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NEWSLETTER

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BY DAVID GARMAISE

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2. NEWS and ANALYSIS: Making progress slowly or not at all? TRP and CCM go back and forth on services for MSM and transgendered persons in Global Fund grants to Ethiopia

BY DAVID GARMAISE

Despite the fact that the Technical Review Panel noted the lack of interventions targeting men who have sex with men, and transgendered persons, when it reviewed Ethiopia's HIV concept note from the 2014–2016 allocations, the TB/HIV funding request for 2017-2019 made no mention of these populations. The TRP and the Ethiopian country coordinating mechanism went back and forth on this issue during the review of the funding request and during grant-making. The TRP suggested that Ethiopia set up male health clinics where MSM could remain anonymous.

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BY AIDSPAN STAFF

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BY DAVID GARMAISE

The Global Fund Board has approved another $1.22 billion in funding for country grants, bringing the cumulative amount awarded to date to $8.86 billion. A fifth batch was approved on 12 January, consisting of 33 grants emanating from 22 funding requests from 16 countries. Interventions worth $383.3 million were added to the Unfunded Quality Demand Register. Also approved as part of Batch 5 was a multi-country grant for Southern Africa.

7. NEWS: OIG commends progress made by Global Fund grants to Bangladesh, but says several challenges remain

BY DAVID GARMAISE

An audit of Global Fund grants to Bangladesh rated them as "partially effective," the second highest rating in the OIG's four-tier rating scheme. The Office of the Inspector General said that Bangladesh has made significant progress in the fight against the three diseases, but that problems remain. The audit identified significant program and financial management weaknesses in the national TB program.

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BY DAVID GARMAISE

We correct two errors in an article on LFA tenders published in GFO 328 on 10 January.

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ARTICLES:

1. NEWS: TRP focuses on gaps in services for key populations in its review of Ethiopia's TB/HIV funding request to the Global Fund

Concerns raised regarding sustainability of national programs

David Garmaise 23 January 2018

When the Technical Review Panel (TRP) assessed Ethiopia's TB/HIV funding request last Fall, it considered the request to be technically sound, but expressed concerns related to coverage of key populations.

"While the request does build on results and impact of previous periods to guide implementation for sex workers and their clients and other vulnerable populations, [it] does not address how HIV prevention, care and treatment services will be provided to the key populations of men who have sex with men (MSM) and people who inject drugs (PWID)," the TRP said. In addition, the TRP said, the request did not fully describe the TB/HIV situational analysis by sub-populations, gender, age and geographical locations.

The TRP recommended that the funding request proceed to grant-making with some issues to be cleared by the TRP and the Secretariat. The request successfully completed grant-making and, on 1 December 2017, the Global Fund Board approved the two grants emanating from the request as part of the third batch of grant approvals for 2017–2019 (see GFO article).

The Board approved $239.8 million for the within-allocation portion of the funding request. Ethiopia also asked for $113.8 million in a prioritized above-allocation request (PAAR), of which $90.7 million was deemed to be quality demand and was added to the Unfunded Quality Demand (UQD) Register. The two principal recipients (PRs) are the Federal Ministry of Health (FMOH) and the Federal HIV and AIDS Prevention and Control Office.

EPI SITUATION AND CURRENT STRATEGIES

Ethiopia has a low intensity HIV epidemic (prevalence was estimated at 1.2% in 2016), with disproportionately high infection rates among key populations (e.g. 23.0% for female sex workers; 6.0% among PWID; 4.9% among truck drivers; and 4.2% among prison inmates). There are no formal published reports on HIV prevalence among MSM.

Ethiopia is a high burden country for TB, TB/HIV and multi-drug-resistant TB (MDR-TB), with estimated TB incidence at 192 per 100,000 and a mortality rate of 26 per 100,000. The treatment success rates among drug-sensitive TB patients and drug-resistant TB (DR-TB) patients are 89% and 70%, respectively.

Global Fund–supported strategies and activities planned under the Ethiopia HIV program include the following:

- implementation of a prevention program for female sex workers (FSWs), migrants and other vulnerable populations;
- intensification of targeted HIV testing and counselling services to perform eight million tests per year and increase the proportion of people living with HIV tested from 72% to 90% by 2021;
- virtual elimination of mother-to-child transmission of HIV; and
- increasing antiretroviral therapy (ART) coverage to 83% (from 423,000 in 2017 to over 626,000 by 2021).

Global Fund–supported strategies and activities planned under the TB program include the following:

- improving case notification and access to quality TB, DR-TB and TB/HIV services so that 473,000 additional TB cases and 4,850 MDR-TB cases are notified over 3.5 years;
- increasing enrolment on MDR-TB treatment from 730 in 2017 to 1,590 in 2021;
- increasing the proportion of TB cases with drug susceptibility testing from 9% to 40% in 2021; and
- increasing the proportion of TB cases with documented HIV status to 96% in 2021.

The GAC acknowledged the ambitious targets of the HIV and TB programs. However, considering the context of a paced reduction in the allocation, and given that the Global Fund currently supports 100% of the cost of antiretrovirals (ARVs) and first- and second-line anti-TB drugs, the GAC said, there is a risk that funding for ARV and MDR-TB treatment will not be sustainable beyond the current implementation period without increased country ownership and significant additional domestic contributions. The GAC expressed concern about the discrepancy between the number of patients to be covered by ART by 2021 in the Global Fund-supported budget (500,000) and the national target for this period (626,000). The GAC said there are risks that further scale-up would create financial gaps in Years 2 and 3 of the program. This is an issue in many countries, not just Ethiopia; Aidspan reported at length on this issue in GFO 327.

The mention of "paced reductions" in the previous paragraph refers to the fact that when the 2014–2016 allocations were announced in March 2014, Ethiopia's HIV component was categorized as being "significantly over-allocated." Ethiopia was told to expect that future allocations for its HIV component would be gradually reduced until such time as the component was no longer over-allocated.

STRENGTHS OF THE FUNDING REQUEST

The TRP said that the funding request is aligned with national priorities and most international normative guidance. The TRP noted that the request covers a significant percentage (68%) of the estimated TB care and treatment gap. As well, the TRP applauded the fact that differentiated care models are being piloted in six "high-load" hospitals.

The TRP observed that the funding request demonstrated linkages between TB and other services, such as integrated management of neonatal and childhood illness and routine maternal and child health services contributing to improved TB care.

In addition, the funding request reflects good coordination amongst donors and government, with planning undertaken to maximize impact, the TRP said. Examples include the Federal Ministry of Health annual resource mapping exercise to align and harmonize donors' investments.

ISSUES AND CONCERNS

The TRP identified nine issues which it said should be addressed during grant-making and one issue to be taken up during grant implementation. The Review and Recommendation Form for Ethiopia's TB/HIV funding request describes each issue as well as the actions recommended by the TRP. For some of the issues, sources provided Aidspan with information on how the issues were addressed in grant-making.

For space reasons, we have had to be selective concerning which issues we include in this article.

Issue #1 — Lack of targeted programming for key populations that are not accepted by society

The TRP said that the funding request did not make any reference to the key populations of MSM and transgendered people (see separate article in this issue), and made only a passing reference to PWID.

The TRP suggested that the CCM assess the extent to which PWID are accessing services and develop an action plan to enhance access. The TRP also suggested that a mechanism be established to ensure that PWID are able to provide meaningful input to the development of the action plan, while protecting their privacy and safety.

In response, we understand that the CCM outlined an action plan that contained interventions to prevent substance abuse, and to provide social, counselling, rehabilitation and HIV services to victims of substance abuse, including PWID. The CCM said that the interventions will include establishing or strengthening anti-drug clubs in schools and institutes of higher education; developing educational posters and brochures; and scaling up services for substance users in health facilities. There were no harm reduction interventions planned. Nor was there any information on whether and how PWID provided input into the development of the action plan.

According to our sources, the TRP pointed out that the action plan did not include opioid substitution therapy (OST). However, the TRP said, OST could be considered in the future when health structures and personnel and law enforcement agents are more able to address the needs of PWID.

Issue #2 — Lack of a human rights and gender framework

The TRP said that the funding request lacked a human rights and gender analysis of barriers and opportunities to enhance access to, and use of, HIV and TB services. The TRP explained that the barriers include social barriers, such as stigma and discrimination, as well as legal barriers. Examples of legal barriers are laws limiting political, civil, economic or social rights of groups affected by HIV; laws that criminalize and penalize key and vulnerable populations and, therefore, foster stigma and discrimination; and laws that fail to protect the equality of women, as well as protect them from violence.

The TRP requested that the CCM (a) identify the key barriers that impede access of key populations to HIV and TB services; and (b) in consultation with the affected communities, develop an action plan with practical steps to remove the barriers or mitigate their impact. These steps may include changing laws, the TRP said, but that does not imply that that legal change is the only or primary option.

We understand that in its response, the CCM identified barriers such as stigma in health facilities, fear of stigma, and fear of non-confidentiality (based on a study of most-at-risk populations). The CCM also listed factors that contribute to gender inequality and gender-based violence.

The CCM listed several interventions that it said are incorporated in the funding request — such as conducting a national survey of most-at-risk populations to produce estimates of population size and service utilization, and to help understand the barriers; scaling up services in drop-in centers and clinics; providing training to law enforcement personnel on stigma and discrimination and gender issues; and providing female sex workers with human rights literacy training.

The TRP was said to be satisfied with these clarifications.

Issue #3 — Gaps in HIV prevention for female sex workers (FSWs) and their clients

The TRP said that proposed prevention interventions targeted to FSWs and their clients were under-resourced in the current funding request, while prevention interventions targeted at the general population were unduly prioritized. The TRP recommended that the CCM consider reprogramming resources from prevention aimed at the general population to activities targeting FSWs, their clients, and other sub-populations at risk. The TRP also recommended that these groups receive "enhanced coverage" with an essential package of services. Finally, the TRP recommended that the CCM provide a one-page summary that includes targets designed to achieve at least 65% coverage of combination prevention services for sex workers and their clients.

We understand that in response, the Ethiopian CCM noted that the country's investment case gives high priority to combination prevention interventions for FSWs. There is a national package for provision of combination prevention services to FSWs being implemented through the support of the Global Fund, PEPFAR and other partners, the CCM said. Services include social mobilization and demand creation, mainly using group discussion approaches; condom distribution and education; HIV testing and counselling; referral and linkage of community-level interventions to health facilities that provide other health services; and care and treatment services. The CCM said that these initiatives, when combined with other activities, will enable Ethiopia to reach at least two-thirds of FSWs and their clients with combination prevention services.

We understand that the TRP was satisfied with the clarifications provided.

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Issue #4 — HIV testing not optimized

The TRP said that the funding request does not adequately prioritize HIV testing and counselling (HTC) for sub-populations at risk, in particular FSWs, MSM, transgendered persons, PWID, prisoners and other priority populations with higher HIV prevalence. The TRP recommended that Ethiopia consider reprioritizing HTC resources towards interventions that identify key and priority populations and link them to treatment services. The TRP requested that the CCM provide a two-page summary of key targeted testing approaches.

We understand that in response, the CCM said that one of the objectives of the national HIV strategic plan for 2015–2020 is intensifying targeted HIV testing services that are designed to identify the majority of new infections and link patients to care and treatment. To achieve this, the CCM said, Ethiopia designed and implemented a national Catch-Up Campaign starting in November 2016. Thirteen key populations were identified, including FSWs and their clients, inmates, truck drivers and orphaned and vulnerable children (but not MSM, transgendered persons or PWID). The CCM listed several prioritized interventions, including:

- strengthening targeted demand creation for HIV testing services through community peer support groups among partners of index cases;
- strengthening facility-based and outreach HIV testing services;
- strengthening partner notification; and
- integrating HIV testing services in social support settings of selected health facilities established to support victims of substance abuse, including those who inject drugs.

The TRP indicated that it was satisfied with the clarifications provided.

Issue #6 — List of key populations for TB care incomplete

The TRP said that although Ethiopia plans to implement targeted interventions addressing the needs of prisoners, children, health workers, (some) refugees, pastoralist communities and urban poor – there is limited information on how the needs of other high-risk groups will be addressed, including South Sudanese and Somali refugees, internally displaced persons and miners. The TRP requested that the CCM provide a more robust description of key affected populations for TB and provide strategies to enhance case finding among these groups. We are not aware of how this issue was addressed in grant-making.

Issue #8 — Targets for TB care and prevention and MDR-TB not ambitious enough

The TRP said that the targets for case notification for drug-susceptible and DR-TB were conservative and unambitious. It recommended that the CCM work with the Secretariat during grant-making to revise the targets. We do not know if this issue was resolved.

Issue #10 — Insufficient planning to increase domestic financing

The TRP said it was concerned that there has been insufficient planning to support increased investment from government and other country-level sources of finance for national HIV, TB and malaria programs. The development of innovative financing approaches and increased government commitment were mentioned in the funding request as alternate sources of financing in an increasingly constrained external assistance environment, the TRP said. However, there weren't many details. The TRP recommended that the CCM further clarify how government, insurance, private sector, household, and innovative financing approaches will support key interventions. This issue is to be addressed during grant implementation.

CO-FINANCING AND THE FISCAL CYCLE

The GAC said that the Ministry of Finance and Economic Cooperation has made an indicative commitment to increase the funding for the disease programs by $38.4 million, which exceeds the minimum co-financing requirement.

According to the GAC, in order to align Ethiopia's HIV and TB grants duration with the country's fiscal cycle, the grants will have an implementation period of three years and six months, from 1 January 2018 to 30 June 2021. In light of this, the GAC said, and to mitigate potential programmatic disruption, "Ethiopia will also benefit from a one-time flexibility to facilitate financing of commodities arriving in country after the end of their current allocation utilization period."

(*Translation:* Ethiopia is being given a one-time waiver from the rule that says that funding from a given allocation period [e.g. 2017–2019] for a given country must be used within the three-year allocation utilization period established for that country. When Ethiopia received its allocation letter for 2017–2019, it was informed that its allocation utilization period was 1 January 2018 to 31 December 2020, a period of three years. But the implementation period for Ethiopia's HIV grants extends beyond 31 December 2020 (to 30 June 2021). Without the waiver, Ethiopia would have had to finance the last six months of its HIV grants from its allocation for the 2020–2022 allocation period.)

Some of the information for this article was taken from GF-B38-ER02 (Electronic Report to the Board: Report of the Secretariat's Grant Approvals Committee) and the Funding Request Review and Recommendation Form for Ethiopia's TB/HIV application. These documents are not available on the Global Fund's website.

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2. NEWS and ANALYSIS:
Making progress slowly or not at all?
TRP and CCM go back and forth on services for MSM and transgendered persons in Global Fund grants to Ethiopia

TRP suggests the country set up male health clinics where MSM could remain anonymous

David Garmaise 23 January 2018

The exchanges back and forth between Ethiopia's country coordinating mechanism (CCM) and the Technical Review Panel (TRP) during the review of Ethiopia's recent TB/HIV funding request illustrate just how hard it can be to make headway in providing services for men who have sex with men (MSM) and transgendered persons in a country where sexual activity between persons of the same sex is criminalized, and where stigma and discrimination toward MSM and transgendered persons are pervasive.

Initial TRP review

When it reviewed the funding request, the TRP noted that it did not make any reference to MSM and transgendered people. The TRP said that it appreciated that there may be some profound cultural and political obstacles to even acknowledging the existence of persons who engage in sexual practices that are not accepted in society in Ethiopia — and that this might also extend to people who inject drugs (PWID). However, it said, in the context of the epidemiological situation in Ethiopia, the lack of access to services for these populations is a major flaw and amounts to discrimination and the denial of basic human rights of these populations.

The TRP pointed out that this issue was raised by the TRP and the GAC when they reviewed previous concept notes; that recommendations were made; and that this has not resulted in the inclusion of interventions for these populations in the current funding request.

The TRP requested that Ethiopia reconsider its position towards MSM, transgendered people and PWID, and develop approaches to collect data on HIV risks and vulnerabilities, needs assessments, and stigma and discrimination related to these populations. The TRP further requested that the CCM provide a clear plan of action to ensure that services are provided to these populations through government or alternate systems. The TRP also requested that the CCM ensure a mechanism be put into place that enables MSM, transgendered persons and PWID to provide meaningful input to the plan of action, while protecting their privacy and

safety. The TRP said that technical partners and other organizations should be able to assist in this process.

Response from the CCM

Aidspan understands from sources that when the CCM responded to the TRP's clarifications, it did not mention MSM or transgendered persons. Apparently, the CCM said that it is addressing the TRP's concerns within the context of the legal framework and the culture of the country. We understand that the CCM said that the Federal Ministry of Health (FMOH) is responsible for the delivery of health services to all citizens of Ethiopia without discrimination; and that the constitution states that every Ethiopian has the right of equal access to publicly funded social services.

In its response, the CCM said that one of the agendas of Ethiopia's Health Sector Transformation Plan (HSTP) is to ensure quality and equitable health services "which [are] safe, reliable, patient-centered, efficient and provided to all in need in an equitable and timely manner," and which "[do] not differ by any personal characteristics including age, gender [and] socioeconomic status." (Source: Health Sector Transformation Plan, Federal Democratic Republic of Ethiopia.)

The CCM further noted that the HSTP calls for a health workforce that is "caring, respectful and compassionate," and health facilities that are free of stigma and discrimination. The CCM said the health sector is fulfilling its duties, although it acknowledged that discrimination could occur. The CCM mentioned female sex workers, saying that fear of stigma and concerns about confidentiality are among the barriers to testing cited by this population.

The CCM said that the response to HIV in Ethiopia is targeting female sex workers, truck drivers, inmates, daily laborers and other vulnerable population groups, but it did not name MSM or PWID.

We further understand that in its reply, the CCM said that it would conduct an assessment of the attitude of health professionals toward at-risk populations; and that it would strengthen user-friendly HIV services in the context of its HIV Catch-Up Initiative.

TRP comments on the CCM clarifications

Sources told Aidspan that the TRP replied that it was "not fully satisfied" with the clarifications. The TRP said that it would be reasonable to assume that MSM and transgendered persons are covered by the provisions of the constitution and the HSTP, but that even though may be entitled by law to access services, the TRP said, they are likely to confront barriers to the use of these services for several reasons, including the persistence of stigma and discrimination, particularly on the part of health care providers; and the fact that MSM and transgendered persons may exclude themselves from accessing services for fear of being reported to authorities.

We understand that the TRP also said that MSM and transgendered persons have specific needs that regular health services may not be prepared to provide. For example, the TRP said,

they need to know how to use condoms properly and where to procure them; how to prevent HIV and STI transmission; why and how to test periodically for HIV; and how to access peer counseling and support. Information of this kind is rarely provided in health facilities serving the general public, the TRP said.

We understand that the TRP suggested that Ethiopia consider creating male health clinics staffed by specially trained personnel where MSM and transgendered persons could remain anonymous. Global Fund financing has been used in several countries to support this type of facility, the TRP noted.

Sources told Aidspan that the TRP called on the Secretariat, with support from technical partners, to negotiate with the Ethiopian CCM a "work-around" that will guarantee access to services for MSM and transgendered persons while protecting their privacy.

Final word from Aidspan

These challenges are not unique to Ethiopia, and the Global Fund always walks a delicate line between country ownership and its own strategic objectives. Many of the cultural sensitivity challenges to implementing programing for certain key populations require longer-term solutions, however frustrating that may be for the persons needing the services now and for the people advocating on their behalf. In Ethiopia, these longer-term solutions will hopefully be explored by the CCM, the principal recipients of the grants and the fund portfolio manager during the life of these grants.

See separate article in this issue on the approval of Ethiopia's TB/HIV funding request.

Do you have any reaction to this article (or any article in GFO)? To send a note to the editor, just click here. **We value your feedback**.

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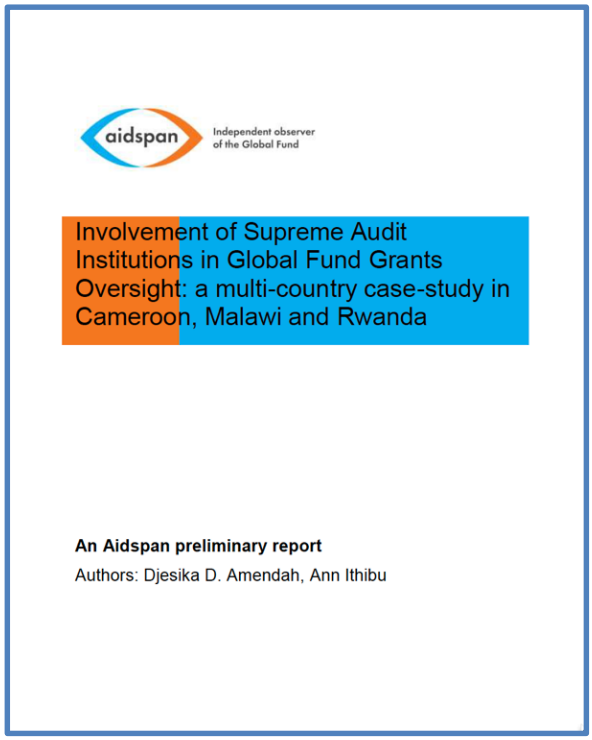
3. NEWS: Supreme Audit Institutions in some countries in Africa may not be involved in Global Funds grants: Aidspan report

Aidspan Staff 23 January 2018

In many African countries that receive Global Fund grants, implementers may not take advantage of the services their Supreme Audit Institutions (SAIs) could provide. This is one of the key findings of a study conducted by Aidspan on the involvement of SAIs in auditing Global Fund grants.

SAIs, which go by various names in different countries — e.g. Office of the Auditor General, National Audit Office — may provide substantial value by helping improve grant implementation.

The report on the study, which can be found here, is based on case studies conducted in three countries: Cameroon, Malawi and Rwanda; plus information provided by the Global Fund Secretariat and the Office of the Inspector General (OIG).



The study was carried out with the support of the BACKUP Health, a global program working on behalf of the German Federal Ministry for Economic Cooperation and Development. Since 2013, the program has been co-funded by the Swiss Agency for Development and Cooperation. The countries chosen are low-income and high priority for BACKUP Health.

The Global Fund Secretariat requires that grants be externally audited yearly by a reputable institution. Guidance by the Secretariat does not insist on which institution, private or public, should conduct the audits; rather, it appears that the Secretariat mostly cares that a quality audit is conducted. In addition to these yearly audits, the OIG audits grants periodically.

In most African countries, under dual track financing, a state institution — often the Ministry of Health — is a principal recipient (PR) along with a non-state recipient. The state PRs typically manage the highest share of the grants. In the three countries studied, state PRs manage between 90% and 100% of the grants. (The country at 100% is Rwanda.) In the past, medications or money thefts, fraud and mismanagement have most often occurred under the watch of state PRs, as several OIG reports have documented. National SAIs are empowered to audit state institutions that receive public funds.

“In an ideal situation, the SAI will audit these grants and identify potential problems before they happen,” said study co-author Djesika Amendah.

Mixed results on Supreme Audit Institutions involvement with grants

The report found high-level involvement of the SAI in Rwanda but little in Cameroon and Malawi. In Rwanda, the Ministry of Health is the only PR. The Global Fund grants are audited by the Office of the Auditor General which reports findings to the Parliament.

“The Rwanda situation reinforces country ownership,” said study co-author Ann Ithibu.

In Cameroon and Malawi, the SAI is not involved in the Global Fund grants; grant audits are conducted by private entities. Regrettably, those audit reports are not in the public domain, contrary to the reports on audits conducted by an SAI or the OIG.

However, other forms of collaboration with in-country oversight exist. In Cameroon, where the Ministry of Health is an implementer, its internal audit unit is involved in oversight and collaborates with the OIG during its audits. In Malawi, the Anti-Corruption Bureau has collaborated with the OIG to campaign against drug thefts in public facilities in the country.

While this study focused only on three countries and as such is not a representative of all countries in Africa, it nevertheless raises issues that deserve to be explored further, the authors stated.

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4. NEWS: LAC region remains overly dependent on funding from the Global Fund and other external donors, says new report

Need for better transition planning

Kataisee Richardson 23 January 2018

The Latin America and Caribbean (LAC) region remains overly dependent on external funding for HIV programs targeting key populations, and there is a need for more concrete and detailed plans to transition away from this dependency. These are two key Global Fund–related themes in a recent report by the Pan American Health Organization (PAHO) and UNAIDS, *HIV Prevention in the Spotlight: An Analysis from the Perspective of the Health Sector in Latin America and the Caribbean.*

The report warns that the region is off target when it comes to reducing the number of new infections. The UNAIDS Fast Track target is a 75% reduction between 2010 and 2020. Instead, the rate has remained steady at 120,000 new infections per year from 2010 to 2016 with the vast majority (64%) of new infections occurring among key populations such as men who have sex with men (MSM), transgender people, people who use drugs, and sex workers and their clients and partners.

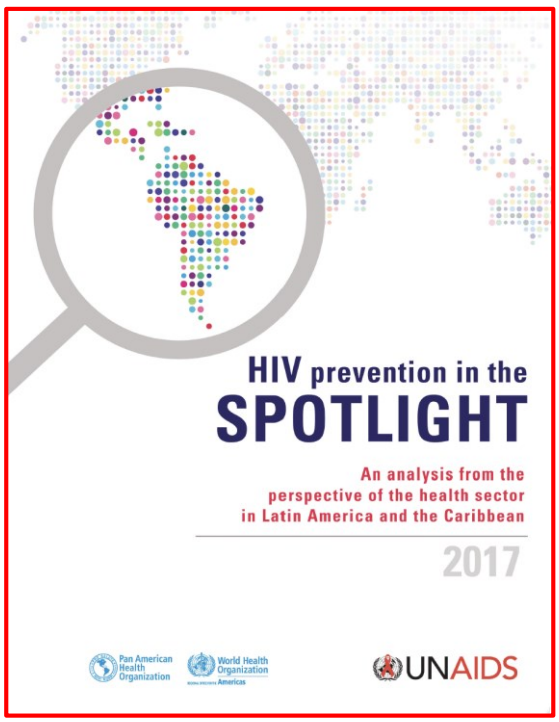
The report highlights the countries' achievements and challenges in HIV prevention and implores them to bolster their efforts in this area. The report primarily uses information from the 2017 country reports for Global AIDS Monitoring (GAM), a database maintained by UNAIDS, and also relies on information provided by civil society.

Dependency on external funding

Countries in the region have followed the Global Fund's requirement that grant applications from countries with concentrated epidemics should focus on key populations. The Global Fund finances HIV grants in 18 LAC countries, of which all but one focus on key populations. The Fund also provides money for a regional grant focused on HIV prevention

among key populations in the Eastern Caribbean. While these grants have resulted in increased access to prevention for key populations, they have not been accompanied by increases in domestic funding for these interventions.

For example, one of the Global Fund's key interventions has been to invest in the purchase of prevention packages. The packages contain male condoms; in 80% of the grants, they also include lubricants. At present, nearly all countries in LAC provide free condoms to young people, MSM, sex workers and transgender women. The majority of countries also provide lubricants. However, only one-third of the countries report purchasing condoms with domestic resources; the remainder use funds from the Global Fund and PEPFAR. Strikingly, in many countries, no lubricants are purchased with domestic resources; they are *only* provided by the Global Fund. What's more, even with external assistance, civil society informants report that the number of condoms and amount of lubricant cannot meet the needs of key populations. This means that HIV prevention efforts for key populations are especially financially dependent on external donors and particularly vulnerable to external donor withdrawal should governments not step in to fill in the gap.



Based on data from 33 countries surveyed by UNAIDS (including six countries that receive no Global Fund grants at all), only 12% of total HIV expenditure comes from external sources. However, when one looks at HIV prevention for key populations, all but six countries depend to some extent, but to widely varying degrees, on external funding. For example, in the Bahamas, 95% of prevention for key populations is funded by the government. This is in stark contrast to Haiti, where the government only funds 5% of prevention for key populations. Among countries that report that they have prevention programs geared to key populations, only a small fraction of the total prevention budget (7%) is allocated to interventions for key populations despite the fact that they are the key to ending the epidemic.

Need for detailed transition plans

The report stated that HIV prevention transition plans are needed in three-quarters of the countries in the region. To have any hope of making a dent in new infections, the report said, the proportion of prevention funding allocated to key populations in the region must be increased from 7% to at least 25% by 2020, in line with regional prevention targets agreed to at the Second Latin American and Caribbean Forum on the HIV Continuum of Care in 2015.

Additionally, civil society must be engaged and supported as trusted partners that are uniquely positioned to reach key populations with prevention activities, the report said.

Government support (financial and otherwise) to civil society organizations is frequently inadequate. The report recommended that there be clear mechanisms to channel funds from the public purse to civil society and that where such mechanisms already exist, they should be strengthened by implementing fair and transparent systems for selecting and contracting service providers — the goal being to move incrementally closer to the UNAIDS Fast Track target of ensuring that 30% of services are community-operated by 2030.

Critically, the report said that it is important for countries to have a clear sense of the scale of expenditure required to address the unmet prevention needs of key populations. According to the report, there are no reliable country estimates of the cost of funding all prevention needs, including services that civil society provides for key populations. Some countries struggle to quantify how much money is actually spent on interventions for key populations. One key to resolving this, the report stated, is improving the quality of information on the financing of HIV prevention — for example, by institutionalizing the development of national health accounts (NHAs) and systematic national AIDS spending assessment (NASA) exercises to better monitor progress and gaps.

With several countries indicating low levels of prevention spending on key populations, a high degree of dependency on international donors, and an HIV incidence rate that refuses to bend downward, it is fair to conclude that LAC will miss the mark on achieving UNAIDS' prevention targets. Given the Global Fund's large role in investing in prevention services for key populations and the precariousness of those investments going forward, the report provides ammunition for sustained advocacy to hold governments to account for investing in key populations.

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5. NEWS: TRP praises Kenya's TB/HIV funding request to the Global Fund for its sensitivity to key populations and human rights

Devolution cited as both an opportunity and a challenge

Charlie Baran 23 January 2018

"The funding request demonstrates evidence-based prioritization of key populations affected by both HIV and TB and proposes appropriate high-impact interventions to expand services in high-burden counties as informed by a clear geographical prioritization."

This was one of the observations of the Technical Review Panel (TRP) when it reviewed the TB/HIV funding request submitted by Kenya. The TRP also mentioned other strengths of the request as well as several weaknesses and concerns. This article summarizes the observations of the TRP and the Grant Approvals Committee (GAC).

On 1 December 2017, the Global Fund Board approved four grants under Kenya's 2017–2019 allocation, as part of the third batch of approvals (see GFO article). The grants, totaling $313.0 million, emanate from the "full review" TB/HIV funding request submitted by the Kenyan country coordinating mechanism (CCM) in Window 2 on 23 May 2017. The $313.0 million includes $17.5 million in catalytic matching funds. The Board approved $24.8 million in matching funds, but some of this amount has been folded into RSSH interventions in Kenya's malaria component, which was also approved in December.

Aidspan reported on the content of the TB/HIV funding request in June 2017.

The four grants are managed by three principal recipients (PRs). The National Treasury serves as PR for the majority of the funds, via two grants: KEN-H-TNT ($179.5 million) and KEN-T-TNT ($30.0 million). Although the National Treasury is the PR, the Ministry of Health, as lead sub-recipient, is the implementing agency. The Kenya Red Cross Society manages a $70.7 million HIV-focused grant (KEN-H-KRCS) and the African Medical and Research Foundation is PR for a $32.6 million TB grant (KEN-T-AMREF). The same organizations served as PRs for grants during the 2014–2016 allocation cycle.

The funding request also included a prioritized above allocation request (PAAR) totaling $140.0 million. The TRP deemed all of the PAAR to be quality demand. During grant-making, two TB modules from the PAAR were integrated into the within-allocation request, and there was some additional shifting of allocation and catalytic funds among the various components. In the end, the total amount added to the Unfunded Quality Demand (UQD) register was $112.8 million.

The funding request was reviewed by the TRP on 30 June 2017 and, following grant-making, was recommended for funding by the GAC in early November. The information in this article is drawn mostly from the TRP's Funding Request Review and Recommendation Form and the GAC's Electronic Report to the Board. (These documents are not available on the Global Fund's website.)

Strengths

The TRP praised the quality and technical sophistication of the funding request. It said that the programs described in the request aim to increase HIV prevention and care program coverage for men who have sex with men (MSM) (+130% in the amount invested over three years), and to expand services for sex workers (+80% invested), as well as to strengthen programs for people who inject drugs. These key population prevention modules accounted for 6% of the total HIV budget in the funding request. (Six percent may not seem like a lot, but the grant is heavily commoditized — more on this below — so there was not much room for discretionary spending.)

The TB component included specific interventions for TB key populations — namely refugees, prisoners, displaced people, migrants, ethnic minorities, miners, children, urban poor and the elderly — as well as the above-mentioned HIV key populations.

The TRP applauded the funding request for its "detailed and honest appraisal" of challenges and program gaps, particularly regarding human rights barriers; and it considered the activities designed to reduce those barriers to be "commendable." The CCM's analysis of the funding landscape was also praised by the TRP.

The GAC highlighted that the funding request was responsive to a 2016 TB prevalence survey which revealed that up to 40% of TB cases in Kenya remained undetected. The funding request proposed several new approaches to address the TB epidemic, which is larger than previously believed. These new interventions include enhanced proactive case detection initiatives, optimization of GeneXpert machines, and scaling up of sputum transportation and X-ray use.

Concerns and weaknesses

On the Review and Recommendation Form, the TRP specified 10 areas of concern, gaps and weaknesses in the funding request. For each issue, the TRP made a recommendation on how the issue might be addressed during grant-making or grant implementation. A selection of these issues is highlighted below.

One concern was the case of 220 health workers (clinical officers, lab technicians and specialists, and data management assistants) and a number of National Treasury staff whose salaries and incentives will be paid with grant funds, but for whom there was no explicit plan for the Government of Kenya to eventually take on their salaries. The TRP viewed this as an issue of sustainability, and it recommended that the CCM and the country team develop a human resources for health transition plan during the course of grant-making and implementation. The Kenya CCM has since committed to developing a personnel "exit plan" during grant implementation.

A weakness identified in the funding request related to insufficient description of strategies to improve antiretroviral treatment (ART) retention. The funding request noted declining rates of treatment retention over time but did not describe how the program would address this challenge. Given that improved treatment retention and outcomes are critical impact

indicators, the TRP recommended that, during grant-making, the CCM strengthen its approach to achieving better outcomes on the HIV care cascade regarding the 90-90-90 targets. According to the Secretariat, this issue was addressed during grant-making by the CCM providing additional explanations concerning how planned interventions will contribute to achieving the 90-90-90 targets.

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Noting that "adolescents and youth are the key drivers of Kenya's HIV epidemic with more than 50% of new HIV infections occurring among young people," the TRP expressed concern that the funding request only included a small allocation for HIV prevention for young people. The TRP described the budget for youth HIV prevention as a "significant[ly] disproportionate allocation," and encouraged Kenya to carefully consider its HIV prevention priorities as the modules and interventions are finalized during grant-making. This issue was also addressed to the country team's satisfaction.

The funding request included interventions for expanding TB case-finding in the private health care sector, where many TB cases elude identification and registration with national TB control systems. The TRP supported this approach but recommended that the Kenyan program expand private sector engagement to include HIV services in addition to TB. Specific mechanisms for this expansion, however, were not detailed in the TRP feedback. This issue was marked "addressed," in grant documents, but there was no explanation regarding how it was resolved.

In its recommendation to the Board, the GAC highlighted that despite progress and plans for continued ARV coverage scale-up, "available resources from the 2017–2019 allocation are under extreme pressure." The GAC noted that secured resources appeared to be sufficient to continue ART for the 1.1 million people currently receiving treatment, but that adding more patients would be challenging. A $65.0 million ART funding gap was identified and registered as UQD. Based on this calculation, the GAC recommended that the Global Fund Secretariat and partners "intensify their engagement and collaboration with the country to explore ways to address the financing gap." Aidspan recently reported on this emergent challenge in Kenya and across the Global Fund portfolio.

It appears there won't be an easy fix here, given that the Government of Kenya has already committed $966.0 million towards HIV programs during the 2017–2019 allocation cycle, an increase of $123.0 million over the previous period. These contributions more than satisfy Kenya's co-financing requirement which was $71.1 million, 20% of the total allocation.

Domestic funds are primarily used to procure key commodities such as ARV and TB drugs. See the table below for more details on the HIV funding landscape.

Table: Overview of funding landscape ($ million)

Component: Kenya HIV			
Estimated funding need for program:	3,707 m	**As % of funding need**	**Change vs. previous period**
Total domestic resources	966 m	26%	Increase
Total external resources (non-GF)	1,719 m	46%	Increase
Total Global Fund resources	231 m	7%	Decrease
Total resources available	2,916 m	79%	Increase
Unmet need gap	791 m	21%	Decrease

(We note, in passing, that Kenya's co-financing requirement, at 20% of the allocation, is five percentage points higher than the minimum required under the Sustainability, Transition and Co-Financing Policy. For lower-middle-income countries like Kenya, the policy states that the co-financing requirement must be at least 15% of the allocation. But the Secretariat has the discretion to increase the percentage in individual cases.)

Both the TRP and the GAC noted the complications for grant oversight caused by devolution in Kenya. Devolution is the process of decentralizing state power throughout the country, most notably from the national government to county governments. In Kenya, devolution has been underway since the new constitution was promulgated in 2010. The GAC considered devolution to be an opportunity to be fully exploited, but one which comes with the need to implement appropriate financial and programmatic safeguards. The National Treasury, the Ministry of Health and the Council of Governors (COG) are currently engaged in a consultative process whereby best practices for funds flow and financial oversight between the national and county levels are being reviewed. According to the GAC, a report of the findings of this process will be presented (timeline unknown), and an operationalization roadmap will be developed and implemented by the PRs, the National Treasury and other stakeholders.

The COG is a non-partisan organization comprised of the governors of each of Kenya's 47 counties. According to the website of the Government of Kenya, the COG provides a forum for discussion of issues relevant to county government and for the promotion of best practices. The GAC noted that counties, through the GOC, have become much more active in Global Fund processes. For example, the GAC said, the COG has seats on the CCM and was represented on the writing team for the funding request.

TOP

6. NEWS: Global Fund Board approves fifth batch of country grants from 2017–2019 allocations, in the amount of $1.22 billion

Cumulative amount awarded to date: $8.86 billion

David Garmaise 23 January 2018

On 12 January 2018, the Global Fund Board approved 33 country grants worth $1.22 billion. This was the fifth batch of approvals from the 2017–2019 allocations, and brings the cumulative amount awarded to date to $8.86 billion.

The 33 grants were from 22 funding requests submitted by 16 countries. The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC).

The $1.22 billion total included six matching funds requests valued at $24.2 million. Interventions totaling $383.3 million were added to the Unfunded Quality Demand (UQD) Register. Domestic commitments to the programs represented by the approved grants amounted to $2.29 billion.

See Tables 1 and 2 for details.

As is customary, the approved funding is subject to availability of funding and will be committed in annual tranches. Where more than one grant has been approved for a component, the Secretariat has the authority to redistribute the approved amounts among the grants (except that any material change must be validated by the TRP).

Of the 22 funding requests, four were of the program continuation variety; four were full review; and 14 were tailored. Five of the funding requests were from Window 1 (20 March 2017); 11 from Window 2 (23 May); and six from Window 3 (28 August).

In its report to the Board, the GAC said that the grants were found to be disbursement-ready by the Secretariat after a thorough review process and in consultation with partners. During grant-making, the GAC said, each applicant refined the grant documents, addressed issues raised by the TRP and GAC, and sought efficiencies where possible. The GAC endorsed the reinvestment of efficiencies in one of the following: (a) the same grant, in areas recommended by the TRP; (b) other disease components of the same applicant – where the TRP did not recommend reinvesting in the same grant; or (c) the general funding pool.

Judging by the end dates shown in the GAC report, more than three-quarters of the approved grants had a proposed start date of 1 January 2018. The Secretariat told Aidspan that it was confident most of the confirmations for these grants will be signed very quickly and that few extensions of existing grants will be required. When the grants go to the Board for approval, they are already disbursement ready.

Table 1: Country grants approved from the 2017-2019 allocations — Fifth batch — A–K ($US)

Applicant	Comp.	Grant name	Principal recipient	Amount approved	UQD	Domestic commitment
Azerbaijan	TB	AZE-T-MOH	Ministry of Health	6,529,446	346,787	48,233,781
Cameroon	HIV	CMR-H-CMF	C. N. Assoc. Fam. Welf.	26,264,891	30,195,705	74,660,590
		CNMR-H-MOH	Ministry of Health	101,946,377		
	TB	CMR-T-MOH	Ministry of Health	12,097,015		2,419,367
C.A.R.	Malaria	CAF-M-WVI	World Vision Intl.	32,828,198		288,101
	TB/HIV	CAF-C-CRF	Croix-Rouge Fr.	34,819,991	16,904,384	10,987,553
Ghana	HIV	GHA-H-WAPCAS	W. A. Prog. AIDS & STIs	7,445,969	9,688,309	161,690,652
	TB/HIV	GHA-C-MOH	Ministry of Health	76,502,454		
	Malaria	GHA-M-AGAMal	AngloGold Ashanti	15,884,008	47,679,165	491,061,978
		GHA-M-MOH	Ministry of Health	94,148,208		
Guinea	TB/HIV	GIN-C-PLAN	Plan International	14,550,605	2,315,427	22,848,873
India	TB/HIV	IND-C-WJCF	Clinton Foundation	18,283,889	N/A	N/A
	TB	IND-T-CHRI	Centre Health Res. & Inn.	15,596,592	141,537,407	740,000,000
		IND-T-CTD	Ministry of Finance	201,344,390		
		IND-T-FIND	F. for Inn. New Diag.	33,135,609		
		IND-T-IUATLD	Intl. Union vs TB & L. D.	15,511,945		
Kosovo	HIV	QNA-H-CDF	Comm. Dev. Fund	1,751,226	518,349	3,710,723

Notes:

1. *Amounts shown are upper ceilings.*
2. *For countries using euros, the amounts were converted to U.S. dollars at a rate of 1.2115 euros to the dollar.*
3. *The domestic commitments shown are for the disease programs and exclude RSSH unless otherwise indicated.*
4. *The amounts approved for Cameroon include $11.3 million from a Government of Spain Debt2Health swap.*
5. *The domestic commitment shown for Cameroon TB only reflects the minimum co-financing commitment to be invested in health products.*
6. *The UQD and domestic commitments for India TB/HIV were previously shown (under HIV in Batch 4).*
7. *The amounts approved for Cameroon HIV include matching funds in the amount of $9,176,325.*

More to come

There were just over 200 country grants approved in the first five batches. Three more windows have been scheduled for 2018, as follows (with the TRP meeting dates shown in parentheses):

Window 4 — 7 February (TRP: 19-29 March)
Window 5 — 30 April (TRP: 3-11 June)
Window 6 — 6 August (TRP: 9-21 September)

Multi-country grant

In this latest batch of approvals, there was one multi-country grant, known as "Southern Africa WHC." Submitted by the Southern Africa Regional Coordinating Mechanism, this grant will continue the work of the existing regional grant on TB in the mining sector, with

the Wits Health Consortium remaining as PR. The grant has a budget of $22.5 million and covers the following countries: Lesotho, Swaziland, Mozambique, South Africa, Botswana, Namibia, Zambia, Zimbabwe, Tanzania and Malawi. Aidspan plans to publish a separate article on this grant in the near future.

Table 2: Country grants approved from the 2017-2019 allocations — Fifth batch — N–T ($US)

Applicant	Comp.	Grant name	Principal recipient	Amount approved	UQD	Domestic commitment
Namibia	Malaria	NAM-M-MOH	Ministry of Health	2,370,582	915,902	35,400,000
	TB/HIV	NAM-C-MOH	Ministry of Health	29,132,416	12,107,987	333,700,000
		NAM-C-NANASO	NANASO	6,603,874		
Pakistan	TB	PAK-T-MC	Mercy Corps	15,000,000	48,440,500	84,600,000
		PAK-T-NTP	Natl. TB Control Prog.	89,163,205		
		PAK-T-TIH	The Indus Hospital	40,000,000		
P.N.G.	TB/HIV	PNG-C-WV	World Vision	21,076,614	10,194,132	47,850,000
Paraguay	HIV	PRY-H-CIRD	CIRD	4,432,967	1,326,021	58,289,530
Rwanda	HIV	RWA-T-MOH	Ministry of Health	154,462,907	23,039,981	70,441,245
	TB	RWA-T-MOH	Ministry of Health	14,154,994		5,594,153
	Malaria	RWA-M-MOH	Ministry of Health	41,460,255	21,841,668	55,929,592
Sénégal	RSSH/TB	SEN-Z-MOH	Ministry of Health	13,016,168	9,728,017	8,503,116
	Malaria	SEN-M-PNLP	Natl. Mal. Control Prog.	39,205,119	N/A	22,389,950
Tajikistan	HIV	TLK-H-UNDP	UNDP	12,939,544	6,069,027	12,975,346
Tanzania	TB/HIV	TZA-C-Amref	Amref Health Africa	24,969,148	N/A	N/A
Timor-Leste	HIV	TLS-H-MOH	Ministry of Health	3,024,901	486,389	2,390,032

Notes:

1. *Amounts shown are upper ceilings.*
2. *For countries using euros, the amounts were converted to U.S. dollars at a rate of 1.2115 euros to the dollar.*
3. *The domestic commitments shown are for the disease programs and exclude RSSH unless otherwise indicated.*
4. *At the time of the preparation of the GAC report, Sénégal had not yet submitted its Prioritized Above-Allocation Request.*
5. *The amounts for Tanzania UQD and domestic commitments were previously reported (in Batch 3).*
6. *The amounts approved include matching funds for Namibia TB/HIV ($1,000,000) and Pakistan TB ($13,999,990).*

Grant extensions

The Board approved extensions for an HIV grant in Guatemala and two HIV grants in Nigeria.

The Guatemala HIV grant (GTM-H-HIVOS) was extended for 12 months to 31 December 2018 to allow for essential services to continue while a new funding request is reviewed. The TRP reviewed the original request in August 2017 but sent it back for iteration. The extension budget of $4.9 million will come from Guatemala's 2017–2019 allocation.

HIVOS will be the PR during the extension. Previously, HIVOS was co-PR with the Ministry of Health (MOH), but the MOH has withdrawn. When the new grant is approved, the co-PR is expected to be the Institute for Nutrition of Central America and Panama (INCAP). According to the GAC, the decision to change PR was mainly motivated by the need to lower program costs, promote sustainability, and facilitate coordination with the government. During the extension, the focus will be on providing services to men who have sex with men, and transgendered persons; providing HIV testing; and providing linkage to care for people living with HIV.

The two Nigeria grants (MGA-H-LSMOH and NGA-H-SFHNG) were extended for 18 months. Aidspan previously reported on four other HIV grants that received similar extensions.

Note: The $8.86 billion figure cited in this article for cumulative funding awarded to date is an unofficial figure based on Aidspan's interpretation of the reports of the Grant Approvals Committee. The $8.86 billion includes matching funds but excludes multi-country grants of the type that used to be called "regional grants" — except for the Regional Artemisinin-resistance Initiative (RAI) in Southeast Asia. The RAI is a hybrid grant with a total value of $243.7 million, of which $119.0 million comes from the multi-country funding stream in the catalytic investments funding pool; $1.3 million from matching funds; and $123.4 million from country allocations. There is a second type of multi-country grant which covers groupings of small island states; these grants are included in the $8.86 billion figure.

Aidspan reported on the first batch of grant approvals for 2017-2019 here; on the second batch here; on the third batch here; and on the fourth batch here.

Most of the information for this article was taken from Board Document GF-B38-ER05 (Electronic Report to the Board: Report of the Secretariat's Grant Approvals Committee). This document is not available on the Global Fund website.

TOP

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7. NEWS: OIG commends progress made by Global Fund grants to Bangladesh, but says several challenges remain

Audit identifies significant program and financial management weaknesses in the national TB program

David Garmaise 23 January 2018

Bangladesh has made significant progress in the fight against the three diseases. TB and drug-resistant TB treatment success rates are 94.6% and 73.0%, respectively. The country has low HIV prevalence among the general and key populations, except for people who inject drugs. Challenges remain in several areas, including low TB case detection rates, low coverage of HIV prevention and treatment interventions, and gaps in the supply chain.

These are the main conclusions of an audit by the Office of the Inspector General (OIG) of Global Fund grants to Bangladesh. A report on the audit was released on 22 December.

Sustained economic performance has helped to lift a significant proportion of the population of Bangladesh above the national poverty line, although it remains one of the poorest countries in the Southeast Asia region. Bangladesh attained lower-middle-income status in 2016. With an estimated population of 162 million at the end of 2016, Bangladesh is ranked 139th out of 188 countries in the UN Development Program's 2016 Human Development Index, and 145th out of 176 countries in the Transparency International's 2016 Corruption Perceptions Index.

Bangladesh has experienced political unrest and severe flooding which have affected health care delivery and programmatic results. It is one of the Global Fund's high-impact countries.

Politically, the country is divided into eight divisions including the capital and largest city, Dhaka, which is the political and economic center. The divisions are sub-divided into 64 districts (zilas) and 488 sub-districts (upazilas). The country does not have enough skilled health workers. Around 155,000 health workers (both clinical and non-clinical) were available at the Ministry of Health and Family Welfare (MOHFW) in 2012 against expected staff size of about 187,500.

Bangladesh has seven active grants worth $117.0 million. Four of the grants are implemented by international NGOs, "mainly due to the weak capacity of the national programs," the OIG stated. In the short term, this has meant that program targets are consistently met or exceeded; however, the OIG said, a longer-term transition plan is needed to address the capacity and leadership challenges in the national programs.

About two-thirds of Global Fund grants to Bangladesh are spent on procuring medicines and health products. There are significant weaknesses in the country's supply chain processes and systems, which affect the storage and distribution of medicines financed by the Global Fund, the OIG reported. The Secretariat has instituted several measures, including parallel arrangements, to ensure that Global Fund–procured medicines are effectively distributed. Those measures have mitigated stock-outs at health facilities, the OIG said, but the underlying systemic weaknesses continue to impact supply chain arrangements.

The NGO PRs have generally effective financial management controls to support activities financed by Global Fund grants, the OIG said; however, there are significant financial control weaknesses at the National TB Control Program (NTP) which, as PR, is responsible for 27% of total grant funding.

The OIG audited grants managed by all four principal recipients (PRs). (See Table 1.) The audit covered the period July 2015 to December 2017.

Table 1: Active Global Fund grants to Bangladesh ($ million)

Principal recipient	Comp.	Grant name	Signed amount
BRAC	TB	BGD-T-CRAC	45.6 m
Ministry of Finance		BGD-T-NTP	31.7 m
BRAC	Malaria	BDG-M-BRAC	9.7 m
Ministry of Finance		BGD-M-NMCP	15.5 m
International Centre for Diarrhoea Disease Research	HIV	BGD-H-ICDDRB	5.8 m
Ministry of Finance		BGD-H-NASP	0.7 m
Save the Children Federation		BGD-H-SC	7.8 m
		Total	**116.9 m**

Notes:
1. All grants had an end date of 31 December 2017 or just prior.
2. The MOF grants are implemented via the respective national disease programs in the MOHFW.

The OIG stated that a decline government funding has created a heavy dependence on donors for the delivery of programs. There are challenges concerning the government's coordination of donor activities, resulting in gaps and potential duplication of activities, it added. Finally, although the availability of routine and survey data for decision making has improved, the OIG said, inaccurate recording and reporting compromise its reliability.

Table 2 lists the three areas assessed in the audit, and the OIG's ratings and summary comments for each area.

Table 2: Bangladesh audit findings at-a-glance

AREA 1: Effectiveness of the implementation arrangements to ensure efficient and sustainable achievement of grant objectives	**Rating:** Partially effective
OIG comments: The implementation arrangements have supported the consistent achievement of the agreed programmatic performance targets. However, challenges in TB case detection, routine monitoring of patients and potential inefficiencies need to be addressed.	
AREA 2: Effectiveness and efficiency of the procurement and supply chain to ensure availability of quality assured medicines and health commodities to patients	**Rating:** Partially effective
OIG comments: The Secretariat instituted several measures to ensure Global Fund procured medicines are effectively stored and distributed. Those measures mitigated stock-outs at health facilities but underlying systemic weaknesses continue to impact supply chain arrangements under the TB grants.	
AREA 3: Design of the internal financial controls on incentive payments and apportionment of costs to Global Fund grants	**Rating:** Partially effective
OIG comments: Internal financial controls are adequately designed, but a number of issues identified at the National TB Program affect the effective management of grant funds.	

The OIG has a four-tiered rating scheme, as follows: Effective; partially effective; needs significant improvement; ineffective.

ACHIEVEMENTS AND GOOD PRACTICES

The audit revealed the following achievements and good practices:

Good programmatic achievements. Bangladesh has reduced the mortality of children under five, and has made significant progress towards the other health-related Millennium Development Goals (MDGs). Global Fund grants have consistently achieved performance targets. For instance, the TB treatment success rate has been consistently above 90%. There was a decline in malaria-related deaths from 588 in 2002 to just nine in 2015. The country is working towards malaria elimination with 51 out of the 64 districts considered to be non-endemic.

Increased government financial commitment. The government has been funding the procurement of all antiretroviral medicines and other HIV-related commodities since 2012. The government has also committed to procuring all first line TB medicines from 2018 on. Its contribution to Bangladesh's malaria programs is projected to increase significantly in the 2018–2020 implementation period of the grants. These financial commitments enable donors to focus resources on other critical aspects of health care delivery.

Interventions are targeted at high-risk and key populations. The HIV program employs drop-in centers to reach key populations in 23 high-priority districts. The centers provide access to information, resources and support services. This approach has increased access to HIV services in a country where stigma and discrimination are high. The malaria interventions target key populations such as refugees, ethnic groups living in hard-to-reach areas, high-risk mobile populations and migrants in the 13 malaria endemic districts.

Good community engagement in grant implementation. BRAC, the PR responsible for most outreach activities under the TB grant, has extensive community-level structures which ensure direct contact with TB patients. More than 67,000 TB volunteers are mapped to specific communities to diagnose TB cases quickly, ensure treatment adherence and contact tracing. A similar arrangement has been designed for the malaria program with over 1,900 volunteers providing health care in the 13 high-malaria-endemic areas and hard-to-reach areas.

The OIG also noted that Bangladesh has been exploring innovative measures approved by the World Health Organization (WHO) to prevent and manage TB cases. For example, the country has started implementing short course multi-drug-resistant TB treatment.

KEY ISSUES AND RISKS

The audit report described several concerns, including the following:

- If left unaddressed, low case detection could compromise gains made against TB.
- There is low coverage of HIV prevention and treatment interventions.
- More operational efficiency and value for money are needed.
- There is a need to progressively build the capacity of the national disease programs for long-term transition from the NGO PRs.
- Gaps in the supply chain adversely affect the efficient and effective delivery of medicines and other commodities.
- Gaps in financial control systems may expose the grants to financial loss.

Below, we summarize the audit findings related to each of these concerns.

TB case detection

The OIG noted that a large proportion of case detections occur at advanced stages of the disease. It said that limited planning and use of diagnostic machines, as well as limited private sector engagement in TB screening, contribute to low case detection. Only 11% of reported TB cases in 2015 and 2016 were diagnosed using the GeneXpert machines. The OIG attributed the low utilization of the machines to four factors:

- Diagnostic algorithms are not updated to include molecular testing and to identify drug sensitive cases.
- There are delays in rolling out the machines.
- The machines are not well maintained.
- An effective sputum sample transport mechanism has yet to be implemented countrywide.

Although 62% of patients sought health care from private health facilities (according to a recent prevalence survey), the OIG stated, there are limited mechanisms to ensure that TB case notification is routinely carried out in those facilities. In 2014, the government made case notification in private health facilities mandatory, but this is yet to be systematically enforced. In addition, a mechanism for case referral from the private sector to public health facilities has yet to be defined.

Agreed management action #1

The Secretariat will work with the MOHFW and the NTP to develop a plan to ensure effective utilization of existing and new GeneXpert machines. The plan will include implementation of revised algorithms, improvements to the sputum sample transportation system, and training of relevant health workers in the use of the machines.

Due date: 30 September 2018

HIV prevention and treatment interventions

The HIV epidemic in Bangladesh is concentrated among key populations, but access to prevention and treatment services is difficult for them, partially due to limited funding and to stigma and legal barriers, the OIG said. National coverage of prevention programs is at 35.0% for people who inject drugs, 25.0% for female sex workers, 23.6% for men who have sex with men (MSM), and 39.8% for transgender people. The OIG said there is an estimated funding gap of $123.5 million to support the scale-up of HIV services in the country.

A national consultation in May 2013 recognized stigma, discrimination and a challenging legal environment as impediments to the smooth delivery of HIV prevention services. The consultation made recommendations and identified laws that needed to be revised, the OIG stated; however, the national program has not yet submitted these recommendations to the Law Commission.

The OIG said that routine monitoring of HIV patients needs to be improved. National guidelines call for routine CD4 and viral load testing. However, the audit found that testing equipment has not been optimally utilized. Only 567 CD4 tests were performed in 2015 and 2016, versus an estimated minimum requirement of 15,688 tests, the OIG said, based on the guidelines and the number of people living with HIV. The OIG said there has been no viral load testing since April 2016; and only 1,030 viral load tests were performed from August 2015 to April 2016, which is significantly below expected target of 8,956 tests. In addition, the OIG stated, the reagents required for the machines and related human resources were not fully available, which limited the use of the machines.

Operational efficiency, value for money

Sub-optimal coordination between implementers of Global Fund grants and the government's health sector development program results in duplication and overlap in the location of drop-in centers, the OIG said. Some districts have more drop-in centers than required while other high-priority districts have none. For example, there are two facilities for an estimated 191 injecting drug users in the Sylhet district while there is only one facility for 1,142 injecting drug users in the Comilla district.

Staff costs at one of the NGO PRs are 24.0% higher than staff costs at the other NGO PR (because human resource costs at the first PR are based on U.N. salary scales). This translates into differences in the cost of interventions. In addition, the two PRs use different approaches for HIV testing. One uses a whole-blood method at a cost of $5.49 per test, while the other uses a serum method at $11.27 per test. Studies conducted in Bangladesh revealed that in terms of quality, the whole-blood method is comparable to the serum method and, therefore, is more cost-efficient. Both PRs will be using the whole-blood method in future.

Agreed management action #2

In order to limit future duplications of HIV drop-in-center interventions, the Secretariat will work with the NGO PRs to prepare a mapping of drop-in-centers and will share this mapping with the National AIDS and STI Program (NASP) so that the location of drop-in-centers can be taken into account when the Health Sector Program implementation plans are formulated by the Ministry of Health.

Due date: 30 September 2018

Capacity of national disease programs

In the opinion of the OIG, frequent changes in leadership at the national TB program has limited its ability to develop and implement capacity building plans. The line director with overall responsibility of the national programs has been changed seven times in the last two years.

Persistent weakness in the NTP has led the Global Fund to resort to using NGOs for the implementation of key components of the TB grants that had initially been assigned to the national program, the OIG stated. For example, the NTP significantly delayed the procurement and installation of diagnostic machines. The NGO PR managing the TB grant was engaged to procure the accessory equipment and arrange the renovations for the placement sites. The OIG stated that a transition plan has not yet been developed to build the capacity of the NTP and to gradually shift responsibilities to the national program.

Regarding HIV care, support and treatment, the OIG said, the government has indicated that it intends to assume responsibility for these programs from September 2017 on, but there are few transition arrangements in place and no clear plan to guide the transition. The ability of the public health facilities to provide the services is yet to be assessed, the OIG said; and staff required to manage and implement the interventions had not yet been recruited as of August 2017.

(Dr Lima Rahman, Chief of Party for the HIV/AIDS Program at Save the Children, Bangladesh, told Aidspan that the transition of the responsibility for care, support and treatment programs from the PLHIV networks, NGOs and community-based organizations to the government has started. The AIDS/STD Program [ASP] has held several planning meetings with the civil society groups. Training has been provided to staff at six government hospitals. ART service delivery from these hospitals started on 1 October 2017. About 2,500 patients had received ARVs from the hospitals by the end of October.

(Dr Rahman said,

> "ASP has its own Operational Plan under the 4th Health Sector Program where care, treatment and support component is included. However, detail plan on approaches, service modalities, including CBOs engagement to ensure coverage and treatment adherence yet to develop. Broader stakeholder engagement to develop a comprehensive plan would be necessary."

(As well, Dr Rahman stated, the government has to plan for how it will contract with the civil society groups to implement a community component. Save the Children, Bangladesh is the PR for one of the HIV grants.)

Supply chain

The Global Fund, along with the government and partners, finances a temporary central warehouse to store and distribute medicines. However, the OIG said, the effectiveness of the supply chain is adversely affected by delays in clearing goods from the port; inadequate storage conditions; and gaps in the management of expired commodities. The audit found that the NTP delayed port clearance of TB medicine for more than 30 days in 74.0% of cases in 2016 and 2017. In addition, the OIG said, there is limited space available at the central level for the storage of medicines and commodities. These constraints are preventing effective reconciliation of incoming shipments, stock rotations, physical counts, temperature and humidity controls and effective implementation of the first-expired-first-out principle at the central level. The OIG stated that a long-term solution to good storage, warehouse management and distribution needs to be developed.

Agreed management action #3

The Global Fund Secretariat will work with the NTP and partner organizations to devise a plan for the enhancement of procurement and supply management systems at the NTP which will seek to: (a) Move the central store of TB medicines from the temporary Shyamoli store to a warehousing facility which meets internationally accepted standards (GSP); and (b) improve the storage and distribution systems for TB at the peripheral levels (including through improvements to staffing and capacity).

Due date: 31 December 2018

Financial controls

The OIG reported that fiduciary controls at the NTP have remained weak despite measures taken by the Secretariat to address the problem, including hiring an international independent financial consultant.

In addition, the OIG said, there is a need to improve financial monitoring of sub-recipients (SRs) by BRAC, one of the two NGO PRs. BRAC implements its interventions through

47 SRs and 389 field offices. It has a team of 23 staff that provide onsite financial and programmatic oversight over the SRs. The OIG stated that BRAC is yet to develop a risk-based oversight and management plan for the SRs. As a result, it said, there is no difference in how BRAC oversees each of the 47 SRs, despite significant variations in their grant size and risk level. BRAC's internal assurance mechanisms are not always able to identify significant issues at the SRs. For example, despite regular onsite visits to SRs, BRAC had not identified material issues reported by the local fund agent (LFA) in nine different reviews conducted in 2016.

Agreed management action #4

The Secretariat will work with the NTP and the LFA to ensure implementation of revised and enhanced financial management systems at NTP by conducting: (a) regular and ongoing spot checks for the rest of the current and succeeding grant periods to ensure that financial managements system have been implemented and complied with; and (b) regular and unannounced spot checks in the central and field level to verify programmatic activities and their associated expenditures.

Due date: 30 June 2018

PREVIOUSLY IDENTIFIED ISSUES

The OIG last audited grants to Bangladesh in 2011. That audit identified weaknesses mainly in financial management, procurement and supply chain management. The OIG said that the latest audit noted improvement in the financial management of the portfolio, largely due to the strengthening of internal financial controls at the NGO PRs. However, it added, the financial controls at the national TB program have not improved since the 2011 audit.

Unsupported expenditures of $2.1 million were identified in the last audit (and a subsequent investigation). Bangladesh has not paid back this amount. The Global Fund had to resort to its allocation reduction approach whereby the Fund reduced the country's 2014–2016 allocation by double the recoverable amount.

Since the 2011 audit, there has been some improvement in the supply chain management of the HIV and malaria programs with significant reduction in stock-outs and expiries, the OIG stated. However, there are still major challenges in the procurement and supply chain systems for the TB grant due to the capacity constraints at the NTP.

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8. NEWS: Two corrections to our article on LFA tenders

David Garmaise 18 January 2018

On 10 January, we published an article with the headline "Global Fund LFA tenders will be for six years instead of the current four." There were two errors in the article.

First, the headline and the text of the article erroneously stated that as a result of a Board decision, LFA tenders will be for six years instead of the current four. The decision provided more flexibility with respect to the timing of re-tendering, but did not set any specific time frame for the re-tenders.

Second, the article stated that in 2012, the Global Fund launched a process to strengthen LFA management by, among other things, adding services to be covered by the LFAs. This last part was incorrect. The process launched in 2012 was designed to ensure that LFA services add value; it was not designed to add services covered by the LFAs.

In bringing these errors to our attention, the Secretariat provided the following additional information:

> The six-year length of the LFA framework contracts, which is now based on the Board decision, is not connected with the timing of LFA tenders. The contractual relationship between the Global Fund and LFAs is formed by the framework contracts, an annual work plan for a specific country/portfolio, and corresponding purchase orders. While LFA framework contracts contain legal terms and conditions governing the LFA work, these are generic and do not change significantly over time. The framework contracts do not contain any cost information or obligations, including financial, for the Global Fund to engage LFAs in any country and do not assign countries or portfolios upon signing. The terms and conditions, pre-agreed by the parties in the framework contracts, would only be applicable in case a service provider is requested to provide LFA services for a certain portfolio under an annual work plan which defines the list of LFA services and costs. A specific country/portfolio can be re-tendered at any time, based on considerations described in the Board paper. If a framework contract is already in place with a selected LFA service provider, this framework contract will be applicable for the annual work plan, and potentially future work plans. If there is no existing framework contract, a framework contract will be signed for six years, but this does not mean the LFA service provider will provide LFA services for a particular country for six years.

We regret any inconvenience caused by these errors.

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