more than 30 active Global Fund grants have strong anti-fraud policies and procedures: OIG

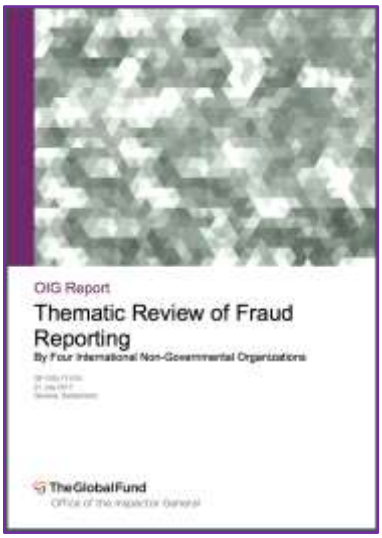
David Garmaise 8 August 2017

A thematic review of fraud reporting by four international NGOs (INGOs), conducted by the Office of the Inspector General (OIG), has concluded that all four had strong anti-fraud policies and procedures in place. The OIG said that there were only a few examples of under-reporting, which have since been rectified through the implementation of improved procedures.

A report on the thematic review (GF-OIG-17-015) was released on 21 July 2017.

The four INGOs are Catholic Relief Services, Population Services International, Save the Children and World Vision International. The four are responsible for implementing more than 30 active Global Fund grants totaling over $1.2 billion in countries categorized as extreme or high risk by the Global Fund.

The report provided the following information on the four INGOs:



Catholic Relief Services (CRS) was founded in 1943 to serve World War II survivors in Europe. It has since expanded with a global reach of more than 107 million people in 101 countries on five continents. Headquartered in Baltimore, Maryland, U.S., CRS had, as of 2014, over 5,000 employees and revenues of $733 million.

Population Services International (PSI) was founded in 1970 as a global non-profit health organization headquartered in Washington, D.C., U.S., with programs targeting malaria, child survival, HIV and reproductive health. PSI operates across 60 countries and employs over 8,900 staff. Its revenues in 2015 were just over $652 million.

Save the Children Federation, Inc. was founded in 1932 and is headquartered in Fairfield, Connecticut, U.S. Save the Children International was founded in 1977 and is a worldwide non-profit organization comprising 30 member organizations. Headquartered in London, U.K., it has over 14,000 employees. Its combined revenues in 2015 of over $2.1 billion were used to reach around 62 million children in over 120 countries. Save the Children Federation, Inc. is the principal recipient (PR) for a number of Global Fund grants; however, the grants are implemented by Save the Children International, which acts as a sub-recipient under the grant agreements.

World Vision International (WVI) is a global Christian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. Its predecessor was originally founded in the U.S. in 1950. WVI now comprises offices in 90 countries with headquarters in London, U.K., Monrovia, California, U.S. and other locations. The combined revenues for the World Vision global partnership in 2016 amounted to around $2.7 billion and it has approximately 41,000 staff.

Under the Global Fund's Grant Regulations, all PRs are required to "notify the Global Fund promptly in writing of any audit, investigation, probe, claim or proceeding pertaining to the operations of the principal recipient or any of its sub-recipients or suppliers." The Fund's Code of Conduct for Recipients imposes a similar obligation.

All four INGOs have whistle-blowing or counter fraud policies which require their employees to report suspected fraud, the OIG reported. However, the OIG noted, while fraud reporting mechanisms were in place in all four INGOs, not all such mechanisms currently

provide for online anonymous reporting. In addition, some gaps and inconsistencies in the implementation of fraud reporting policies and procedures were found at country level.

In its report, the OIG made seven recommendations which it said all Global Fund implementers should adopt, as required. The following is Aidspan's summary of the recommendations:

1. For INGOs and other implementers with fraud reporting policies and procedures and professional investigation resources, record *all* allegations and suspicions of fraud received, both at country and HQ level. The subsequent assessment and the rationale for taking the decision to investigate or not investigate must always be fully recorded. For implementers without such fraud reporting policies and procedures and professional investigation resources, *all* reports must be relayed directly to the Global Fund.
2. Clarify in whistle-blowing policies that any acts of retaliation against whistle-blowers will be taken seriously and could potentially lead to disciplinary action.
3. Communicate clearly to sub-recipients their contractual obligations concerning fraud reporting and the response to fraud to ensure that they meet their obligations under the grant agreement and the Code of Conduct for Implementers.
4. Be clear in guidance and procedures to country offices on how to report and respond to fraud reports.
5. Implement anonymous reporting mechanisms at a country level, including training and awareness of the complementary whistle-blower anti-retaliation policies.
6. Notify the OIG prior to starting investigative fieldwork so that it can provide input to terms of reference and consider undertaking a joint investigation, where warranted.
7. Provide the Global Fund and the OIG with copies of internal investigation reports relating to Global Fund resources as well as any recommended remedial actions to mitigate the risk of similar future occurrences of fraud.

To assist implementers to understand, identify, manage and respond to wrongdoing, and as part of its "I Speak Out Now!" initiatives, the OIG has created an Anti-Fraud and Anti-Corruption Tool Kit for Implementers.

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8. NEWS: In brief: Important HIV-related developments

David Garmaise 8 August 2017

Several important HIV-related announcements were made in the last few weeks. We provide short summaries.

"The scales have tipped"

UNAIDS announced on 20 July 2017 that in 2016, for the first time, more than half of the people living with HIV (19.5 million of the 36.7 million living with HIV) were able to access HIV treatment. In addition, AIDS-related deaths have almost halved since 2005 – from 1.9 million to 1.0 million.

UNAIDS said that provided scale-up continues, this progress puts the world on track to reach the global target of 30 million people on treatment by 2020.

The region showing the most progress is eastern and southern Africa, which has been most affected by HIV and which accounts for more than half of all people living with HIV. Since 2010, AIDS-related deaths in this region have declined by 42%. New HIV infections have declined by 29%, including a 56% drop in new HIV infections among children. UNAIDS referred to this as "a remarkable achievement" and said that HIV treatment and prevention efforts are putting eastern and southern Africa on track towards ending its AIDS epidemic.

A report, a news release and various other documents are available here.

"Unacceptable death tolls" – MSF

The tide may have turned in the global fight against AIDS, but too many people in sub-Saharan Africa are developing and dying of AIDS-related diseases due to limited testing and problems with treatment, Medecins Sans Frontieres (MSF) told the Thomson Reuters Foundation on 25 July.

Despite much improved access to ARVs in sub-Saharan Africa, an "unacceptably" high number of people are developing AIDS and dying due to drug resistance, treatment being interrupted and late diagnoses, MSF said.

Donor funding for HIV dips

Donor government funding to support HIV efforts in low- and middle-income countries decreased by $511 million from $7.5 billion in 2015 to $7.0 billion in 2016, according to a report produced by the Kaiser Family Foundation and UNAIDS.

"Donor government funding for HIV continues to be on the decline," said Kaiser Family Foundation Vice President Jen Kates, director of global health and HIV policy. "Recent proposed cuts from the U.S., amidst other competing demands on donor budgets, will likely contribute to an ongoing climate of uncertainty around funding for HIV going forward."

According to a news release from UNAIDS, this marks the second successive year of declines, and is the lowest level since 2010. UNAIDS said that the decrease stems from actual cuts in funding (accounting for about half of the decline); exchange rate fluctuations (20%); and the timing of U.S. contributions to the Global Fund (30%), due to U.S. law that limits its funding to one-third of total contributions. Some of the decline was due to donor decisions to front-load their funding early in the 2014-2016 Global Fund pledge period.

Swaziland: major strides

Dramatic new data from Swaziland provide some of the most convincing evidence yet that aggressively ramping up treatment for HIV works on a population level to cut the rate of new infections, according to an article in Science Magazine published on 24 July. The data was presented in Paris at the international conference of the International AIDS Society.

The kingdom had one of the worst HIV/AIDS epidemics in the world, but since 2011 a massive scale-up of testing and treatment has slashed the rate of new infections by 44%.

A survey in 2011 showed that 32% of the Swazi population between the ages of 18 and 49 was living with HIV – the highest prevalence of any country in the world. At the time, only 72,402 of those people were receiving ARV treatment. Only 34.8% of the infected population had suppressed the virus. The rate of new infection, or incidence, was 2.5% per year.

Today, 171,266 HIV-infected people in Swaziland receive ARVs, thanks to support from the Global Fund and PEPFAR. A 7-month survey, funded by PEPFAR and completed last March, found that 73.1% of the infected population now has fully suppressed virus, and the HIV incidence had dropped to 1.4%—a 44% decrease. In addition to ramping up treatment, the country also has seen big increases in men opting to be circumcised.

When the survey results were presented at the conference, the room erupted into hoots and applause.

“These findings are cause for celebration,” said Wafaa El-Sadr, an epidemiologist at Columbia University whose group helped Swaziland conduct the surveys. “It’s a dramatic blunting of new infections.”

Undetectable viral load = zero transmission

Another study whose results were presented at the IAS conference in Paris found that no transmissions occurred in encounters between HIV-positive men with an undetectable viral load. The Opposites Attract study, led by professor Andrew Grulich from the Kirby Institute, followed a cohort of 358 gay male couples – one partner HIV-positive, the other HIV-negative – in Australia, Thailand and Brazil.

Not a single HIV transmission occurred across the almost 17,000 times participants reported having anal sex without a condom; 12,000 of those sexual encounters were protected solely by the HIV-positive partner's undetectable viral load.

See also here.

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