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NEWSLETTER

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GFO is an independent newsletter about the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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4. OIG investigation in Mozambique finds embezzlement of funds by CCM Executive Secretary

BY ADÈLE SULCAS

The Executive Secretary of Mozambique's Country Coordinating Mechanism was found to have embezzled $22,593 from Global Fund grant monies and was responsible for 'non-compliant expenditures' of $26,020 overall, including payments not supported by appropriate documentation. The OIG released a report on its investigation into the misappropriation of funds on 13 November 2018. The Secretariat is seeking the recovery of $24,587, which takes into account one reimbursement already made by the Executive Secretary.

5. Funding requests to the Global Fund in next allocation period will need to scale up investments in RSSH, TRP says

BY DAVID GARMAISE

The Technical Review Panel recently released a report on RSSH investments in the 2017–2019 allocation period. Although there has been progress, the TRP found, a greater focus on resilient and sustainable systems for health will be required in the 2020–2022 allocation period if the Global Fund is to achieve its RSSH-related strategic objectives. The TRP analyzed 50 funding requests from Windows 1–5. This overview is one of three GFO articles on the report; the other two, on integrated health systems and human resources for health, will be published in a future edition of the GFO.

6. OIG audit praises Kenya's procurement and supply chain processes, identifies implementation challenges

BY ANN ITHIBU

An audit by the Office of the Inspector General (OIG) shows that Kenya has made significant progress against HIV, TB and malaria. This is partly due to the country's ability to successfully procure and distribute Global Fund-supported health products. The OIG, however, found issues in the quality of services, measurement of grant performance and grant implementation in the context of devolution of health services from the central government to 47 county governments following constitutional changes in 2010.

7. Three countries, three different applications of co-financing in Global Fund grants in sub-Saharan Africa

BY DJESIKA AMENDAH

Kenya, Uganda and Guinea are three African countries at different levels of economic development, and with different epidemiology for the HIV, tuberculosis and malaria. The application of co-financing within their programming for the three diseases differs largely by country. It is important that the Secretariat harmonizes the application of the policy across countries despite the need for customization.

8. New report finds improvements in Malawi's Global Fund program for key and vulnerable populations, credits community engagement

BY GEMMA OBERTH AND EMMA GAUSI

A new report from ICASO published on January 8, 2019, highlights improvements in Malawi's Global Fund program during the 2017-2019 funding cycle. The authors summarize the report's findings for the GFO. The total funding requested for key and vulnerable populations rose dramatically, and service packages for these groups were defined in greater detail. According to the report, a broad and systematic community engagement process contributed to these positive changes. However, community monitoring initiatives are direly needed to ensure greater accountability during grant implementation.

9. Global Fund announces $14 billion target for Sixth Replenishment

BY AIDSPAN STAFF

On January 11, 2019, French President Emmanuel Macron and the Global Fund Secretariat announced the Fund's $14-billion target for its next three-year funding cycle, at a high-level meeting in Paris. The announcement comes ahead of the preparatory meeting for the Replenishment to be hosted by the Indian government in New Delhi on February 8, 2019.

10. Mobile apps for *Global Fund Observer* and *Observateur du Fonds Mondial* now available

BY AIDSPAN STAFF

Aidspan has launched a mobile app for its English and French newsletters, the Global Fund Observer and the Observateur du Fonds Mondial, now accessible for both iOS and Android users. The app is available free of charge in the Google Play and Apple stores.

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ARTICLES:

1. Global Fund Executive Director discusses priorities laid out in his first Report to the Board

Fund plays "a vital and irreplaceable role" in accelerating the delivery of SDG3

Adèle Sulcas **15 January 2019**

Peter Sands became the Executive Director of the Global Fund in March 2018. He gave his first interview to the Global Fund Observer after the 40th Board Meeting in Geneva, in November 2018. This is the first article of a two-part interview.

GFO: *In the runup to the Sixth Replenishment, your first priority as laid out in your Report to the Board, you have said that you want to complement the core narrative with other*

themes, the first of which is the "Global Fund's vital role in the delivery of the SDG agenda and in accelerating the journey towards UHC". How you would like to see the Fund position itself to do this?

Peter Sands: I think we play a vital and irreplaceable role in the delivery of Sustainable Development Goal 3 and in accelerating the journey towards universal health coverage. One of the most tangible and concrete elements of SDG3 is ending the epidemics of AIDS, TB and malaria. And without a fully funded Global Fund there is simply no chance of achieving that goal.

Achieving universal health coverage by 2030 will require significant investments in building resilient and sustainable systems for health. The Global Fund is the largest multilateral provider of grants for strengthening health systems and I think that achieving SDG 3 will require an unprecedented degree of collaboration and coordination across various actors in global health. We are playing an active and leading role in driving that collaboration.

(Editor's note: See separate article in this issue of GFO on the Fund's investments in resilient and sustainable systems for health.)

***GFO:** At the Amsterdam AIDS conference in July and elsewhere, you spoke about three sources of potential financing: public, private, and domestic. For Replenishment, how do you – or do you – think it's realistic to get a significantly increased share of domestic financing commitments? And how will you engage countries to generate (where needed) the political will to increase domestic financing? At country level there are so many competing priorities – how can you influence the internal discussion?*

Peter Sands: I think the first thing is that the Global Fund's co-financing model has been proven to be successful as a catalyst for stimulating increased domestic resource mobilization for health. The co-financing commitments in the previous cycle were roughly 30 percent above what was committed before that, and in this cycle are 40 percent above the previous one, at about $4.5 billion. So we're seeing very significant steps in countries' commitments to mobilizing their own resources to end epidemics and strengthen health systems.

We will want to see similar significant steps in domestic resource mobilization in the next cycle. How do we get there? It's a combination of things. One, we've got to continue to develop and communicate a compelling investment case is for ending the epidemics of AIDS, TB and malaria, and more broadly for improving the health of a country's people. Two, we have to help *with* our partners, and this is very much a collaborative exercise. We have to help countries find ways of doing that, whether health ministers are winning the internal prioritization debate or the development and implementation of new ways of fiscal mobilization, greater tax efficiency, sin taxes, health insurance schemes, or improving public finance and management and allocative efficiency. So it's both ensuring more money is spent on health, but also ensuring it's better spent on health.

How do you balance the need for more commodities and where co-financing can play a big role in building the system? I don't think there is a single right answer for every country

about the optimal balance of incremental spending for different component parts, be it commodities, the workforce, infrastructure, technology. Ultimately you want the health system to be domestically resourced in a sustainable way across all these elements. The route to that end point will be different for different countries. There are some difficult trade-offs in there, and those choices have to be made very thoughtfully. But ultimately countries will want to have their own procurement capabilities, domestically financed health workforces, and underlying technology and physical infrastructure. We need to work through the CCM process with countries on what is right mix of external and domestic resourcing, which will change over time.

GFO: *You are clearly very keen on innovation and use of data – where would you like to see a stepped-up use of innovation and/or data in GF programming/implementation/reporting?*

Peter Sands: Fundamentally, there are two or three dimensions of data we've got to work on. First is frequency and freshness of data – in global health we tend to rely too much on relatively old data, and that makes it more difficult to be dynamic in the response to disease. And this is particularly notable for diseases where the intrinsic volatility, the speed with which they vary, is high. Malaria is a good example of that. Second is granularity: We need to have our data even more segmented by age, by gender, by geography, by dimensions that are relevant to the epidemic. This is crucial so that we can target our interventions as effectively as possible, and that in turn means we can increase the efficiency and effectiveness of those interventions. Third is the underlying quality of the data. The more we can be certain that the data is robust, the more we can make decisions off the back of it.

We are playing a role; we are a major investor in health management information systems [HMIS] in national account data, in national health systems, so we're directly supporting the development of data infrastructure and capabilities in countries. In addition, we need to be working with our country partners on why better data makes sense, what's the logic of having better data, in way that, if you have more frequent, higher quality data, you make better decisions that have more impact.

GFO: *What does the framework agreement with WHO allow the Global Fund and WHO to do differently, together? How does the SDG 3 Global Action plan translate into practice for the Global Fund and partners?*

Peter Sands: The anchoring document here is the Global Action Plan for SDG 3, which commits all the actors involved to align, to accelerate, and to account. And the framework agreement with WHO is an example of how we are setting about translating that into reality. How are we going to do that with WHO? This document is in itself a starting point because we're going to use it as the basis for consistent and corresponding framework agreements with the regional organizations, starting with AFRO. In a way, you can think of the SDG 3 Action Plan as being a kind of broad architecture. What we now have to do is, in a sense, fill that in. Fleshing out the Action Plan has two dimensions. Around relationships with other specific institutions, we already made huge progress on deepening synergies and cooperation with Gavi. A similar exercise is taking place with Unitaid, and a framework agreement with WHO has been done. The other dimension is picking specific themes and that's what the

whole notion of the accelerator on sustainable finance is about – how are we going to all work together to help countries as they develop more sustainable ways of financing their health systems and achievement of their health objectives.

A draft of the Action Plan is on the WHO website – a lot of this is about ensuring that we work together well. One good example is about collaboration with entities that can bring different sorts of financial expertise and resources to bear. So, things like, where it's appropriate, using blended finance, which often requires a multilateral bank working with an entity like the Global Fund. How we can streamline that and reduce transactions costs, and that sort of thing.

GFO: *It was clear from the Board meeting that transition (in the context of the Sustainability, Transition and Co-financing policy) is a huge and somewhat contentious topic, and in your report you talk about the political challenges for Transition being more difficult than the technical ones. What are the biggest immediate issues facing the Fund relating to transition?*

Peter Sands: I think the starting point is that achieving sustainable transition is an imperative. Ultimately, we all want countries to be able to finance their own health systems and not be reliant on the GF. So it's in the interests of communities and countries to get onto the path of sustainability and transition really as early as possible. And we need to work together to ensure that roadblocks, issues [are solved], capabilities that need to be built are developed. And this is important partly because that's the long-term, sustainable outcome for each country. But also, getting countries to step up as they become wealthier through economic growth allows the Global Fund to focus its efforts on the places in the world with the highest disease burdens and the least ability to pay, which is where there is still massive unmet need.

Yes, transition is inherently challenging. There are at least three reasons. One: we are asking governments to pay for, or shoulder, financial burdens that some would prefer the Global Fund to keep paying for. Two: transition involves building capacities that some countries find difficult to develop. Three: transition involves governments reaching out to key populations that unfortunately some are inclined to neglect. And we have to confront and overcome all three of those challenges as countries go through the transition process.

Part of the answer to this is good planning, part is partnerships with other actors such as multilateral development banks. Ultimately, though, the key ingredient for a successful transition is political leadership. And that requires broad engagement across governments with civil society, as I think I said in my report. Political commitment and leadership is the sort of irreplaceable ingredient of a successful transition.

GFO: *Another big issue clearly is absorptive capacity - how are you working to identify opportunities to maximize absorption at country level? How do you see role of country teams in helping to improve absorptive capacity through their own proactive measures? And will*

increasing absorption rates affect the scenario planning that will go into the Investment Case?

Peter Sands: The starting point is that absorption has improved across the portfolio quite significantly – running at 75 percent versus 66 percent in the previous cycle. That's a result of both the work of the country teams and the way they work with partners on the ground, be they technical partners, the PRs, governments anticipating and identifying bottlenecks and proactively taking action to resolve them. One of the critical issues here is to be systematically monitoring and measuring absorption challenges both by geography and by disease component, and actually in my report I laid out some of the numbers around that. I don't think we should ever be complacent about absorption but the quality of the grants in this grant cycle sets us up well for further improvements in absorption across the portfolio. Absorption is a long-term challenge, and the challenges vary by country, and we're making good progress. So no, that does not significantly affect our planning for the Investment Case.

The Global Fund announced its target for the Sixth Replenishment on January 11, 2019, in Paris. The Fund's full Investment Case will be sent to participants of the Preparatory Meeting in New Delhi on February 8, towards the end of January.

Part 2 of Aidspan's interview with Peter Sands will be published in a future edition of the GFO.

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2. Global Fund Board approves $229 million in funding for country grants

Three multi-country grants valued at $24 million also approved

David Garmaise **14 January 2019**

On 21 December 2018, the Global Fund Board approved 16 country grants worth $229.4 million. It also approved three multi-country grants valued at $24.0 million. The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC).

By Aidspan's count, this was the 15th batch of approvals from the 2017–2019 allocations, and brings the cumulative amount awarded to date to over $9.5 billion. The 16 country grants emanated from funding requests submitted by nine countries; and one funding request submitted by the Middle East Response (MER) initiative. The MER initiative covers five countries (Iraq, Jordan, Lebanon, Syria and Yemen) whose allocations were pooled to create a single grant.

The $229.4 million for country grants included matching funds requests valued at $18.1 million. Interventions totaling $125.8 million were added to the Unfunded Quality

Demand (UQD) Register. Domestic commitments for the programs included in the approved grants amounted to $460.8 million.

An additional $1.6 million was added to the UQD Register from the approved multi-country grants.

Among the country grants, the largest award, $71.2 million, went to Nigeria for two TB grants and a TB/HIV grant. Mali was next with $53.7 million for a malaria grant.

See Tables 1 and 2 for listings of the country and multi-country grants.

Table 1: Country grants approved from the 2017-2019 allocations — 15th batch ($)

Applicant	Comp-onent	Grant name	Principal recipient	Amount approved [1]	UQD	Domestic commitment [2]
Angola	TB	AGO-T-MOH	Ministry of Health	7,674,176	10,866,918	22,346,260
Botswana	TB/HIV	BWA-C-ACHAP	ACHAP [9]	13,050,005 [5]	0	225,862,450 [4]
		BWA-C-BMoH	Min. of H. & Wellness	4,817,333	0	
Comoros [3]	HIV	COM-H-DNLS	Ministry of Health, Solidarity and Gender Promotion	1,346,017	437,189	1,067,008
	Malaria	COM-M-PNLP		4,625,856	1,206,823	1,079,815
Dom. Rep.	HIV	DOM-H-CONAVIH	CONAVIH [9]	7,557,616	4,458,173	95,080,836
		DOM-H-IDCP	IDCP [9]	8,437,339		
Jamaica	HIV	JAM-H-MOH	Ministry of Health	12,030,638 [6]	2,414,041	31,344,168
Kosovo [3]	TB	QNA-T-CDF	Community Dev. Fund	1,728,086	0	3,051,755
Mali [3]	Malaria	MLI-M-PSI	Pop. Serv. Int.	53,654,542	12,430,698	26,378,489
Middle East Response	HIV, TB, malaria	QSF-Z-IOM	International Org. for Malaria	36,408,368	32,685,572	0 [8]
Nigeria	TB/HIV	NGA-C-LSMOH	Lagos Min. of Health	5,089,851	61,133,561	0
	TB	NGA-T-IHVN	IHVN [9]	29,703,833		32,604,323
	TB	NGA-T-NTBLCP	Federal Min. of Health	36,422,481		
Sri Lanka	HIV	LKA-H-FPA	Family Plan. Assoc.	3,545,721	191,822	22,019,912
		LKA-H-MOH	Ministry of Health	3,346,218		
			Total	**229,438,080**	**125,824,797**	**460,835,016**

Notes:

1. *Amounts shown are upper ceilings.*
2. *The domestic commitments shown are for the disease programs and exclude RSSH.*
3. *For grants denominated in euros, an exchange rate of 1 euro = 1.1313 dollars was used.*
4. *The $225,862,450 shown as the domestic commitment for Botswana includes $209,655,781 for HIV and $16,306,669 for TB.*
5. *The approved funding shown for Botswana TB/HIV includes $2,000,000 in matching funds.*
6. *The approved funding shown for Jamaica HIV includes $2,100,000 in matching funds.*
7. *The approved funding shown for Nigeria TB and TB/HIV includes $14,000,000 in matching funds.*

8. *The co-financing requirement for the Middle East Response grant was waived.*
9. *ACHAP = African Comprehensive HIV/AIDS Partnerships | CONAVIH = Consejo National para el VIH y el SIDA | IDCP = Instituto Dermatológico y Cirugía de Piel | IHVN = Institute of Human Virology Nigeria*

As is customary, the approved funding is subject to availability of funding and will be committed in annual tranches.

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 the 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 — in instances where the TRP did not recommend reinvesting in the same grant; or (c) the general funding pool.

Table 2: Multi-country grants approved from the 2017–2019 allocations — 15th batch ($)

Applicant	Grant name	Principal recipient	Amount approved	UQD
Multicountry EECA TB	QMZ-T-PAS	PAS [2]	4,998,976	1,004,800
Multicountry EECA HIV	QMZ-H-AUA	Alliance for Public Health	13,000,000	546,003
M.C. Sup. Labs TB (WCA) [1]	QMZ-T-PNT	PNT[3]	6,045,626	0
		Total	**24,044,602**	**1,550,803**

Notes:

1. *For the supranational labs grant, which was denominated in euros, an exchange rate of 1 euro = 1.1313 dollars was used.*
2. *PAS = Center for Health Policies and Studies*
3. *PNT = Programme National contre la Tuberculose de la République du Bénin*

In addition, the Global Fund Board approved $599,101 for a Pakistan malaria grant to fund interventions from the UQD Register (see Table 3). The funds for this award come from a portfolio optimization exercise that was carried out for the 2017–2019 allocation cycle. This is the fourth set of interventions to be funded from this exercise. In October and November 2018, the Board approved funding for the first three sets of interventions (see GFO articles here and here).

Table 3: Additional UQD interventions for 2017–2019 funded through portfolio optimization

Applicant	Comp-onent	Grant name	Principal recipient	Amount approved ($)	Revised program budget ($)
Pakistan	Malaria	PAK-M-DOMC	DOMC [1]	599,101	30,538,494

Note: [1] DOMC = Directorate of Malaria Control, Ministry of National Health Services, Regulations and Coordination

The GAC report did not say precisely which interventions for Pakistan malaria on the UQD register were being funded. On the latest version of the register, dated 21 December 2018, there are six interventions shown for Pakistan malaria, totaling $7.4 million.

GAC comments on the approved grants

In its report, the GAC provided comments on the grants for the following seven country components:

- Angola TB
- Botswana TB/HIV
- Jamaica HIV
- Mali malaria
- Middle East Response (MER)
- Nigeria TB
- Sri Lanka HIV

In this article, we summarize the GAC's comments on four of the components: Angola TB, Botswana TB/HIV, Jamaica HIV and Sri Lanka HIV. (See the separate article in this issue, below, on the MER grant.) We plan to publish separate articles on the Mali malaria and Nigeria TB grants in the next issue of GFO.

The GAC report also included comments on three multi-country grants. We plan to publish a separate article on the multi-country grants in the next issue of GFO.

Angola TB

Angola is one of 30 countries with the highest TB burdens. Although Angola recently developed a new TB strategy for 2018–2022, prolonged national stock-outs and structural barriers to accessing TB services have contributed to rising incidence rates.

The Angola TB grant will focus on (a) TB care and prevention; (b) multi-drug resistant TB (MDR-TB) case detection, diagnosis and treatment; and (c) TB/HIV collaborative activities. The grant prioritizes seven provinces most affected by TB and targets key populations, including children under five, prisoners, miners, people living with HIV, refugees, nomads and the elderly.

The TB grant also includes funding for six months of resilient and sustainable systems for health (RSSH) activities as an interim measure pending the resubmission of a separate RSSH funding request in early 2019. These activities, budgeted at $1.6 million, will allow Angola to continue supporting health management information systems, monitoring and evaluation, and supply chain strengthening.

The Government of Angola has made sufficient commitments to meet the co-financing requirements. In the opinion of the GAC, there is only a small risk of the commitments not being realized.

The GAC said that although Angola's current TB grant did not perform well (see next paragraph), the government, stakeholders and partners have worked together to design the new grant and to ensure that it addresses several structural barriers to accessing and expanding TB services. Angola projects an increase in case detection from 59% in 2018 to

80% by the end of the grant (December 2021); and an increase in the treatment success rate from 66% in 2017 to 79% by the same date.

The fund portfolio manager for Angola, Adriana Jimenez Cuen, told Aidspan that in 2017 and 2018 the performance ratings for the previous grant fluctuated between B1 and B2, and that the most recent rating was B2. There are four possible ratings of performance ranging from A (meeting or exceeding expectations) to C (unacceptable). A B1 rating means that the performance was adequate. B2 means "inadequate but potential demonstrated."

The GAC acknowledged that the Government of Angola has historically procured first-line TB drugs but said that the country fell short of this commitment in 2017 when it was facing an imminent stock-out and the government was forced to ask the Global Fund to process an emergency procurement.

The GAC recommended that the government use the Global Drug Facility to procure first-line TB drugs. Jimenez told Aidspan that Angola has previously expressed an interest in using the Global Drug Facility, and that it recognized this would allow for "access to more affordable international prices, assured quality medicines and efficient lead and delivery times."

Jimenez said that the GAC recommendation was intended to reinforce the notion of using the Global Drug Facility and to ensure that future stockouts and emergency procurements are avoided.

Wambo.org, the Global Fund's own procurement tool, currently does not procure first-line TB drugs.

The GAC said that continued partner advocacy and support is required to ensure a strong programmatic performance during implementation of Angola's TB grant.

Botswana TB/HIV

Botswana has a high HIV prevalence rate (22.8%) among persons aged 15–49. TB rates remain among the highest in the world.

The two approved grants will support the goals of ending the TB epidemic: ensuring zero new HIV infections, zero AIDS-related deaths and zero discrimination by 2030.

Botswana received matching funds for two priority areas: Human Rights ($1.0 million); and Adolescent Girls and Young Women (AGYW; $1.0 million).

In order to be eligible for matching funds, applicants need to meet four conditions:

- The program associated with the 2017–2019 allocation includes activities that support the specific strategic priority area;
- The investment in the priority area is higher in 2017–2019 compared to 2014-2016;
- Funding from the 2017–2019 allocation invested in the priority area is at least equal to the matching funds requested (i.e. at least a 1:1 ratio); and

- The initiatives proposed under matching funds have clear potential to accelerate progress in the relevant priority area and to maximize impact of the overall program.

Botswana met all of the conditions for the Human Rights funding, but only three of the four conditions for the AGYW funding. Botswana did not meet the condition on increasing the overall investment in AGYW in the 2017–2019 allocation period compared with its 2014–2016 investment.

The GAC approved an exception to this condition. It said (a) that Botswana fell short of meeting this commitment by a small amount; (b) that as a portion of its allocation, the investment in AGYW activities was actually higher in the 2017–2019 period because Botswana experienced a slight reduction in its allocation for that period; and (c) the matching funds are expected to have a catalytic impact on the program.

The GAC said that the Government of Botswana has submitted indicative commitments sufficient to meet the co-financing requirements. The GAC judged the risk of the government not meeting these commitments to be low.

Jamaica HIV

The GAC described Jamaica as having a mixed HIV epidemic with a low-level generalized epidemic (1.7% prevalence) and concentrated epidemics among female sex workers (2%), men who have sex with men (33%) and transgender persons (45%).

The grant aims to:

- Increase access to comprehensive prevention services to reduce new HIV infections and STIs among key populations;
- Scale up HIV testing targeting key populations to identify new cases and provide timely linkage to treatment and care;
- Improve access to HIV treatment and care services through the protection and promotion of human rights for key populations;
- Provide a comprehensive package of care to improve linkage, retention and adherence;
- Increase the capacity of people living with HIV, civil society organizations and key populations to engage in partnerships, advocacy and monitoring of service provision and delivery; and
- Improve the availability of strategic information to guide program development, implementation and evaluation.

The Government of Jamaica has committed sufficient funds to meet the co-financing requirement.

Jamaica received matching funds for two priority areas: Key Populations Impact ($1.1 million) and AGYW ($1.0 million). The TRP recommended the matching funds because of their catalytic potential even though Jamaica did not meet all of the conditions. The TRP

waived the condition that the investment in the priority area be higher in 2017-2019 versus 2014-2016. Here are two reasons why:

- For the Human Rights priority area, the TRP said that "given the reduction in allocation when compared to the 2014-2016 allocation, meeting the 1:1 condition would entail close to a 400% increase in investment."
- Along the same lines, for Key Populations Impact the GAC said that Jamaica was unable to meet the increase in allocation condition given that the investment in key populations in the 2014-2016 allocation period was larger than the entire HIV allocation for 2017-2019.

Table 4 shows the allocations for Jamaica HIV in 2014-2016 and 2017-2019.

Table 4: Allocations for Jamaica HIV: 2014–2016 vs 2017–2019

Allocation for 2014–2016 ($)				Allocation for 2017–2019($)		
Existing funding	Additional funding	Incentive funding	Total	Base funding	Matching funds	Total
4.2 m	**14.9 m**	**NIL**	**19.1 m**	**9.9 m**	**2.1 m**	**12.0 m**

The GAC expressed concern about what it considered to be a low coverage rate, slow scale-up and limited government financing in Jamaica's program. It said that there is a need for more ambitious scale-up targets and for continuing to invest in improving program quality. The GAC observed that Jamaica's poor fiscal environment is hampering progress. The GAC also noted that the combined Global Fund and government investments are not sufficient to cover "a program at scale."

Sri Lanka HIV

Sri Lanka is a low-prevalence country. Surveys show an HIV prevalence rate of less than 1.0% in the general population and 1.5 % among men who have sex with men.

The Board approved two grants to be managed by the Ministry of Health, for the first grant, and the Family Planning Association of Sri Lanka for the second.

The grants aims "at working towards" ending AIDS by 2025 with a focus on HIV prevention among key populations. Strategies for achieving this goal include the following:

- Preventing new infections of HIV and STIs among key populations and the general public;
- Providing universal access to HIV and STI diagnosis and treatment, and care and support services for those infected and affected;
- Strengthening strategic information systems and knowledge management;
- Strengthening health systems at different levels; and

- Providing a supportive environment to enhance access to and delivery of HIV prevention, diagnosis, treatment and care services.

The Government of Sri Lanka has committed sufficient funds to meet its co-financing requirement.

The GAC noted that for several years, there have been outstanding recoverables associated with the Sri Lanka portfolio. "Given the considerable efforts already expended by the Secretariat and the low likelihood of recovery," the GAC stated, "in October 2018, the Executive Director approved the Recoveries Committee's recommendation to apply a 2:1 reduction amounting to $129,444 to Sri Lanka's 2017–2019 allocation." The GAC noted that the budget of the LKA-H-MOH grant has been adjusted to reflect this. A similar reduction will be applied to Sri Lanka's TB grant that was approved by the Board in November 2018.

Extension approved

The Secretariat informed the Board that it has approved a 12-month extension for a regional grant, Multi-Country Southern Africa ARASA (QPA-H-UNDP), to allow the regional program, which was funded from the 2014-2016 allocations, to transition away from Global Fund support. The extension budget is $1,657,431. No additional funding is involved. The GAC recommended that the PR, UNDP, should make a special effort to ensure that capacity and implementation are transferred to local entities so that activities can continue once the grant ends.

In GFO 345 and GFO 347, Aidspan reported on the 12th, 13th and 14th batches of grant approvals and also listed the grants approved in the 10th and 11th batches. Aidspan reported on the ninth batch of grant approvals here; that article contains links to GFO articles on the first eight batches.

Most of the information for this article was taken from Board Document GF-B40-ER2 ("Electronic Report to the Board: Report of the Secretariat's Grant Approvals Committee"), undated. This document is not available on the Global Fund website.

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3. Global Fund Board approves $36 million for Middle East Response

Funding to support services for refugees and key populations in Iraq, Lebanon, Jordan, Syria, and Yemen

Charlie Baran & David Garmaise **15 January 2019**

As part of a larger package of approvals in December, the Global Fund Board approved a $36.4 grant known as the Middle East Response. This is the second time the several-country arrangement has been funded as such, but now includes an expanded remit.

The Middle East Response 2 (MER2) grant covers five countries in the Middle East region (Iraq, Jordan, Lebanon Syria and Yemen), and aims to provide essential HIV, TB, and malaria services to populations in these countries. The MER initiative was created by consolidating the country allocations for Syria, Yemen and Palestine under one integrated grant-management platform and governance framework, tailored to address healthcare in the context of protracted conflicts (in Syria and Yemen) and a refugee crisis.

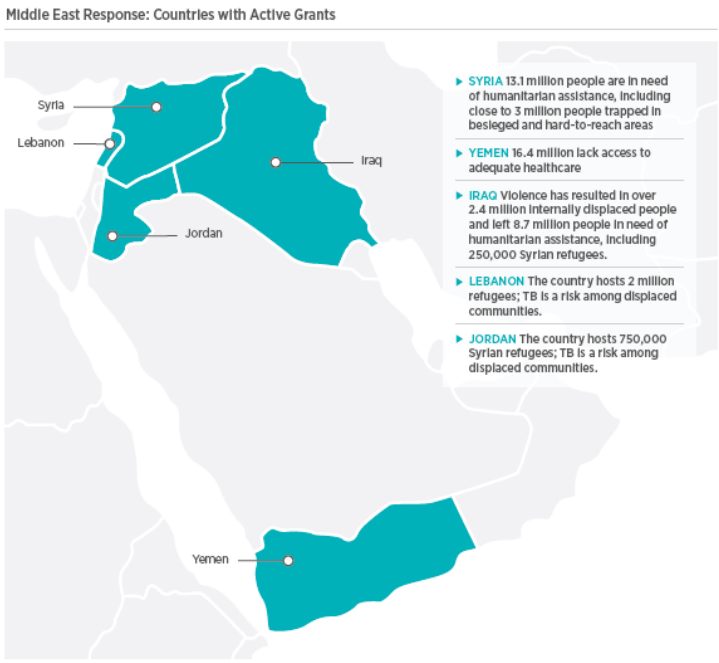

Image: The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Focus on the Middle East Response".

Lebanon is newly eligible to receive an allocation for HIV. Jordan is not eligible for either HIV or TB, but under the Challenging Operating Environments (COE) Policy the Global Fund is able to provide support to Syrian refugees in Jordan.

Lebanon hosts over 1.5 million Syrian refugees, as well as a large population of Palestinian refugees. Jordan hosts an estimated 1.3 million Syrian refugees. The Syrian crisis and the ensuing influx of refugees into both countries has placed their health systems under significantly increased pressure.

Iraq is joining the MER for the first time under this grant. As reported in GFO 334 last year, Iraq was designated as ineligible for Global Fund support, and thus received just $6.7 million in TB transition funding for the 2014-2016 allocation period. Because of challenges driven by the internal and cross-border conflict associated with the ISIS insurgency, the Global Fund extended the transition funding through the end of 2017. Then it was determined that Iraq

should join MER in 2019. To facilitate that, 12-month bridge funding was provided to Iraq for 2018—effectively a second extension of the 2014-2016 transition grant.

The principal recipient of MER2, as with MER1, is the International Organization for Migration (IOM). The IOM, also served as the PR for Iraq transition grants, managed the grants out of its offices in Amman, Jordan.

The MER1 began in January 2017. The MER2 funding represents a continuation and expansion of that grant, and will run from 2019 to 2021. The Global Fund published a brochure on the initiative in October 2018, which can be found here.

In its electronic report to the Board, the GAC cited several achievements of the current MER1 grant:

- Some overhead costs have been shifted to program budgets.
- The countries have developed contingency plans detailing actions that would be needed if the grant enters an emergency phase.
- In the malaria component, services have been scaled up, there has been engagement at the community level, and there is a strong bed-net tracking system that is being presented as a best practice.

MER2 will build on lessons learned from the current grant to deliver additional impact through:

- Scaling-up prioritized interventions in the current program;
- Preventing the collapse of public health services that received considerable support from earlier Global Fund grants;
- Prioritizing and protecting vulnerable populations, especially conflict-affected populations; and
- Enhancing the managerial capacity of national programs to cope with complex emergency situations; and
- Strengthening health systems.

The GAC described how the grant will address the three diseases, as follows:

> **HIV.** According to data from UNAIDS, Lebanon, Jordan, Syria and Yemen have a low incidence of HIV. HIV interventions are focused on the total population in Yemen and Syria, the Syrian refugees in Jordan, and Syrian displaced populations and affected host communities in Lebanon. HIV investments focus on prevention interventions among key and vulnerable populations, with an emphasis on scale-up of HIV testing and linkages to HIV care and treatment services.
>
> **TB**. Yemen, Iraq, Syria and Lebanon have a moderate incidence of TB; Jordan has a low incidence. Programmatic management of MDR-TB has been initiated in all five

countries with financial support from the Global Fund but is still not fully implemented.

Iraq received transition funding for the 2014-2016 allocation period because the country was reclassified as upper-middle-income. However, under flexibilities provided in the Challenging Operating Environment (COE) Policy, Iraq's TB component regained eligibility for the 2017-2019 allocation period. It is on this basis that Iraq's TB component is included within the scope of this grant.

Malaria: Malaria has historically been a major public concern in Yemen. Somewhere between 60% and 78% of Yemen's 2.2 million population live in malaria risk areas. MER2 aims to support prevention and reduction of the impact of malaria outbreaks by early detection and timely responses – with implementation of effective malaria control measures through activities organized around vector control and case management.

The Secretariat granted a waiver for the co-financing requirement for the MER2 countries in light of the protracted emergency situation in these countries.

Although MER2 does fund services in several countries, it is not grouped with the other "multi-country approaches" grants, which form one of the catalytic investment modalities approved by the board for the 2017-2019 period. Thus the $36.4 million for MER2 does not come out of the $260 million set aside for the formal multi-country grants. Rather, it represents a combining of the allocations of participating countries, insofar as they have allocations.

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TOP

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4. OIG investigation in Mozambique finds embezzlement of funds by CCM Executive Secretary

Inadequate oversight and lack of rules for handling expenses were contributing factors

Adèle Sulcas **15 January 2019**

In an investigation of Global Fund grants to Mozambique, the Office of the Inspector General (OIG) has found that the Executive Secretary of Mozambique's Country Coordinating Mechanism (CCM) was responsible for non-compliant expenditures of $26,020 over the period of a year between 2016 and 2017, by claiming false expenses and vouchers. Of this, $22,593 was fraudulent.

The OIG's investigation report was made public on 13 November 2018.

The report focused on three main findings, headlined by the embezzlement of funds by the Executive Secretary of the CCM; the second and third finding – lapses in financial controls by the CCM funding recipient (the PR, in this case), and inadequate CCM oversight and governance – were seen by the OIG as contributing or enabling factors of the embezzlement.

The payment of the embezzled funds was made by the Principal Recipient, the Fundacao para o Desenvolvimento da Comunidade (FDC), which provides financial support to the CCM (itself not a legal entity), including the administration of funds.

The non-compliant expenditures, which included seven fraudulent expenditures ($22,593) and 17 unsupported vouchers ($3,427) come to a total of $26,020. The Executive Secretary of the CCM has already reimbursed $1,433 of this total; the OIG recommended that the Secretariat seek recovery of the remaining $24,587.

Actions already taken

Based on the OIG's findings described in this report, the Executive Secretary of the CCM has been dismissed. In addition, in December 2017, the Secretariat instructed the CCM Chair and FDC Executive Director to develop a clear set of guidelines for the management of CCM funds. The CCM Executive Committee is finalizing new CCM governance procedures, as well as a revised Memorandum of Understanding with FDC.

Origins of the OIG investigation

The investigation was instigated by a Local Fund Agent (LFA) review of CCM expenditures. During this review, the LFA requested documents from the Executive Secretary to support some expenses claims the Executive Secretary had submitted. The LFA found three unsupported payments made by FDC to the Executive Secretary, who immediately admitted that he had submitted vouchers for reimbursements related to CCM oversight visits that had not taken place.

The Secretariat notified the OIG of the LFA's findings on 13 February 2018.

Main findings

The investigation report described three main findings, each with an association Agreed Management Action, summarized here:

1. **The embezzlement of funds by the CCM Executive Secretary**: Between September 2016 and October 2017, the Executive Secretary of the CCM submitted seven fraudulent vouchers totaling $22,593 to the CCM funding recipient, FDC, to obtain CCM funds to which he was not entitled. (FDC was providing financial management support to the CCM, which was not itself a legal entity.) For four of the seven vouchers, the Executive Secretary created false supporting documentation; the remaining three vouchers were for advance payments, and did not include any supporting documentation. FDC paid a further amount of $3,427 for 17 vouchers submitted by the Executive Secretary that were "unsupported but not fraudulent". The

combined 20 fraudulent and unsupported vouchers represent 4% of all CCM vouchers approved by FDC between 2015 and 2017.

2. **Lapses in financial controls by the CCM funding recipient**: An absence of guidance for submitting and paying CCM expenditures "contributed to FDC's lapses of oversight," the OIG report said. FDC paid the four vouchers supported by false documents, because they appeared to be legitimate. But FDC also paid the other three fraudulent vouchers despite the lack of supporting documentation, and without following up with the Executive Secretary to obtain the missing supporting documents, settle outstanding advances, or obtain refunds for unspent portions of the advances that had been paid.

3. **Inadequate CCM governance and oversight**: Lack of oversight by the CCM Chair and the absence of adequate CCM guidance documents were contributing factors in allowing the fraud to occur, the OIG said. Neither the MOU between FDC and the CCM, nor the CCM governance documents provided clear guidance on how requests for funds advances nor other CCM expenses should be processed, by either organization. When the CCM Chair became aware of the Executive Secretary's submission of false vouchers, he did not notify the Global Fund, as required by the terms of the CCM funding agreement.

Types of wrongdoing, and agreed management actions

The report identifies "fraud" and "non-compliance with grant agreement" as the two types of wrongdoing identified in this investigation.

Based on the report findings, the Secretariat will ensure the carrying out of three agreed management actions, summarized below. (For a full table of AMAs, please see page 17 of the OIG report.)

Agreed Management action	**Target date**
1. The full amount of non-compliant expenditures be recovered ($24,587 taking into account one reimbursement of $1,433 already made).	31 December 2019
2. The Global Fund Secretariat will ensure that the Memorandum of Understanding between the CCM and the CCM funding recipient, FDC, is updated, so that it clearly outlines procedures for requesting payments and clearing advances.	31 March 2019
3. The Secretariat will ensure that the CCM revises its governance documents for the oversight of CCM employees,	31 March 2019

and the financial management guidelines for CCM expenditures.	

(See the full table of AMAs on page 12 of the OIG report.)

Country context

The Global Fund has signed a total of 19 grants with Mozambique, worth $1.5 billion, of which $937 million has been disbursed. Six grants are active ($1 billion) of which $464 million has been disbursed to four Principal Recipients, with the Ministry of Health responsible for the largest HIV grant.

Mozambique is a 'high impact' Global Fund country (very large portfolio, mission-critical disease burden) with a population of 28.8 million people, the lowest per capita health expenditure in the southern African region ($42), and a critical shortage of healthcare workers (1.74 per 1,000 people, compared to WHO's recommended minimum of 2.5 per 1,000 people). Mozambique is ranked 181 out of 188 countries in the UNDP human development index report.

Table 1: Mozambique's six currently active Global Fund grants

Principal Recipient	Grant component	Grant	Signed amount (US$)
Centro de Colaboracao em Saude (CCS)	HIV/TB	MOZ-C-CCS	30,295,168
Fundacao para o Desenvolvimento da Comunidade (FDC)	HIV/AIDS	MOZ-H-FDC	28,422,994
Ministry of Health	HIV/AIDS	MOZ-H-MOH	534,466,531
Ministry of Health	Malaria	MOZ-M-MOH	250,627,520
World Vision	Malaria	MOZ-M-WV	79,614,869
Ministry of Health	TB	MOZ-T-MOH	82,477,147
Total			**1,005,904,229**

The full report of the OIG investigation into embezzlement of Global Fund grant funds in Mozambique is accessible on the Global Fund website.

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TOP

5. Funding requests to the Global Fund in next allocation period will need to scale up investments in RSSH, TRP says

TRP releases report on RSSH investments from 2017 to 2019

David Garmaise **14 January 2019**

Despite the progress that has been made, a greater focus on resilient and sustainable systems for health (RSSH) will be required in the 2020–2022 allocation period if the Global Fund is to achieve its RSSH-related strategic objectives, the Technical Review Panel (TRP) says in a report released recently on RSSH investments in the 2017–2019 allocation period.

The 54-page report provides a comprehensive analysis of RSSH-related gaps in funding requests and advances numerous recommendations on how applicants, the Global Fund and partners can address these gaps.

The TRP analyzed RSSH investments in funding requests submitted in the first five windows of the 2017–2019 allocation period. (There were six windows in all.) Fifty funding requests were selected for in-depth analysis. These requests constituted 25% of the number (and 38% of the value) of the requests reviewed by the TRP in the first five windows.

The TRP said that attention to RSSH increased significantly in the 2017–2019 allocation period. Not only were RSSH investments reflected in stand-alone RSSH applications, but they also constituted a considerable portion of the disease funding requests. On average, the TRP said, 13% of the budgets in the funding requests it analyzed was invested in RSSH. The matching funds and 'above allocation' requests also contained RSSH investments.

The TRP observed a number of 'positive investments" in RSSH, including substantial investments into health information systems and progress towards electronic and interoperable data systems; and health systems investments to support innovative service delivery models, including at the community level, to extend services to key populations.

However, the TRP said, considerable challenges remain. The report identified seven high-level issues that need to be addressed. They are:

> ***Issue 1****: Focused attention to RSSH has been observed in funding requests. Further strategic and prioritized RSSH investments should be encouraged across health systems components. However, significant challenges remain.*
>
> ***Issue 2****: Further differentiation of RSSH investments is needed along the health systems development continuum [see below], with a greater shift from systems establishment and support, to systems strengthening and sustainability.*

Issue 3: *Weak RSSH indicators, including low uptake of indicators, negatively impact performance monitoring and accountability.*

Issue 4: *Significant efforts are needed to achieve stronger integration across the three diseases and with other health programs, such as RMNCAH [reproductive, maternal, newborn, child and adolescent health] and non-communicable diseases, where integration can strengthen service delivery, improve efficiency, equity and/or impact and value-for-money.*

Issue 5: *Comprehensive broad engagement beyond the health ministry is needed to strengthen vital elements of the health system.*

Issue 6: *Sustainability: Limited attention in funding requests to strengthening health systems components vital to sustaining disease impacts.*

Issue 7: *There are opportunities to further improve the application approach and process to better respond to RSSH needs.*

The report described the health systems development continuum as a "4S model" — Start-up, Support, Strengthening and Sustainability (see Table 1 below).

Table 1: General evolution of health systems development: the 4S model

Parameter	System start-up	System support	System strengthening	System sustainability
Scope	Emergency; early development of systems	May be focused on a single disease or intervention	Activities have impact across health services and outcomes	Systems are integrated, resourced and fully incorporated into the overall health sector
Longevity	Short term; depending on country situation	Effects limited to period of funding	Effects will continue after activities end	Effects are continuing without external/extra support
Approach	Input heavy for all systems	Provide inputs to address identified system gaps impacting service delivery	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner	Systems are adjusted to adapt to changes and resources are continuous, relevant and available domestically

In the part of the TRP report where the high-level issues are identified (Section 3.1), the issues are described and some recommendations are advanced. In the next part of the report (Section 3.2), most of the same issues are discussed in more detail, but organized differently. Section 3.2 contains nine sub-sections, as follows:

1. Health management information systems
2. Procurement and supply management
3. Human resources for health
4. Integrated service delivery
5. Community systems and responses

6. Private sector engagement
7. Governance, leadership and accountability
8. Health sector financing and financial management
9. Program implementation and management.

For this article, we have chosen to follow the format of Section 3.2. For each sub-section, we describe the issues and we summarize the recommendations advanced by the TRP. For space reasons, we will publish separate articles for Sub-Sections 3 (human resources for health) and 4 (integrated service delivery) in a future edition of the GFO.

Health management information systems (HMIS)

The TRP said that some countries continue to use multiple data management systems with unclear complementarity. In addition, it said, HMIS is often not connected to other relevant management systems, such as laboratory or logistics information systems.

Although large HMIS investments have improved the availability of data, the TRP observed, "use of this data and its influence on program management is often not evident in funding requests."

Many funding requests missed opportunities to analyze, interpret and use available programmatic data to improve the selection of interventions, the TRP stated. "In the case of malaria, opportunities remain for applicants to make better use of existing data on age, sex, population mobility and demographics to facilitate identification of the most vulnerable populations; understand whether they access services; and design appropriate interventions, including selection of vector control interventions."

For HIV, the TRP said that it was still seeing gaps in the availability of certain data, such as the size estimates of key populations; gender and age data breakdown; and data on policy or legal barriers to accessing services for key populations.

In TB, since health management information systems often do not disaggregate treatment outcomes by sex, gender or age, the TRP observed, funding requests do not present sex- and age-differentiated treatment outcomes and identify factors that might be associated with inequities.

TRP recommendations: Health Management Information Systems

- Countries should avoid introducing parallel data systems.
- Available program data should be used to make better resource allocation decisions.
- Applicants should include activities in the funding request that promote the use of, or improve the quality of data.
- The Secretariat should consider updating guidance to shift the focus from establishing integrated information systems to investing to ensure that data is used for program management and monitoring.

Procurement and supply management (PSM)

The TRP noted that a large number of funding requests continue to acknowledge serious PSM challenges. Stock-outs, above-market prices and sub-standard product quality continue in many settings, the TRP said; funding requests documented weaknesses in forecasting, logistics management information systems, quality assurance and control, and coordination among partners.

These challenges are underpinned by human capacity limitations, weak PSM-related financial, operational and administrative systems and — ultimately — weak use of performance indicators to monitor PSM performance, the TRP stated. This issue is linked to several other challenges — specifically the lack of information in funding requests on PSM support from national governments and other donors; inadequate use of performance indicators; and lack of consistent language and definitions used for PSM.

Although countries often focus on interventions to address warehousing and logistics constraints at central, regional and sometimes district levels, the TRP said, delivery of supplies below the district level (the last mile) is infrequently addressed.

Many applicants directed their co-financing commitments to the purchase of commodities, the TRP noted, but the systems were not always in place to support the transition from programs supported by the Global Fund to government programs.

While the Global Fund provides substantial funding for new technologies such as GeneXpert and HIV self-testing, the TRP observed, funding requests do not consistently provide information on the complementary health systems that need to be in place for new technologies to achieve their intended impact. For example, many applicants request funding for new viral load machines without explaining how the challenges of using both existing and new machines will be addressed.

TRP recommendations: Procurement and supply management

- Applicants should ensure that requests for PSM funding are informed by a clear gap analysis and that they identify expected improvements, with targets against which progress will be tracked.
- Applicants should ensure that their funding requests explain how the CCM will work with partners to implement a strategy to address last-mile delivery challenges.
- Monitoring should include measures to track improvements at lower-level health facilities.
- Applicants should work with the Secretariat to mitigate the risks of transitioning drugs to domestic financing. Applicants' analyses of transition readiness and risk mitigation strategies should be made available to the TRP to inform its assessment of whether the proposed transition is technically sound and sustainable.
- Applicants requesting funding for new technologies should include an analysis of the readiness of the health systems to support the introduction of the technologies.

Community systems and responses

"Only a small number of funding requests propose activities for strengthening community systems that are comprehensive and at sufficient scale to make a difference," the TRP observed. "Overall, few applications request support to increase the engagement of communities to address gaps in coverage across the three diseases. Even fewer include funding to support communities to advocate against unsound and inequitable policies, laws, and regulations. Where they exist, such efforts are often limited in scope and scale."

Where support is requested for community systems strengthening, the TRP said, proposed activities tend to focus on extending service delivery at the community level. "Such programming is often limited to deploying CHWs [community health workers] with narrowly defined responsibilities and insecure contractual arrangements," the TRP stated "and does not focus on strengthening broader community responses. Only a few applicants have requested support to strengthen community health systems in ways that ensure integration within the overall health system."

Too few programs are built for sustainability, the TRP said; many programs do not subsume CHWs with disease-specific responsibilities into human resources for health plans. And few funding requests discuss gender considerations in recruitment and deployment of CHWs.

The TRP noted that among countries approaching transition from Global Fund support, few developed robust mechanisms to ensure sustainable funding for community systems responses.

Finally, the TRP commented that evaluations of progress in community systems and response efforts rely too heavily on activity-level indicators. "Too little attention is paid to assessing the degree to which community systems responses are contributing to lifting human rights and gender-related barriers to access, and improving coverage and quality of care."

TRP recommendations: Community systems and responses

- Applicants should include initiatives in funding requests to increase the involvement of civil society organizations (CSOs) in governance, planning, service delivery and accountability monitoring mechanisms.
- The Global Fund, partners and applicants should promote and facilitate capacity building for CBOs and NGOs. Organizations serving key populations deserve special attention.
- Applicants should ensure stronger linkages between emerging community health systems and the formal health system.
- Applicants should enhance collaboration between disease programs and with other primary health care programs.
- Applications should introduce mechanisms to provide official recognition and more reliable compensation packages for community workers.
- Countries nearing transition should be asked to provide country sustainability plans as part of their funding requests and to demonstrate that CSOs were meaningfully engaged in the development of these plans.

- Countries should develop social contracting mechanisms or other innovative financing approaches to support the work of CBOs and NGOs, especially with respect to providing services to key populations.
- Where necessary, community organizations should be provided with technical assistance to strengthen their capacity to interact with governments at different levels.
- The Secretariat should work with partners to identify appropriate indicators to track community systems responses. The indicators should track both the level of engagement of communities in the activities supported by the Global Fund and the results of the investments.

Private sector engagement and public-private mix

There is limited inclusion of private sector health services in national plans and funding requests, the TRP remarked.

In recent review windows, the TRP said, there has been greater acknowledgement of the importance of public-private mix (PPM) in service delivery. "However, how PPM would be leveraged and funded are not clarified," the TRP said. "When PPM is included in the request, the assigned budget or the scope and ambition of the work proposed are inadequate."

Where PPM initiatives have been included, the TRP said, there is usually insufficient information in funding requests to enable the TRP to determine whether the PPM strategies proposed are appropriate. For example, how the private sector will reach key populations such as migrants, refugees and minority groups in remote areas is often not explained.

Although the quality of care provided by private sector facilities is an issue of concern in many countries, the TRP observed, funding requests do not address mechanisms to monitor the quality of service provision, the quality of inputs (such as drugs) to private sector providers, and the quality of outcomes.

TRP recommendations: Private Sector and public-private mix

- The Secretariat should develop guidance on PPM for applicants which situates PPM investments in the context of the 4S development continuum.
- Countries that are new to PPM should include in the funding request pilots and research on costs, access and impact of PPM approaches. Countries with existing PPM approaches should provide evidence in the funding request of the pilots' cost and impact.
- Applicants should undertake strategic planning, including mapping the interventions funded by other donors; identifying and analysing the gaps; clarifying the roles, coordination and collaboration between the non-state actors and government institutions; establishing a social contracting mechanism through which NGOs will be funded; and specifying the capacity-building and other communities systems strengthening needs of the civil society and how exactly and by whom they will be addressed.
- Partners should support countries to strengthen regulatory approaches; to disseminate lessons learned; to better understand private sector delivery models; and to promote cross-learning.

Governance, leadership and accountability

"There has been limited investment by the Global Fund into building leadership, strengthening governance, or supporting institutionalization of health systems in countries (with a few notable exceptions, mainly in transition countries)," the TRP observed.

The TRP said that funding requests seldom propose interventions to strengthen participation in governance systems by groups that are under-represented in decision-making, including women and representatives of civil society.

The TRP noted many cases, including in transition countries, where leadership around the contracting of services to NGOs was not sufficiently robust. "The re-entry of several countries into Global Fund financing after their transition, as well as increasing rates of HIV transmission in some countries approaching transition, gives cause for concern," the TRP said.

TRP recommendations: Governance, leadership and accountability

- The Global Fund and applicants should identify metrics for measuring and tracking stewardship.
- Applicants should link Global Fund investments in the three diseases to broader stewardship of the health sector. Applicants should be encouraged to identify the role of parliament, the extent of negotiations with the ministry of finance, the budget cycle, and accountability processes in their funding requests.

Health sector financing and financial management

Very few funding requests included initiatives to develop national health financing strategies, the TRP remarked. The TRP said that there is insufficient information in most funding requests to enable a sound assessment of the funding landscape and the sustainability of proposals. In addition, the TRP said, there is insufficient emphasis in funding requests on implementation arrangements for the effective flow of funds and financial management.

Based on evidence annexed to funding requests and references to previous grants in most requests, the TRP said, domestic budget expenditure rates are often significantly under 100%. "From a health systems strengthening perspective, spending all available public funds in accordance with planned budgets is vital to building systems, and in itself requires strong, well-managed financial systems," the TRP commented. Few funding requests include support for financial management or public expenditure capacity building, particularly at a decentralized level, it said.

TRP recommendations: Funding Requests

- Funding requests should include a table of basic macroeconomic and financial data.

- The Global Fund should promote sustainable financing systems in all countries eligible for funding by investing in health systems financing.
- Applicants should put greater effort into guilding and tracking progress in health financing and financial management systems.

Program implementation and management

The TRP said that it commonly saw funding requests with program management costs of 25–30% and that a few smaller grants had management costs of 50% or more.

Where separate program implementation arrangements are put in place, the TRP said, they create barriers to sustainability because they build financial management, decision-making capacity and accountability among external entities rather than within the public sector.

"Furthermore," the TRP said, "in countries that rely on contracting, a lack of investment into government or public sector capacity and commitment to contract services (for example, for NGOs to provide services to key populations) puts those services at risk following transition."

The TRP said that it saw funding requests from countries approaching transition that continued to rely on external implementation support funded by the Global Fund.

TRP recommendations: Programme Implementation and Management

- Implementation approaches should reinforce national systems strengthening.
- The Global Fund should develop a best practice guide on project implementation approaches using a health systems strengthening lens.
- Where parallel implementation arrangements are deemed to be essential for successful service delivery, the Global Fund should require applicants to describe the capacity-building activities and support they will undertake as part of grant implementation with a projected timeline and milestones to build a financial management function within national entities.

Editor's note: This overview of the TRP's RSSH report is one of three GFO articles on the subject; the other two, on integrated service delivery and human resources for health, will be published in a future edition of the GFO.

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TOP

6. OIG audit praises Kenya's procurement and supply chain processes, identifies implementation challenges

Gaps in service delivery, grant implementation and measurement of grant performance

Ann Ithibu **15 January 2019**

Kenya has made significant progress against HIV, TB and malaria. This is partly due to the country's ability to successfully procure Global Fund-supported health products, despite not using the Global Fund Pooled Procurement Mechanism (PPM). The country also ensures that health products are available to health facilities as needed.

However, Kenya still faces significant gaps in design and implementation of programs that lead to issues in quality of services and measurement of grant performance. Changes in national governance following constitutional changes in 2010 have compounded these gaps; Kenya has devolved health service delivery from the central government to 47 county governments. Implementers at the county level risk delays in flow of funds from the central level, absorption of funds and subsequent reporting.

These are some of the key findings from an audit of grants to Kenya conducted by the Global Fund's Office of the Inspector General (OIG). A report of the audit was released on 12 November 2018. This article provides a summary of the OIG's findings.

The audit covered grants implemented by the three principal recipients (PRs) - the National Treasury, AMREF Health in Kenya and the Kenya Red Cross Society (KRCS), their sub-recipients, and Kenya Medical Supplies Authority (KEMSA) between January 2016 and December 2017. The audit assessed the efficiency and effectiveness of the design and implementation of the programs, procurement and supply chain processes and systems, grant implementation arrangements in the context of devolution, and frameworks to measure grant performance.

Kenya country context

The Global Fund classifies Kenya as 'high impact' due to its large portfolio and high burden of the three diseases. It has invested close to $1.1 billion in Kenya since 2003. Currently, there are six active grants (see table 1).

Table 1: Active Global Fund grants in Kenya

Grant Number	PR Name	Disease component	Grant period	Signed Amount	Disbursed Amount
KEN-H-KRCS	Kenya Red Cross Society	HIV	Jan 2018 - Jun 2021	70,745,412	10,441,386
KEN-H-TNT	National Treasury of the Republic of Kenya		Jan 2018 - Jun 2021	183,321,179	4,400,553
KEN-T-AMREF	Amref Health Africa in Kenya	TB	Jan 2018 - Jun 2021	32,651,550	10,172,857
KEN-T-TNT	National Treasury of the Republic of Kenya		Jan 2018 - Jun 2021	54,156,636	4,110,177

KEN-M-AMREF	Amref Health Africa in Kenya		Jan 2018 - Jun 2021	13,240,138	3,958,373
KEN-M-TNT	National Treasury of the Republic of Kenya	**Malaria**	Jan 2018 - Jun 2021	30,043,120	4,674,159
Total:				**384,158,035**	**37,757,505**

Kenya, which is a lower-middle income country, is ranked 146 out of 187 countries in the 2017 United Nations Development Program (UNDP) Human Development Index. It ranks poorly in the Transparency International 2017 Corruption Perceptions Index: 143 out of 180.

Kenya adopted a devolved system of government in 2013, following the promulgation of a new constitution in 2010, which led to significant changes within the health sector; county governments are now in charge of health-service delivery, a function previously held by the national government.

Health sector programs are negatively affected by challenges in the health workforce in Kenya, which range from a low health-care workers-to-population ratio – 13 doctors, nurses and midwives per 10,000 people, below the World Health Organization (WHO) recommendation of 23 – to frequent strikes by health workers.

Ratings

The OIG rated four objectives according to its four-tiered rating scheme (effective; partially effective; needs significant improvement; ineffective)

Objective 1: Design and implementation of the programs to deliver quality services to intended beneficiaries are **partially effective.**

Objective 2: Procurement and supply chain processes and systems in ensuring availability of quality assured medicines and health products to patients are **effective.**

Objective 3: Grant implementation arrangements in the context of devolution including governance, oversight and coordination to ensure sustainability are **partially effective.**

Objective 4: Adequacy and effectiveness of frameworks in place to measure grant performance are **partially effective.**

Achievements

The OIG noted that Global Fund grants in Kenya are achieving impact: the number of new malaria cases decreased by 47% between 2015 and 2017; AIDS-related deaths decreased by 38% between 2013 and 2015, and the number of people who are on anti-retroviral therapy (ART) increased by 52% between 2013 and 2016. The OIG also noted that Kenya has increased its financial commitment to the three diseases; indeed, the country meets all its counterpart financing commitments and it fulfilled its five-million-dollar pledge to the Global Fund's 5th Replenishment. Kenya has also developed functional in-country procurement and

supply chain systems and processes that allow the country to purchase quality-assured medicines at prices lower than international reference prices, and distribute medicines directly and efficiently to health facilities.

Key issues and risks

Despite the success in procurement and supply chain, grants in Kenya face key issues and risks. Among them are :

- Issues in the quality of services
- Sub-optimal planning and implementation of interventions for key and vulnerable populations
- Duplication resulting from limited visibility of donor-funded activities
- Increased risks to grant implementation following devolution of service delivery to county governments.

Below, we describe each issue and risk.

Issues in the quality of services

The OIG identified a number of quality of services issues across the three diseases that need to be addressed if Kenya is to sustain or scale up the progress made so far: for instance, Kenya has consistently failed to meet TB case notification targets in the last three years and, related to this, increase the number of people on TB treatment - treatment coverage is low, 45%, against a recommended target of 90%. The OIG also noted inconsistencies in compliance with national HIV testing guidelines, which was caused by limited training and supervision of staff, and delays in the distribution of mosquito nets – in some counties, net distribution took place during the peak transmission periods, which reduced the effectiveness of the campaign.

The OIG reported inconsistencies in the measurement of outcomes and in the reporting of data, which include lack of outcome indicators for some key population groups such as adolescent girls and young women (AGYW) – even though they make up 24% of the grant excluding medicines and commodities – and errors and variances in reported data. The OIG attributed these challenges to errors in the manual aggregation of data, misunderstanding of the indicators at the service delivery level, lack of a unique patient identifier, and inconsistent availability of data-capturing tools. The Secretariat and national TB program had planned an annual data quality audit by the end of 2018.

Sub-optimal planning and implementation of interventions for key and vulnerable populations

Key population programming is currently based on outdated bio-behavioral data, according to the OIG. Efforts to obtain nationally updated, representative bio-behavioral surveillance data via a survey in 2017 were frustrated by a lack of consensus between the national program and key population groups on the use of biometrics.

The OIG also noted that some key components of the AGYW were not implemented as designed. The PR planned for behavioral interventions, meant to complement a cash transfer program, for adolescents 10-17 years old, both in- and out-of-school. The interventions were not effectively implemented; in fact, the OIG reported no progress in 'in school' interventions and little progress in 'out of school' interventions. For the current implementation period, January 2018 to June 2021, the OIG noted that none of the AGYW interventions had commenced at the time of the audit due to delays in the PR engaging the service providers.

Key population programs also face inconsistent availability of selected commodities for diagnosis, prevention and treatment for key populations such as HIV test kits, lubricants, and medicines for sexually transmitted diseases, among others; in fact, during the audit, the OIG noted that all 26 sub-implementers of interventions targeting key populations reported stock outs lasting longer than 90 days, affecting the consistency and comprehensiveness of services provided.

Duplication of donor-funded activities resulting from poor coordination

The OIG cited duplication between programs supported by the Global Fund and other health partners and attributed it to limited information-sharing among partners and the absence of detailed donor mapping at the central and county level. The OIG explained that in some instances, donors funded the same implementers for the same interventions, and in turn, received the same results from the implementers leading to over-reporting at the national level. For instance, the Global Fund and two other development partners provide resources to the same 26 implementers for the same interventions for key populations in the same geographical regions; in turn, they receive the same results from the implementers.

The National AIDS Control Council (NACC), already aware of this problem, has developed an online reporting platform to track all HIV/AIDS interventions funded by donors in Kenya. However, only a handful of implementers report to the NACC: 12% in 2016, 10% the year before.

The OIG underscored the need for engagement of all stakeholders including the government, donors and implementers to address this issue.

Increased risks to grant implementation following devolution of service delivery to county governments

Kenya is making progress in devolving grant implementation to counties, following the devolution of service delivery to the counties. The OIG warned, however, that this change poses significant risks to grant implementation, due to the increased number of implementers, such as delays in the flow of funds from the central level, the absorption of funds and subsequent reporting by the counties, and the increased workload on the PR's Project Management Unit, which will now have to supervise and consolidate reports from the 47 counties. Previously, grant activities were being implemented and managed at the national level, based on a national implementation arrangement, by the National Treasury, which is the state PR, or the Ministry of Health that implements grants on behalf of the state PR.

The main risk, however, is the lack of capacity by the counties to implement activities and account for grant funds in a timely manner; the audit found that some counties had insufficient finance and program staff, while the county health-management teams have limited experience in planning and budgeting, and programmatic and financial reporting under Global Fund grants. The KCM has proposed a capacity assessment of the counties; however, this is yet to be done.

The OIG called for changes in oversight, risk mitigation and assurance arrangements to respond to the changes in the implementation arrangements.

Agreed management actions (AMAs)

The Secretariat will work with the in-country partners on five agreed management actions:

1. To develop an action plan/roadmap for implementation of the TB strategic initiatives
2. To provide an updated implementation strategy for the AGYW interventions based on lessons learned during the pilot phase of implementation
3. To develop an oversight and implementation plan to improve timely identification and management of expiries at the central and facilities level, including measures to address identified control gaps upstream and downstream
4. To agree on an appropriate framework that takes into consideration different options for implementing Global Fund grants in a devolved setting, in line with Global Fund guidelines
5. To develop guidelines for timely engagement of SRs at the start of new implementation periods with a view to ensuring uninterrupted program continuity.

All the AMAs are 'owned' by the Head of Grant Management Division; and are due to be completed by 31 December 2019, except for AMA 2 which is due on 31 March 2019.

For a table detailing the AMAs, see page 22 of the OIG report.

Focus on procurement and supply chain

The OIG highlighted Kenya's procurement and supply chain as a good example of a well-functioning system in a Global Fund country portfolio. This finding is consistent with an analysis conducted by Aidspan on the use of the national procurement authority, rather than the Global Fund's Pooled Procurement Mechanism (PPM). Kenya is one of the few African countries where the government procurement agency (KEMSA) procures Global Fund-supported medical supplies directly on behalf of the state Principal Recipient; most other African countries procure through the Pooled Procurement Mechanism, a Global Fund initiative created to aggregate procurement orders and negotiate lower prices for Global Fund recipient countries. Contrary to expectation, KEMSA obtains commodities at prices lower than those of the PPM; in fact, the prices were 21% lower than PPM prices for 2016 and 2017, according to the OIG. Kenya's supply chain is able to distribute commodities to health facilities; the OIG noted that there were no major stock-outs at the service delivery points. This is unlike many countries in the region, whose supply chains remain sub-optimal,

according to the OIG 2017 annual report. The OIG attributed KEMSA's success to government commitment, oversight and stakeholder coordination.

The full report of the OIG audit of Kenya is accessible on the Global Fund website.

Previous relevant OIG audit work on Kenya:

- *Investigation report of Global Fund grants to the Republic of Kenya: Fraudulent practices in National Tuberculosis and Lung Disease Program (NTLDP) activities, 2018*
- *Audit report of Global Fund grants to the Republic of Kenya, 2015*

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TOP

7. Three countries, three different applications of co-financing in Global Fund grants in sub-Saharan Africa

Inconsistent application of co-financing policy across countries

Djesika Amendah **16 January 2019**

One of the Global Fund's founding principles is "additionality" meaning that the Fund's investments are added to domestic government and private expenditures but do not replace them. The Global Fund Sustainability, Transition and Co-financing (STC) policy follows this principle. Adopted in 2016, the STC policy has replaced a previous one named the Eligibility and Counterpart Financing Policy (this July 2016 GFO article explained the changes).

The co-financing aspect of the STC policy aims "to stimulate increased domestic financing for health and for the three disease programs".

In this article, we aim to showcase the application of the co-financing policy and highlight differences in its implementation by focusing on three countries at different levels of income and epidemiology for the three diseases.

Data for this article comes from publicly available documents on the Global Fund website pertaining to the policy (Board meeting documents, operation manuals, funding requests, grant performance evaluation reports), interviews with officials from the three countries, and the Global Fund Secretariat.

Co-financing requirements

The Global Fund requires all countries in which it invests to:

- Increase government expenditure on health (from one allocation period to the next, or progressively) and
- Increase co-financing of Global Fund-supported programs over each funding cycle to take up progressively the key costs of national disease plans.

The STC policy has a built-in incentive to nudge countries towards its objective: the Secretariat can withhold up to 15% of the allocation if a country is unable to substantiate its expenditures, either because it has not invested those funds in the health sector or because the country lacks a good data system to track and provide evidence of its health expenditures.

The co-financing policy application depends on a country's level of income and disease burden. Low-income countries can use all their co-financing to strengthen their health systems (Resilient and Sustainable Systems for Health, or RSSH); lower-middle-income countries have to spend at least 50% on priority areas within the disease program (Table 1).

Table 1: Global Fund co-financing requirement by income level

Country Income Classification	Disease Burden	Additional Co-Financing Investments
Low Income	Any	Invested in either disease programs or RSSH. Flexibility to spend 100% of their additional investments in RSSH.
Lower Middle Income	Any	At least 50% invested in priority areas within the disease program. Remainder can be in RSSH.
Upper Middle Income	High, Severe, Extreme	At least 75% invested in priority areas within the disease program. Remainder can be in RSSH.
Upper Middle Income	Low and Moderate	Address systemic bottlenecks for transition and sustainability; At least 75% in priority areas within the disease program.
Upper Middle Income	Any	Focused on disease components and RSSH activities to address roadblocks to transition, At least 50% in specific disease components targeting key and vulnerable populations

Source: Global Fund's Sustainability, Transition and Co-financing Policy

The current version of the co-financing policy no longer has a mandatory minimum requirement for domestic funding as had the previous Eligibility and Financing Policy had, which was more prescriptive about minimum levels of domestic funding in relation to Global Fund investments. For instance, minimum counterpart funding for low-income countries was at least 5% of the Global Fund grant; for lower-middle income countries, 20%; for upper lower-middle income countries, 40%; and upper-middle income, 60%. Countries often exceeded those minimum requirements, making them inconsequential as part of the policy.

Kenya, Uganda and Guinea vary in income and disease epidemiology

Kenya, a lower-middle income country with a population of 47 million, has a high HIV prevalence (4.8%), and a high TB incidence (319 per 100 000, including those with HIV and TB) which earns the country a place among the world's 20 designated high TB-burden countries. Malaria is endemic throughout the year in some regions.

Uganda, an East African neighbor to Kenya, with a population of 44 million, is a low-income country. Uganda's HIV prevalence is even higher than that of Kenya (5.9%) but TB incidence is lower (201 per 100 000). Malaria is endemic throughout the year in the country.

Guinea, a low-income West African country with 13 million inhabitants, has a much lower HIV prevalence (1.5%) and lower incidence of TB (176 per 100 000 for HIV and TB). However, malaria transmission occurs year-round across the whole country. Guinea is classified as a Challenging Operating Environment by the Global Fund. The country has barely recovered from an Ebola epidemic in 2014 that exposed the weaknesses of its national health system.

Kenya: co-financing dedicated mostly to health commodities

To fund and account for its co-financing for the HIV/TB grant, Kenya has established a line in its national budget. The HIV and TB co-financing amounts are dedicated to purchasing health commodities: ARVs, test kits, laboratory reagents, and some laboratory equipment, according to officials. The co-financing for malaria covers mainly human resources for health and drugs, according to the funding request. For the current funding cycle, the budgeted co-financing is $22 million for HIV for the fiscal year 2017/18 – this amount corresponds to about 11% of the HIV allocation – and $3 million for TB. Kenya's co-financing for each fiscal year for malaria is $4 million. According to officials, Kenya co-financing increases by 10% every year.
The funding request also asserts that in the previous funding cycle, the Government of Kenya met 100% of the counterpart funding.

The main challenge in Kenya in terms of co-financing is to absorb the total annual government budget allocation during the year.

Kenya does not use the Global Fund's Pooled Procurement Mechanism (PPM). Instead, the country procures health commodities (including ARVs) for all government-owned facilities – and some non-profit ones – through the state-owned Kenya Medical Supplies Authority (KEMSA). While procurement through KEMSA is efficient, as the recent Office of the Inspector General (OIG) audit report attested, the lead time is long: it takes six to nine months from the time of quantification until delivery of the ordered health commodities.

By government rules, goods are ordered only when there is a budget line for them, and invoices are paid entirely upon delivery. Government budget is allocated annually to different State institutions. Funds that are likely to go unused by an institution can be transferred to

another one, towards the last quarter of the current fiscal year; the following year, the institution that failed to absorb its full allocation may receive a lower budget.

In practice, this means that KEMSA awaits the co-financing in the budget before it publishes tenders, selects a manufacturer, places an order, assures the quality of the shipment, warehouses ordered commodities, and distributes them during the same fiscal year.

This long procurement process affects the absorption rate. Any delay at any point in the process, whether at the beginning related to quantification, in the middle related to the tendering process or at the end related to logistics, may push the delivery into the following year and reduce budget-line absorption. If the delivery occurs during the following year, then the current year's funding is lost for the disease program and the following year's budget may be lower.

The government's co-financing current absorption rate is a closely guarded number suggesting it is not 100%. A couple of years ago, it stood around 70%.

Uganda: National Health Accounts as proof of co-financing

Uganda uses its national health accounts to demonstrate the level of government funding for health for the last and current funding cycles. With its health accounts, the Uganda government demonstrates that its level of current expenditures covers not only health commodities and personnel but also infrastructure use, on-the-job training, and other important aspects of the health system.

National health accounts constitute a "systematic, comprehensive and consistent monitoring of resource flows in a country's health system" according to the World Health Organization. Health Accounts recap health expenditures by sources of funds (e.g. government, private, other donors), schemes through which the funds are channeled (e.g. national health insurance, out-of-pocket expenditures), characteristics of the beneficiaries of expenditures (e.g. gender or age-group) and all diseases/conditions (e.g. HIV, TB, malaria, vaccine-preventable diseases, other diseases and conditions).

For the current funding cycle of 2017-2019, the government has committed $61.2 million annually and will continue using the health accounts to demonstrate its fulfillment of the commitments. This amount represents about 13% of the country allocation from the Global Fund.

In the previous grant allocation period (2014-16), Uganda committed to spending $34 million of domestic funding for HIV/TB and $4.2 million for malaria, according to the funding request, which explained that the government over-delivered on its commitment. To meet its commitment to the three diseases, the Government of Uganda had:

- Ring-fenced $27 million for the National Medical Stores for procurement of drugs and supplies
- Spent $32 million a year on salaries for health workers

- Spent $58.4 million on infrastructure, utilities, maintenance and other running costs of health facilities.

For this current allocation period, the CCM has committed to advocate for an increase in co-financing dedicated to (1) ACTs, ARVs, and anti-TB medicines; (2) Increase in human resources to ensure that staffing levels are raised from the current 75% to 85%; (3) Strengthening procurement and supply management systems to improve quality and continuous supply of prevention, treatment and care services to beneficiaries.

Guinea: a bank account dedicated to the co-financing

Guinea has a "new funding model (NFM) account" where it deposits its committed co-financing according to the funding request. For the current funding cycle spending, Guinea has committed to spending $19,857,143 on ARVs. This amount represents about 41% of the total HIV grant signed. In the previous funding period, Guinea had similarly committed to procure ARVs as part of its co-financing for its HIV grant. The country honored its commitment partly by contributing $10,844,930, i.e. 54.61 percent for the co-financing commitment.

Unfortunately, the government procurement of ARVs does not always follow the planned schedule, resulting in recurrent stock-outs of medicines, causing treatment disruptions. (More on this in an article in GFO 347 about Guinea's implementation issues.)

For malaria, the funding request indicates an increase in the state's contribution of 22%, from $3,579,005 in 2015 to $4,619,046 in 2016. For the malaria grant, the co-financing includes recurrent loss of state revenues or expenditures such as tax exemptions on purchases of antimalarial supplies, payment of workers' salaries, and the provision of electricity and water. In addition, the State made a significant capital expenditure commitment by granting the disease program new offices valued at $400,000.

Customization and harmonization: the need for an appropriate balance

These three countries illustrate three different customizations of the co-financing policy. Kenya, with its good health procurement system, channels most of its co-financing through its state-owned procurement authority for health commodities; Uganda uses national health accounts in a health system perspective to demonstrate its expenditures on the system and on the three diseases. Both countries meet or exceed the requirement associated with their income levels. On the other hand, Guinea, with its weak health system, uses a separate account to demonstrate its co-financing. We asked the Global Fund why Guinea's co-financing is used for ARVs instead of strengthening its health system as the policy allows, and considering the country's numerous difficulties. The answer was that the country's Global Fund allocation could not cover all of Guinea's ARV needs, raising the necessity for the government to buy ARVs for its citizens.

Opening a separate account for the co-financing element demonstrates compliance more easily, but does little to strengthen health systems or – worse – can weaken them. Such bank

accounts give undue influence to heads of HIV, TB or malaria programs for which the funds are earmarked. In fact, bank accounts dedicated only to the purchase of commodities in low-income countries with weak systems might inadvertently favor corruption. The reason is that governments use their own systems to procure ARVs or the health commodities funded by domestic sources; the inefficiency of those systems is the 'raison d'être' of the PPM in the first place. In addition, one might question the quality of the commodities procured outside the PPM for countries that use this mechanism for at least 80% of their expenses.

The difference among those three countries is not peculiar: in a meeting with seven African countries (including Kenya and Uganda but not Guinea) organized by Aidspan in March 2018, all seven had different ways of accounting for co-financing. While this situation may be legitimate owing to different country contexts, wide variations call for harmonization of the implementation of this policy.

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8. New report finds improvements in Malawi's Global Fund program for key and vulnerable populations, credits community engagement

Challenges persist in achieving effective community monitoring of grant implementation

Gemma Oberth and Emma Gausi **14 January 2019**

A new report from the International Council of AIDS Service Organizations (ICASO) finds that Malawi's Global Fund program improved in a number of ways during the 2017-2019 funding cycle. The total funding requested for key and vulnerable populations rose dramatically, and service packages for these groups were defined in greater detail. According to the report, a broad and systematic community engagement process contributed to these positive changes.

Yet, the title— "No such accountability is available on the ground"—draws attention to one of the report's key conclusions: despite the many strengths of the funding request and its development process, there is a lack of community monitoring initiatives to ensure follow-through during grant implementation.

Aidspan has previously reported on Malawi's 2017-2019 Global Fund funding request (see July 2017 GFO article) as well as studies that show community engagement in Global Fund processes to be particularly effective there (see August 2015 GFO article).

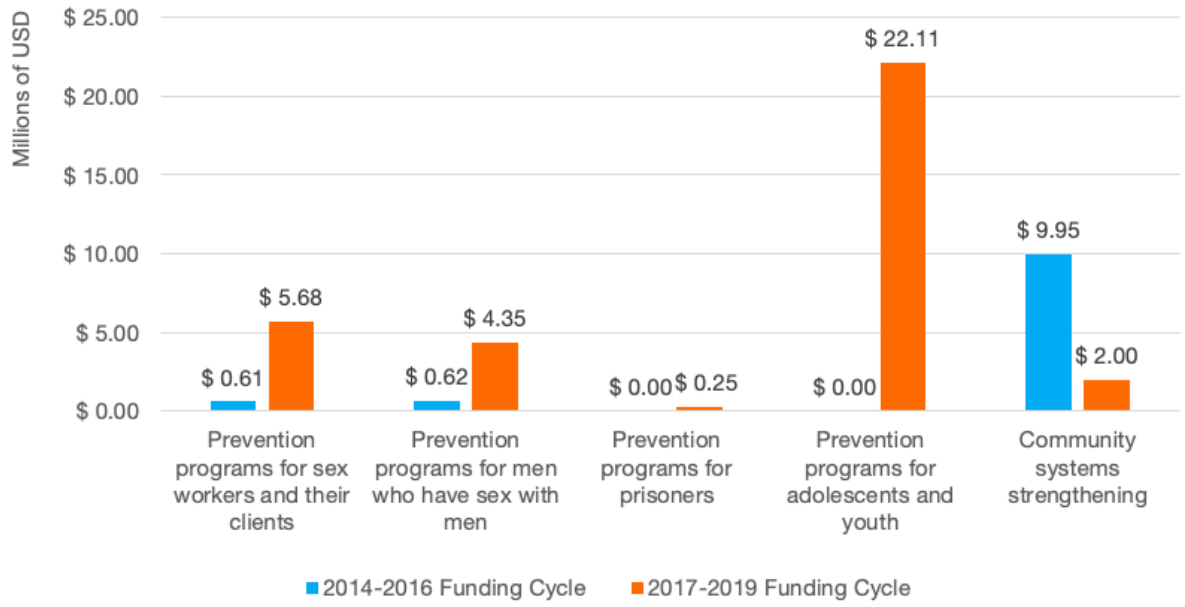
The ICASO report covers five main dimensions of the 2017-2019 funding-request development process in Malawi: (1) The amount of funding requested for community-focused interventions, (2) the quality of program design, (3) the inclusion of community-

articulated priorities, (4) perspectives from community representatives, and (5) a good-practice road map based on lessons learned. The report concludes with a series of recommendations for different stakeholders.

Increased funding for key and vulnerable populations in Malawi

In total, $10.28 million was requested for prevention programs among sex workers, men who have sex with men (MSM) and prisoners, in the 2017-2019 cycle, compared to $1.23 million in the 2014-2016 cycle (Figure 1). The amount of funding for adolescents and youth also increased dramatically. Malawi is among the 13 countries prioritized by the Global Fund for intensified investments in adolescent girls and young women (AGYW) (see January 2017 GFO article).

Figure 1. Comparison of total funding requested in Malawi's 2014-2016 and 2017-2019 Global Fund funding requests (select modules)



For community systems strengthening (CSS), there was a significant decrease in requested funds. Key informants quoted in the report suggest that there was pressure from the CCM to focus on human resources and commodity security instead. This de-prioritization of CSS is linked to the report's top-line finding that improved community monitoring is direly needed in Malawi.

At the 39th Global Fund Board Meeting in May 2018, a strategy implementation update highlighted the limited CSS funding in grants. Money for CSS constitutes just 5% of approved funding for building resilient and sustainable systems for health (RSSH). The update says the Global Fund is pursuing ongoing internal engagement to build consensus on the value add of community-based monitoring and feedback mechanisms.

More comprehensive service packages

Along with increased funding for key and vulnerable populations in the 2017-2019 cycle, there are also clear improvements in program quality in Malawi. The report includes a comparative table with the specific language in the 2014-2016 and the 2017-2019 funding requests for key community-focused modules.

The reach targets for sex workers and MSM significantly increased to scale up access to services. The grant aims to cover 6000 sex workers and 3600 MSM with a comprehensive package, compared to 2000 and 1350 in the last cycle, respectively. These key populations programs expressly move from partial service packages to comprehensive ones, as well as from fragmented delivery to a one-stop-shop approach.

For AGYW, the 2017-2019 funding request explicitly mentions a focus on quality over quantity, reducing the reach targets to expand and improve the depth and breadth of the package of services offered. Structural elements are introduced for AGYW, including activities to address gender-based violence, keep girls in school, and strengthen economic opportunities.

The report raises a concern that, unlike the other modules, the community responses and systems module (formerly called CSS) is lacking in specificity and missing key human rights and gender considerations.

Inclusion of community priorities in the funding request

Community priority-setting and advocacy efforts are linked to the improvements in requested funding and program quality for key modules. With support from ICASO, a broad consultative country dialogue process was led by the Malawi Network of AIDS Service Organizations (MANASO) and by the vice-chair of the Country Coordinating Mechanism (CCM), who represents civil society. A set of community priorities were documented during this process.

Of the 26 priorities set by communities during country dialogue, 16 were either fully or partially included in the final submission to the Global Fund (Table 1). Many priorities related to key and vulnerable populations were included. However, priorities related to monitoring treatment stockouts, developing community scorecards, conducting community oversight and feeding back monitoring information to communities were not fully taken on board.

Table 1. Inclusion of community priorities in Malawi's Global Fund funding request (2017-2019)

Community Priority	Level of Inclusion in Funding Request
Increased condom education and distribution	Partially Included
Reduce HIV incidence among AGYW through both testing and treatment of potential sexual partners (men 15-40) and primary prevention	Included
Creating an enabling work environment for sex workers (safety & security)	Not Included
HIV treatment adherence support for female sex workers (FSW)	Not Included
Access to HIV treatment for men who have sex with men	Included
Services for prison populations, including condom provision in prisons	Partially Included
Services for marginalized populations, including women and people with disabilities	Partially Included
Stigma reduction among people living with HIV	Not Included
Training of health workers in key population and human rights	Not Included
Reaching key populations with HIV testing	Included
Scale up HIV testing services in rural areas	Not Included
Community-based HIV testing services	Not Included
Male engagement to increase HIV testing among men	Included
Placement of CD4 equipment in rural health facilities	Not Included

Community Priority	Level of Inclusion in Funding Request
Monitoring viral load suppression	Partially Included
Increased diagnostic technology for TB to reduce diagnosis time	Included
Test-and-start should be rolled out, together with TB screening	Partially Included
Increase the number of community health workers	Partially Included
Community and health center linkage, in order to increase referrals	Included
Involvement of community-based organizations in service delivery	Partially Included
Orienting community-based organizations (CBOs) in demand creation for HIV testing	Not Included
Reporting to communities and beneficiaries on grant progress	Not Included
Harmonization of interventions on community oversight of health facilities	Not Included
Coordination meetings at the district and national level	Partially Included
Evidence-based advocacy with community data scorecards	Partially Included
Monitoring of stock outs and malpractices	Partially Included

A more inclusive country dialogue, gaps in grant monitoring

To help explain the abovementioned successes and challenges, the report shares perspectives from 13 key informant interviews.

Informants link the improvements to Malawi's Global Fund program with a concrete priority-setting process, led by MANASO and civil society CCM representatives, and conducted through a wide and inclusive country dialogue. According to a key informant from a civil-society umbrella body:

> *"Now [in 2017], we were able to go beyond Lilongwe. We were able to go subnational. The people on the ground—those that are at CBO [community-based organization] level—had their voices added to the table in the new grant. We were also able to expand the constituencies. We included the key populations, FSW, MSM, prisoners, women and young people. In the other round [in 2015], this was not comprehensive and now we were able to get the input of these groups to the table, which does really matter [for what gets included in the grant]."*

However, significant gaps remain. A key informant from the National AIDS Commission flags the need for increased civil society capacity and community monitoring support:

> *"Due to the lack of capacity on the part of the CSOs [civil society organizations] to check the accountability of the PRs, SRs [sub-recipients] and SSRs [sub-sub-recipients]—if they are properly implementing on the ground—the transparency and accountability is also very weak. Since it is weak, no such accountability is available on the ground."*

The report's emphasis on the need for improved community monitoring coincides with a November 2018 statement from Malawi's National Civil Society Consultative Forum for Global Fund. In that statement, 19 undersigned civil society organizations call for increased scrutiny over how Global Fund resources are being utilized in Malawi. Recent reports from the

Office of the Inspector General raised similar accountability concerns (see January 2017 GFO story on OIG 2017 audit and August 2017 GFO story on OIG investigation into drug thefts).

Another shared theme in the ICASO report and the Consultative Forum statement is the need for sub-granting flexibilities so that more local CBOs are able to access Global Fund resources.

Ways to improve accountability

Based on lessons learned, the ICASO report concludes by urging communities in Malawi to stay engaged throughout the funding cycle, especially during grant implementation. Recommendations are targeted at civil society, technical partners, CCM members, and the Global Fund Secretariat.

The report calls for partners to invest in strengthening the monitoring, evaluation, oversight, and knowledge management mechanisms of MANASO, as the key coordinating body for CSOs. The authors suggest that CCM members identify innovative ways of providing feedback to their constituencies, including electronic-based systems. The report is also forward looking, recommending that the Global Fund ensures enough time between the issuance of allocation letters and submission windows, so that rigorous and meaningful community engagement can take place in the development of the request. The release of the allocation letters for the 2020-2022 funding cycle is anticipated towards the end of 2019.

Gemma Oberth and Emma Gausi are the co-authors of the ICASO report. Gemma is a policy advisor for ICASO, based in Cape Town, South Africa. Emma is a Lilongwe-based independent consultant.

Disclosure: Gemma also consults directly with the Global Fund, supporting the Community, Rights and Gender Strategic Initiative. This was declared to Aidspan and was not considered a conflict of interest in light of the authors' unpaid contribution to the GFO in order to share the report's findings.

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9. Global Fund announces $14 billion target for Sixth Replenishment

This level of funding would help save 16 million lives, build stronger health systems by 2023, and cut mortality rates from the three diseases in half

Aidspan Staff **14 January 2019**

On January 11, 2019, Global Fund Executive Director Peter Sands announced the $14 billion fund-raising target set for the organization's Sixth Replenishment, which will take place in Lyon, France, in October 2019.

The announcement, based on a summary of the Sixth Replenishment Investment Case, was made in Paris by Global Fund Executive Director Peter Sands, led by an "expression of support" by French President Emmanuel Macron, and alongside World Health Organization Director-General Dr Tedros Adhanom Ghebreyesus, and French Minister of Solidarity and Health Dr Agnes Buzyn.

The Investment Case lays out what a fully-funded Global Fund could achieve, the new threats global health is facing, and the risks ahead "if we don't step up now".

The summary of the Investment Case has brought up mixed reactions from members of civil society, with some stating that the Investment Case is not ambitious enough with respect to the existing needs and gaps within the HIV, TB and malaria responses.

We will report more fully on the Investment Case for the Sixth Replenishment in the next edition of the GFO.

See the Global Fund's own news release on the announcement, and UNAIDS' 14 January 2019 call to fully fund the Global Fund.

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10. Mobile apps for *Global Fund Observer* and *Observateur du Fonds Mondial* now available

For first time, both English and French newsletters accessible via app for all devices

Aidspan Staff **15 January 2019**

Aidspan is delighted to introduce our mobile-based applications for both Android and IOS users. Our GFO newsletter in English and OFM in French can be accessed via the GFO Newsletter apps, diversifying the way we deliver our bimonthly newsletter to subscribers.

These newsletter apps are downloadable free of charge:

1. For Android: Go to Google Play store and search for GFO Newsletter
2. For iOS: go to the Apple store and search for GFO Newsletter.

To install the GFO/OFM newsletter app, Android devices must be running system 4.3 or above. For Android, the app is relatively small (only 1.7 megabytes), making it relatively affordable to run. For iOS users, the app is compatible with iPhone, iPad and iPod touch, and requires iOS 11.1 or above. The size of the app for Apple devices is about 7.5 megabytes.

These highly responsive versions of the GFO and OFM revolutionize our newsletter publishing, offering subscribers alternative ways of accessing or receiving our content. The GFO newsletter app for Android was initially launched in July 2018, and the iOS-compatible

app in November 2018. With testing on both now fully complete, this is the first announcement of their joint availability.

We encourage our subscribers to use these apps as they are faster than mobile websites, offer instant access, and make it easier to retrieve our content. Importantly, the apps reduce data costs for users when accessing our bimonthly newsletters.

As an independent watchdog of the Global Fund to Fight HIV, TB and malaria, Aidspan strives to keep improving the means we use to deliver information, critical analysis, and commentary on developments at the Fund. For further assistance and advice on usage of the apps feel free to contact michelange.muberuka@aidspan.org. We hope you enjoy our apps – and your ratings in the app stores would be greatly appreciated.

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