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NEWSLETTER

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BY SHOBHA SHUKLA AND BOBBY RAMAKANT

At the Global Fund's Pre-Replenishment meeting in New Delhi, in February 2019, the India Health Fund launched the nationwide 'Quest for Innovations towards Eliminating Tuberculosis', in partnership with the Global Fund, Tata Trusts, and India's national TB control program, among others. The fund, launched in 2016, was designed to stimulate and motivate domestic innovative financing in order to fund innovations in TB and malaria programming. Its work to create a "pipeline of innovations" currently focuses on ten projects, involving diagnostics, adherence, increasing case notifications, and open source drug development, among others.

5. NEWS: OIG investigation in Democratic Republic of Congo finds tender manipulation and overpricing in malaria grant

BY ADÈLE SULCAS

The Office of the Inspector General has found that between 2015 and 2017, the Global Fund's malaria grant in the DRC was subject to "systemic manipulation of procurement and supply-chain related expenses" through collusion and deliberate schemes to overprice, designed by senior managers appointed by Population Services International, the Principal Recipient. The cumulative losses of more $7,386,066 have since been repaid to the Global Fund in full.

6. COMMENTARY: Global Fund country coordinating mechanisms are good; they could be better

BY IDA HAKIZINKA AND DJESIKA AMENDAH

The Global Fund country coordinating mechanisms have been called "cornerstones of the Global Fund architecture" in-country. With by their broad representation and mandate, CCMs can help improve the performance of the grants. In a joint commentary from Aidspan's CEO and its senior policy specialist, Aidspan puts forward suggestions to improve CCMs' functioning and effectiveness.

7. ANALYSIS: Malawi faces wide-ranging challenges in Global Fund grant implementation

BY ANN ITHIBU

Malawi has made significant progress in the fight against HIV, tuberculosis (TB) and malaria since it started receiving Global Fund funding in 2003. Malawi faces significant challenges in implementing Global Fund grants, such as low domestic contributions to the health sector, low absorption of Global Fund grants, and a weak health system, which undermine achieving maximum impact against the three diseases. Some challenges relate to Global Fund processes while most relate to Malawi's economic and political context. Solutions include increased country investments in health systems, addressing bottlenecks to effective absorption of funding, and increased oversight of grant implementation.

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BY AIDSPAN STAFF

As part of the Global Fund Advocates Network (GFAN) campaign for the Sixth Replenishment for the Global Fund, GFAN is developing short videos thanking donors for their contribution to the Global Fund and implementing countries for their commitments to health. GFAN is looking for additional contributions, by March 31.

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ARTICLES:

1. NEWS: Global Fund Board approves an additional $16 million from 2017–2019 allocations

Multi-country grant for Southern Africa receives $12 million

David Garmaise **19 March 2019**

On 22 February 2019, the Global Fund Board approved one multi-country grant, one matching funds request and one set of interventions on the Unfunded Quality Demand (UQD) Register — worth a total of $16.0 million. The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC). This was the 17th batch of approvals from the 2017–2019 allocations.

The multi-country award was for a malaria grant for Southern Africa, QPA-M-E8S, worth $12.2 million. Interventions totaling $1.3 million were added to the UQD Register.

Matching funds in the amount of $2.1 million were approved for a Liberia malaria grant, LBR-M-MOH. The funds were added to a grant previously approved (in December 2018) worth $23.3 million, bringing the revised program budget to $25.4 million.

Interventions from the UQD Register valued at €1.5 million were approved for a TB/HIV grant to Guinea-Bissau, GNB-C-MOH, taking the total program budget from €13.5 million to €15.0 million.

Multi-country grant

This grant, which covers eight countries in Southern Africa (known as the Elimination 8 or E8 countries), is a continuation of an existing regional initiative aiming to eliminate malaria within the sub-region.

Four of the countries – Botswana, Namibia, South Africa and Eswatini – have reduced malaria transmission and, according to the World Health Organization, have passed the threshold between pre-elimination and elimination. However, these “frontline elimination” countries face importation of malaria from four neighboring (“second-line”) countries to the

north — Angola, Mozambique, Zambia and Zimbabwe. The GAC said that the second-line countries are unlikely to achieve elimination before 2030.

The grant aims to "accelerate zero local transmission" (i.e. strengthen efforts to maintain zero transmission) in the four frontline countries by 2020 by:

- Strengthening regional coordination in order to achieve elimination in each of the E8 countries;
- Expanding access to early diagnosis and treatment for border communities as well as mobile and migrant populations; and
- Strengthening regional epidemiological and entomological surveillance systems.

The grant will provide support (a) to health cadres staffing 48 diagnostic and treatment sites for mobile and migrant populations in border districts; and (b) to indoor residual spraying (IRS) operators in Southern Angola.

The GAC said that there are challenges associated with the lack of sustained financing for the malaria programs in all eight countries, which could lead to a risk of resurgence. The GAC emphasized the need to mobilize additional resources, including from domestic sources, and to explore innovative financing mechanisms.

The GAC echoed concerns expressed by the Technical Review Panel (TRP) regarding (a) the need for greater synergies between this grant and the MOSASWA multi-country grant, a public-private initiative involving Mozambique, South Africa and eSwatini (see GFO article from 25 February 2019); and (b) the need for alignment with the national malaria programs in the E8 countries.

Matching funds

The $2.1 million in matching funds will be added to the Liberia malaria grant that the Board approved in December 2017 (see GFO article from 12 December 2017).

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 the impact of the overall program.

Liberia met three of the four conditions, but not the 1:1 ratio. The GAC approved an exception to this criterion (as it has for numerous other matching-funds requests), noting that Liberia's 2017-2019 allocation was slightly reduced from its 2014-2016 allocation, thus making it difficult to achieve the 1:1 ratio.

Portfolio optimization

The €1.5 million for interventions on the UQD Register will allow Guinea-Bissau to cover some gaps in its HIV program regarding testing and treatment. It will enable Guinea-Bissau to increase the number of people receiving treatment by 2020 from 14,000 (31% coverage) to 18,080 (40% coverage).

The funds will also assist Guinea-Bissau to implement a differentiated approach to testing (i.e. provider-initiated HIV counselling and testing at the health facility level; and targeted testing for vulnerable populations).

The funds for this award come from a portfolio optimization exercise that was carried out for the 2017–2019 allocation cycle.

Most of the information for this article was taken from Board Document GF/B40/ER06 ("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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2. NEWS: U.S. President's 2020 Budget backpedals on his pledge to end AIDS "in America and beyond"

Proposed cuts, if approved, would undermine U.S. leadership in global health, advocates say

Adèle Sulcas **19 March 2019**

President Donald Trump's proposed budget for fiscal year 2020 has, made public on 11 March, has contradicted the pledge he delivered in his February 2019 State of the Union address to increase spending on HIV. The budget, which proposes major cuts to the United States' global health spending, includes a 29 percent reduction (compared to fiscal year 2019) in appropriations for the Global Fund, and has caused profound concern within the global health advocacy community. (The proposed cut to PEPFAR would be 22 percent.)

"My budget will ask Democrats and Republicans to make the needed commitment to eliminate the HIV epidemic in the United States within 10 years," Mr Trump said in his February pledge. "Together, we will defeat AIDS in America and beyond."

The proposed budget calls for a $1-billion cut to the United States' three-year commitment to the Global Fund in the next Replenishment period.

"Any way you look at it, this is a devastating proposed cut," said Chris Collins, President at Friends of the Global Fight. He explained that this budget proposes $1.1 billion for 2020 instead of the $1.56 billion advocates are seeking. The $1.56 billion level would be consistent with the U.S. continuing to provide 33% of resources to the Global Fund in the next replenishment cycle, assuming a $14-billion replenishment ($14 billion is the Global Fund's official target). But the budget also calls for a change to the policy on this proportion, suggesting that the U.S. reduce its contribution to 25 percent of the Fund's overall budget instead of the 33 percent it has historically maintained.

"This proposed budget is more than just a funding cut," Collins said. "If enacted, it would signal a rapid retreat in U.S. global health leadership and would seriously undermine the Global Fund's replenishment." Expanding on the idea that the President's proposed budget "stands in stark contrast to his February State of the Union pledge to 'defeat AIDS in America and beyond'," Collins said, "We welcomed the President setting the goal of ending the global AIDS epidemic but his budget is totally inconsistent with that vision – it would actually take us backward in the fight against AIDS and risk resurgence of the disease around the world, because of cuts to proven and effective programming and health research."

However, Collins said, "Let's be clear, the White House budget does not represent the U.S. Global Fund replenishment pledge - Congress appropriates funding." Collins said he is "confident that Congress will reject this attempt to undermine American leadership on global health".

Other media reports on the proposed budget

Devex reported on the proposed cuts in the broader context of the U.S. Administration's call for increased "burden sharing" (where other donors play a greater role) and proposed policy changes relating to the "reorganization" of U.S. aid. The Devex article also said that it is "widely expected that Congress will reject the administration's proposal when determining its budget".

The New York Times described the proposed cuts to PEPFAR and the Global Fund as well as to domestic health insurance programs Medicare and Medicaid, and cuts to safety nets for farmers, as making way for more military and border spending.

From the global advocacy community, Jen Kates, the Kaiser Family Foundation's Vice President for global health and HIV policy told NBC News that "proposed cuts to the President's Emergency Plan for AIDS Relief and the Global Fund, which fund treatment and prevention in poor countries, could work against the most well-intentioned efforts to end the HIV/AIDS epidemic."

The U.S.-based Treatment Action Group said in a statement that the group opposed the President's budget, which "makes a mockery of the administration's purported strategy to end AIDS in the United States over the next decade", and said that the budget's "defunding" of other equally important areas including global health, social services and research "raises tremendous doubt about the administration's commitment to end HIV."

Further reading:

- *"With Budget, President seeks retreat in U.S. global health leadership; would undermine Global Fund Replenishment," from Friends of the Global Fight.*
- *"US budget slashes global development funding, stresses burden sharing," from Devex.*
- *"Trump Lauded Farmers, Medicare and AIDS Programs. Then Came His Budget Knife," from the New York Times.*
- *"Trump's budget adds domestic HIV funding while slashing global outlays," from NBC news online.*
- *"Experts React to White House FY2020 Budget Request Calling for Increase in Domestic HIV Funding, Cuts to Bilateral HIV Spending," from the Kaiser Family Foundation.*

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3. NEWS: OIG audits of Global Fund grants to Rwanda and Benin raise issues related to data availability and quality

For grants in Rwanda, which follows a results-based financing model, availability of good and reliable data is especially critical

David Garmaise **19 March 2019**

The recent audit of Global Fund grants in Rwanda by the Office of the Inspector General (OIG) was primarily about data — specifically, the availability and quality of data. Similar issues were raised in the OIG's recent audit of grants in Benin. This article provides a summary of the OIG's findings for both audits.

The OIG published a report on the Rwanda audit on 25 February, and one on the Benin audit on 8 March.

Rwanda Audit

"Rwanda continues to achieve impressive programmatic results with the support of the Global Fund and partners," the OIG observed. Rwanda has experienced a decline in HIV- and TB- related deaths, with an increased number of people on antiretroviral treatment and relatively high TB treatment success rates. HIV-related deaths fell from 9,600 in 2007 to 3,100 in 2017, partly due to the implementation of a "treat all" policy.

The audit found that although Rwanda's systems and controls to safeguard data quality are adequately designed, there are weaknesses in implementing the systems and controls, especially for malaria. (Financial assurance is generally effective, the OIG observed.)

The audit covered all three active grants in Rwanda, one for each disease, for the period January 2016 to 30 June 2018. The principal recipient (PR) for all three grants — RWA-H-

MOH, RWA-T-MOH and RWA-M-MOH —was the Ministry of Health (MOH). However, the OIG said that its findings concerning data were limited to the malaria grant, which accounts for 20% of the Global Fund's active grants in Rwanda. The OIG found fewer issues related to data in the HIV and TB grants.

Despite prevention efforts, the OIG said, malaria cases rose threefold, from 1.7 million in 2014 to 4.9 million in 2017, the highest increase in Africa. The OIG observed that Rwanda's data quality measures are not robust enough to respond to the increase in cases. The OIG recommended that the effectiveness of Rwanda's prevention activities be re-examined.

The Global Fund has been using a results-based financing model, also known as national strategy financing, in Rwanda since 2014. According to the OIG, Rwanda is the only major portfolio using this model. Under the model, annual disbursements are directly linked to reported programmatic results, so the availability of good and reliable data is critical.

The OIG rated the systems and processes to safeguard the reliability of the data as "partially effective." It rated overall assurance and oversight mechanisms as "needing significant improvement." (The OIG has a four-tiered rating scheme: effective; partially effective; needs significant improvement; ineffective.)

The OIG said that the weaknesses it identified "do not necessarily call into question the relevance of the results-based financing model in Rwanda, a country that has demonstrated strong accountability mechanisms and a track record of effective program implementation."

The OIG noted that a separate review, commissioned by the Secretariat in 2018, confirmed the continued relevance of the model (see GFO article from 7 November 2018). "However," the OIG said, "failure to strengthen controls over data and the scope of assurance would undermine, over time, the reliability of the results based on which the Global Fund is supporting Rwanda's health programs."

Problem areas

The audit identified four main problem areas, as follows:

- There are weaknesses in data systems and controls.
- There are differences between consumption and patient data.
- Limited survey results are used to validate programmatic achievements.
- There is insufficient oversight and assurance over data.

Below, we briefly describe each problem area.

Data systems and controls

HMIS

Rwanda uses an electronic health management information system (HMIS) to record and report program results. The OIG said that there a number of controls in place — e.g., qualified data management staff; monthly and quarterly data validation — but that these controls are not being effectively implemented and that weaknesses exist that may affect the quality of data. This was an issue primarily for the malaria grant.

The audit revealed a number of control deficiencies. (There was a similar finding in the previous OIG audit conducted in 2014.) For example, the OIG said, although standard operating procedures outline the required approval levels before reported results can be altered, two-thirds of the health facilities visited during the audit had changed the malaria results without obtaining approval after they had already been reported. The changes resulted in an increase of 19% in the reported number of malaria cases at the facility level.

Incomplete malaria registers

National guidelines require that all results reported in HMIS be supported by primary records, referred to as "registers." However, the OIG noted, almost two-thirds of the 100 community health workers (CHWs) sampled during the audit did not have registers for prior periods.

The audit identified problems with the data entered on registers. For example, the results of malaria tests were generally not recorded in the registers, making it difficult to determine the outcome of the diagnosis and subsequent treatment recorded in the HMIS. (A spokesperson for the OIG explained to the GFO that the register is the main source document. If it is not properly maintained, it is not possible to ensure that the HMIS data is correct.)

Inadequate supervision of community health workers

The 45,000 CHWs in Rwanda have limited capacity to record data in a timely manner, the OIG stated. As a result of a resurgence in malaria cases, in December 2016 the MOH revised its guidelines to enable CHWs to manage malaria cases in adults as well as children under 5. This further strained the CHWs' capacity.

Staff in the health centers are supposed to visit each CHW monthly. However, for more than three-quarters of the CHWs sampled, the OIG found no evidence of any visits for the 12 months preceding the audit. Since the audit, the OIG said, the MOH has started redesigning the supervision framework.

Routine data checks not consistently performed

Staff at health facilities are supposed to perform monthly and quarterly data validation exercises before reporting their results. The OIG found that only 59% of the health facilities it visited were performing the validations.

Part of the problem, the OIG explained, is that a new structure for health facilities was implemented in June 2017, resulting in some changes in personnel. The MOH is rolling out an electronic learning platform for newly recruited data managers and supervisors.

Differences between consumption and patient data

The MOH has installed an electronic Logistics Management Information System (eLMIS) in all district pharmacies, district hospitals and health centers to record medicines received and issued to patients and CHWs. The Central Medical Store utilizes an inventory management system known as "SAGE." The SAGE and eLMIS systems had yet to be integrated at the time of the audit.

According to the OIG, the malaria data showed that the number of patients diagnosed with test kits and treated with anti-malaria drugs was about 41% higher than the quantity of test

kits issued. The number of patients treated for uncomplicated malaria was 34% higher than the quantity of anti-malaria medicines consumed.

"These results are contrary to audit findings in most other countries which typically show that more test kits and anti-malaria medicines have been used compared to the number of cases recorded," the OIG declared.

Use of limited survey results

The MOH uses two main mechanisms to collect the data reported to the Global Fund: routine data and survey data. For 2015-2017, nine of the performance indicators for the malaria grant were assessed through surveys (which are conducted only once every two years) while 14 indicators were monitored using routine data.

The OIG said that some indicators assessed through surveys could more easily be monitored using routine data. The latest community level survey for malaria case management covered only 57 of the 45,000 CHWs, the OIG said, and may not be representative of the national average. The OIG also said that the survey methodology should be reviewed.

Insufficient oversight and assurance over data

In line with the principle of country ownership, the OIG stated, the Secretariat relies on Rwanda's existing national systems and controls rather than independently verifying reported results. Following the OIG's 2014 audit, the Secretariat undertook to routinely review the systems and controls; however, this practice has not been effectively implemented, the OIG said.

The MOH is responsible for conducting bi-annual integrated supportive supervision and data quality audits (ISS-DQAs). These audits verify the systems to validate reported results for one indicator (out of 14) for each grant. The OIG said that the audits did not cover the effectiveness of the IT systems and controls that produce the results. In addition, the audits were inconsistently performed.

Through the local fund agent, the Secretariat conducted a review in January 2016 which found that the systems issues identified in the 2014 audit had not been fully addressed.

Agreed management actions (AMAs)

There were four AMAs (see Table 1 below). All are owned by the Head, Grant Management Division and all have a target date of 31 December 2019.

Table 1: OIG audit of Rwanda – Agreed Management Actions

	Agreed management actions
1.	Following the actions taken by the country since the audit, the PR, with support from the Secretariat and in collaboration with partners will: a. Further strengthen the electronic HMIS and associated IT controls including: ensuring automatic locking of the HMIS after each reporting period; updating data validation rules to prevent entry of negative numbers; securing access for users to physical servers; and restricting super-user access to a minimum; and

	b. Improve community level data and the supervision arrangements by recruiting and training additional Community and Environmental Health Officers in data management and supervision of CHWs; and standardizing use and management of registers across health facilities and communities.
2.	In order to improve the reliability of supply chain data, the Secretariat will support the PR and partners to: a. Perform further analysis of the differences identified in the audit report in order to identify the underlying reasons for discrepancies between consumption and patient data in line with terms of reference that are to be agreed with the OIG; b. Develop an action plan including timelines and responsible parties to address the identified underlying causes; and c. Conduct at least annually data triangulation or external consistency checks in line with WHO guidelines on data quality review.
3.	a. In light of the progress made in the country's routine data systems, the Secretariat in collaboration with partners will support efforts to ensure the PR uses available routine data from the HMIS to report on malaria treatment; and b. The Secretariat will review and approve all survey protocols developed for the collection of survey-based data used by the PR for reporting on the agreed indicators in the grants. The protocols will include sample sizes and data collection methodologies.
4.	a. The Secretariat will update the portfolio's assurance plan to include independent verification of data systems and related IT systems that produce the results. This plan will include: assurance activities relative to the identified controls on data systems; the frequency of these activities; and the assigned assurance providers; and b. The Secretariat will ensure that the PR develops an action plan to address outstanding audit recommendations from Rwanda's Office of the Auditor General.

Note: The Community and Environmental Health Officers supervise the CHWs. At the time of the audit, there was only one officer at each health facility.

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Benin Audit

The audit of grants to Benin found that the country has made significant progress in the fight against the three diseases despite challenges related to program implementation. The audit covered the period June 2016 to June 2018 and included all five active grants — two HIV, one TB, one malaria and one RSSH.

The PRs for the HIV grants were the national AIDS program (BEN-H-PSLS) and Plan International (BEN-H-PlanBen). The PR for TB grant was the national TB program (BEN-T-PNT); for the malaria grant, the national malaria program (BEN-T-PNLP); and for the health systems strengthening grant, the Health System Performance Program (BEN-S-PRPSS).

Examples of the progress Benin has achieved are as follows:

- Benin has one of the highest rates of HIV treatment coverage in West and Central Africa.
- At the time of the audit, Benin's TB treatment success rate exceeded 89%, compared to an average of 79% in the region.
- Malaria mortality rates dropped significantly between 2011 and 2016. Malaria cases confirmed through testing rose from 354,223 to 1,219,975 due to increased use of rapid diagnostic tests.

The audit identified three overarching issues and risks:

- Non-compliance with procurement plans and guidelines;
- Uneven quality of services; and
- Deficiencies in the quality of data.

Below, we briefly describe each of these issues and risks.

Procurement plans and guidelines

Procurement of health commodities in Benin is in line with national guidelines, the OIG said. Annual quantification exercises are carried out, leading to the development of a consolidated procurement plan.

The OIG said that there are "stock tensions" at the central level and stockouts at the facility level due to a failure to comply with the consolidated procurement plan. (A spokesperson for the OIG told the GFO that "stock tension" refers to a situation where there are persistent low stocks, with buffer stocks becoming depleted.)

The audit found delays in delivering health commodities: Malaria drugs that were supposed to be supplied by the government were not procured in 2017 and 2018 due to budget insufficiencies and complex public procurement processes. Delays in some of the partners' procurement processes aggravated the situation, the OIG observed.

At the central level, the audit found, there was less than the required three-month buffer stock of malaria drugs. In addition, there was a stock-out of rapid diagnostic tests.

In addition, the OIG noted, managers at district and community levels rarely complied with procurement guidelines. The OIG said that a key root cause of these problems is the low number of trained pharmacists: There were no pharmacists at eight district warehouses and hospitals sampled by the audit.

Quality of services

The audit found that access to quality malaria services is low, particularly at the community level.

Malaria treatment is not consistent with what the treatment guidelines call for, the OIG stated. Registers show more people treated than people testing positive; people testing negative receiving treatment; and people testing positive not receiving treatment. The OIG said that these problems were due to the limited capacity of CHWs, who lack malaria health care–related training as well as support and supervision from health facility nurses.

The audit found that for HIV, there are no appropriate national guidelines for "therapeutic education" for prevention of mother-to-child transmission (PMTCT). ("Therapeutic education" refers to the advice and support midwives provide to pregnant women.) Services vary depending on each midwife's understanding, the OIG said, and at times some services are not even performed. In addition, there are delays in performing tests to diagnose HIV infection in infants.

Data quality

The OIG observed that the unavailability of data and inconsistencies in the data impede effective monitoring and decision-making.

Community data for malaria are not being reported at the national level, the audit found. The data reported from each community is not aggregated at the health facility level due to a lack of adequate tools. Instead, the OIG said, the health facility sends a detailed report for each community to the health district. Limited human resources and a heavy workload at the district level — a single statistician at the district covers on average 270 CHWs — makes it challenging to capture the disaggregated data. Since health facilities do not send community reports to upper levels directly, the OIG noted, the reporting of community data in the national information health system is lacking.

The audit showed that the community data being reported to the Global Fund comes from a parallel system maintained by a sub-recipient, Catholic Relief Services (CRS). This is not sustainable, the OIG said, because it is not based on the national system; it only covers regions supported by the Global Fund and does not guarantee strong assurance over the information reported.

The uneven quality of data and services has led to gaps in the services provided to pregnant women, the OIG stated. In 2017, 28% of HIV-positive pregnant women did not give birth in PMTCT sites, meaning that deliveries were not necessarily performed using the recommended protocol. Although 83% of children born to HIV-positive mothers are tested for HIV using polymerase chain reaction (PCR), one-third of these tests were not performed within the required timeline of 6-8 weeks post-partum (to detect very early infections before antibodies have developed), and there is no system in place to monitor whether HIV-positive babies are put on treatment.

Ratings

The OIG concluded that the programs are currently only partially effective in providing adequate quality of services to patients and reliable data for decision-making. The OIG said that activities related to procurement and supply management have also been only partially effective.

Agreed management actions (AMAs)

There were two AMAs (see Table 2 below). Both are owned by the Head, Grant Management Division.

Table 2: OIG audit of Benin – Agreed Management Actions

Agreed management actions		Target date
1.	The Secretariat will support the Ministry of Public Health (MPH), the (U.S.) President's Malaria Initiative and Chemonics to develop a logistic surveillance report on monthly basis to monitor the stock status and the buffer stock available of malaria health commodities at central, district, zonal warehouse and health facility level.	28 Feb 2020
2.	The Secretariat will support the MPH and partners to: • Update the health facilities reporting template to integrate the malaria community data;	30 Jun 2020

	• Conduct a reconciliation exercise for the malaria community data reported through the national system with data reported by CRS; and • Update the therapeutic education standards and tools and re-train the midwives and the health staff working in PMTCT sites on the updated therapeutic education standards and tools.	

Note: Chemonics is a private sector technical partner involved in procuring health products and managing stockouts for USAID.

Further reading:

- *Benin: Diagnostic Review of Global Fund Grants to Benin (published 23 October 2012, report number GF-OIG-12-001)*
- *Rwanda:*
  - *Audit of Global Fund Grants to Rwanda (published 23 December 2014, report number GF-OIG-14-023)*
  - *Audit Report on the Global Fund Grants to Rwanda (published 11 March 2011, report number GF-OIG-10-003)*

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4. FEATURE: India Health Fund provides platform for domestic financing to combat TB and malaria

The collaborative initiative, seeded by Tata Trusts, supports 'the journey of innovation'

Shobha Shukla and Bobby Ramakant **19 March 2019**

With an acute need to increase health budgets, innovative financing, especially mobilized within nations, is increasingly in the spotlight. At the Global Fund to Fight AIDS, Tuberculosis and Malaria's 39th Board Meeting in May last year, the Fund stated that given the changing financing landscape and existing financial and programmatic gaps, the Fund should leverage opportunities to use innovative finance to increase funding flows for itself and other actors, as well as to increase the efficiency of its investments and national programmes.

The Global Fund's 2017-2022 strategy incorporates co-financing as a key element to increasing domestic resource mobilization, requiring countries that receive Global Fund resources to make contributions to their own disease programmes and health systems.

The India Health Fund (IHF), launched in 2016, is one example of domestic partners joining hands to leverage innovative financing domestically in order to fund critical gaps that are slowing India's progress in end TB and malaria.

“The India Health Fund is a collaborative initiative, seeded by the Tata Trusts, with strategic support from the Global Fund, to strengthen India’s ability to fight and eliminate the public health challenges of TB and malaria,” said Manoj Kumar, IHF’s Chief Executive Officer. IHF’s focus is on innovations, an area for which resource allocation is limited, Kumar says.

India Health Fund envisages creating a platform for the private and public sector, as well as national and global philanthropic foundations and aid agencies, to initiate and scale up innovative solutions, business models, and financing mechanisms that align with, and augment, national efforts to fight these diseases. It aims to mobilize and invest up to $150 million over 5 years to scale up high impact innovations in India.

Ten projects launched by IHF

“Supporting the journey of innovation from laboratory to market – and policy – is the mainstay of the India Health Fund,” says Kumar. The IHF has a portfolio of ten projects covering diagnostics, adherence, increasing case notifications, and open source drug development, among others. Its efforts are “towards building a pipeline of innovations” that will sustain progress in the fight against TB and malaria through pooled resources, and through support to expedite innovations, Kumar further explained.

For example, one of the projects funded by the India Health Fund is to better understand how to prevent transmission of TB in the homes of patients. It has been estimated that one person with active untreated TB disease can infect 10-15 people within a very short time, with family members at heightened risk of being infected by the disease. The grant recipient, Foundation for Medical Research in Mumbai, is undertaking this study over a 3-year period.

Another project funded by the India Health Fund is studying how mosquitoes succeed in finding, searching and locating a human host from a distance of at least 400m away, and suck blood within 2 minutes. The grant recipient is the National Institute of Malaria Research (under the umbrella of the Indian Council of Medical Research), which hopes that the study outcomes will lead to identifying crucial genetic factors (how mosquitoes manage host-seeking and blood-feeding behavioural events) that could be valuable in manipulating and designing new molecular tools to disrupt mosquito-human bit exposure.

At the Global Fund’s Pre-Replenishment Meeting held on February 8, 2019, in New Delhi, the India Health Fund launched the nationwide ‘Quest for Innovations towards Eliminating Tuberculosis’ (TB Quest) in partnership with the Global Fund, Tata Trusts, Social Alpha, the Stop TB Partnership, C-CAMP (Centre for Cellular And Molecular Platforms, an initiative of Department of Biotechnology, Ministry of Science and Technology, Government of India) and the Revised National TB Control Programme of India. The TB Quest is envisioned as a means to fast-track adoption and scale-up of already-validated product and process innovations. TB Quest’s main areas of focus are: bringing the ‘missing’ TB patients within the purview of care; screening and management for latent TB infection in high-risk populations; airborne infection control; and addressing gaps in the supply chain of anti-TB drugs and consumables in public and private sector.

New interventions for TB control

While the India Health Fund aims to provide scientific evidence for scaling up game-changing innovations, there is another initiative to advance technology and product development by delivering better diagnostics, shorter drug regimens, and effective vaccines along with newer interventions for TB control. Formally called the India TB Research Consortium (ITRC), this initiative is led by the Indian Council of Medical Research (ICMR) of which Tata Trusts (which hosts the India Health Fund) is also a partner.

Dr Soumya Swaminathan, Chief Scientific Officer of the World Health Organization (WHO), sees big potential for the India Health Fund and ITRC joining forces. "Very often we have new discoveries made by academic centres, or by small companies, but they never get scaled up," Dr Swaminathan says. "There is a big gap here, which ITRC is trying to fill up. So, while the focus of ITRC is on accelerating translational research, the India Health Fund is looking at developing better and innovative operational implementation strategies for controlling TB. There is a lot of scope for both [IHF and ITRC] to work together."

Global Fund funding as 'catalytic' and supplementary

Dr Swaminathan, who is the former Deputy Director General for Programmes at WHO and former Director General of ICMR, said that while at ICMR there was discussion with Tata Trusts as to how the two entities could become more synergistic and complementary. She also underlined the necessity that low- and middle-income countries step up their investments in health through domestic financing.
"With an increased focus on Universal Health Coverage and knowing that outcomes for all these 3 diseases depend on how good your health system is, domestic investment for health systems' strengthening and support is eventually going to pay dividends for HIV, TB and malaria as well."

While wishing that the Global Fund achieves its replenishment target of $14 billion for the next three years (see the Investment Case summary), Dr Swaminathan hopes that countries would use Global Fund resources to supplement their domestic funds, and as a sort of a catalytic fund to boost the key areas of their health systems that are lagging behind. "All countries should have a transition plan so that eventually they are able to sustain [programs] on their own." (The Global Fund's Sixth Replenishment conference will be held in October 2019, in Lyon, France.)

However, civil society believes that the $14 billion should be the 'floor' rather than the ceiling target, as this amount of funding will only support maintenance rather than scaled-up responses in countries. "Communities and civil society are calling for donors to increase their pledges and pledge earlier for the Sixth Replenishment, to ensure a successful replenishment," said Rachel Ong, Regional Coordinator, Global Fund Advocates Network Asia-Pacific (GFAN AP).

Public spending on health in India is currently at around 1.2% of the country's GDP, not yet close to the target set by the National Health Policy 2017 of 2.5% by 2025. "India needs to take progressive steps immediately and not wait to increase health expenditures - India must increase state-sector health spending to over 8% of the budget by 2020 to reach the targets set by the National Health Policy adopted in 2017 to end TB by 2025 and to end AIDS and malaria by 2030," said Dr Sonal Mehta, Chief Executive of the India HIV/AIDS Alliance.

Further reading:

- *Civil society organizations push for a target of $18 billion for the Global Fund's Sixth Replenishment (GFO 350, 13 February 2019)*
- *Are African countries ready for the Global Fund's Sixth Replenishment's push toward greater domestic financing to end HIV, TB and malaria? (GFO 349, 30 January 2019)*
- *Global Fund announces $14-billion target for Sixth Replenishment (GFO Issue 348, 16 January 2019)*
- *The Global Fund's Guidance Note: Sustainability, Transition and Co-financing of programs supported by the Global Fund (13 January 2017)*
- *National Health Policy 2017 of Government of India*

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5. NEWS: OIG investigation in Democratic Republic of Congo finds tender manipulation and overpricing in malaria grant

Population Services International has already paid over $7 million in estimated losses

Adèle Sulcas **19 March 2019**

Senior managers appointed by the Population Services International (PSI), the Principal Recipient (PR) for the Global Fund's malaria grant in the Democratic Republic of Congo, were responsible for tender manipulation leading to "systemic and significant overpricing" of contracts for transportation, warehousing and customs clearance, resulting in an estimated loss to the Global Fund of $7,386,066.

The OIG investigation was triggered by 'red flags' raised by PSI in May 2017, after the PR carried out its own internal audit in March-April 2017. The OIG initiated an investigation based on PSI's initial findings.

The OIG's investigation report, made public on 12 March 2019, identifies three types of wrongdoing: collusion, abusive practices, and non-compliance with the grant agreement. The report acknowledges both PSI's and the Global Fund's respective roles in the wrongdoing: PSI's poor oversight of its DRC operations and inadequate measures at headquarters level to identify issues at country level, and the Global Fund's lack of evaluation of PSI's own internal controls, which contributed to the Fund's inability to detect any irregularities in grant implementation.

The proposed recoverable amount is the full $7,368,066, which PSI has already paid back. PSI is no longer a Global Fund PR in the DRC.

In a comment emailed from the Secretariat to the GFO, Head of Communications Seth Faison said, "The investigation report identifies serious wrongdoing, and it is very good that PSI found the problem, reported it swiftly, and paid back the full amount. We have taken several steps to reduce the risk of similar occurrences in the future."

The investigation included two field missions by the OIG, to DRC from 11 to 23 December 2017, and to Washington, DC (where PSI is based) from 11 to 15 June 2018. The scope of the OIG's investigation was limited to the procurement and supply-chain management components of the PSI grant, which came to a total of $38.15 million (out of $178 million of expenditures across all line items for the implementation period January 2015 to December 2017). Of the $38.5 million spent on procurement and supply-chain related line items, 32% was reviewed by the OIG.

Table 1: DRC's currently active Global Fund grants for New Funding Model 2 (2018-2020)

Principal Recipient	Grant component	Grant	Signed amount (US$)
Stichting Cordaid	TB/HIV	COD-C-CORDAID	149,742,258
Ministry of Health and Population of the DRC	HIV/AIDS	COD-H-MOH	23,913,524
Ministry of Health and Population of the DRC	Malaria	COD-M-MOH	74,908,613
SANRU Asbi	Malaria	COD-M-SANRU	275,717,435
Ministry of Health and Population of the DRC	Tuberculosis	COD-T-MOH	18,679,294
Total			**542,961,124**

Source: Global Fund Secretariat

Main OIG findings and Agreed Management Actions

The OIG's investigation report lists five main findings with associated Agreed Management Actions (AMAs):

1. **A PSI senior manager in DRC approved special tender conditions and deviations from PSI's headquarters' procurement policies, without PSI headquarters' approval in advance.** This meant that bidders with lower prices were consistently eliminated from tender evaluation processes, with contracts awarded to higher-priced bidders. Further deviations included overpricing in land transportation contracts, customs clearance charges, warehousing expenses, air and river transportation, and communications.

AMA 1: The Secretariat will evaluate the design and effectiveness of the internal controls implemented by PSI through the creation of the Global Fund Management Unit (within PSI) and its corresponding functional and administrative reporting lines, to mitigate similar future risks. (Due 30 September 2019; owner: Chief Financial Officer)

2. **A restricted tendering process to hire transportation vendors facilitated the creation of an anti-competitive, bid-rotation scheme that resulted in significant overpricing.** This came about as a result of PSI in DRC hiring four fiduciary agents to manage payments related to LLIN mass campaigns in different provinces, two of which were authorized by PSI to carry out tenders for transportation contracts in their respective zones of the country.

   AMA 2: The Secretariat will address the supplier misconduct in accordance with the policy on supplier misconduct and the Sanctions Panel Procedures. (Due 30 September 2019; owner: Head, Grant Management).

3. **Ineffective governance and oversight by PSI headquarters enabled the misuse of fiduciary agents**: PSI headquarters did review fiduciary agents' contracts and verify invoices before payment through headquarters, but "did not identify the limiting nature of their contractual arrangements," the OIG said. PSI did not require the agents to follow PSI's own administrative policies and procedures.

   AMA 3: The Secretariat will update its Guidelines for Grant Audit to ensure that auditor engagement includes a review of the controls related to PR-hired third-party agents, as well as review the terms and conditions of engagement of third-party agents. (Due 31 December 2019; owner: Chief Financial Officer)

4. **PSI's decentralized business model resulted in a lack of visibility of, and control over, program implementation in DRC**. Because PSI headquarters lacked a "proper understanding of the DRC context," the OIG said, it was unable to challenge its DRC senior managers' decision or proactively address potential issues relating to procurement and supply chain.

   AMA 1: (see above)

5. **The assurance framework agreement between the Global Fund and PSI was insufficient, and reduced both parties' ability to identify risks proactively.** The Global Fund relied on internal controls designed by PSI without evaluating their effectiveness, the OIG report says, (the framework did not require such evaluation, either by the Local Fund Agent [LFA] or PSI's external auditors) and because of this the Fund had inadequate assurance on key portfolio risks. Practically, this meant that the LFA did not review tenders that were initiated in DRC but were paid by PSI headquarters, thereby reducing the Fund's visibility into tenders carried out by PSI in DRC. It also meant that the Fund did not verify the PSI-hired fiduciary agents' terms of reference or performance; furthermore, the Fund considered the fact of PSI having hired fiduciary agents a risk-mitigating factor (page 21 of the report provides substantial further detail).

AMA 4: The Global Fund will re-evaluate its framework agreement with PSI to clarify the scope of responsibility between different assurance providers, and will review assurance arrangements with other INGOs to determine whether revisions are needed in current arrangements or framework agreements. (Due 31 December 2020; owner: Chief Risk Officer)

Breakdown of financial losses

The "systemic manipulation of procurement and supply-chain systems" described by the OIG included restrictions and deviations to tender processes that had been designed or approved by PSI-appointed senior managers in DRC. Of the total estimated losses, $7.36 million was related to procurement and supply chain, and $29,710 related to communication expenses. The breakdown of the $7.36 million comprised:

- Transportation expenditures overpriced by 29% and restricted transportation tenders carried out by PSI-appointed fiduciary agents, overpriced by 38% (a combined loss of $6,136,275)
- Warehousing contracts overpriced by 21% (a loss of $633,429)
- Customs clearance charges on containers of Long-lasting Insecticidal Nets overpriced by 20% (a loss of $586,651).

Actions already taken

Both Population Services International and the Global Fund have already acted to redress – or prevent recurrence of – the issues the OIG has identified. PSI has refunded in full the amount of the combined overpricing and dismissed the individuals responsible for the wrongdoing in DRC. In addition, grant management for all Global Fund-supported programs are now consolidated in the Global Fund Management Unit (GFMU), among other measures.

Though predating this investigation, in 2016, the Global Fund created a dedicated Supply Chain Department (unrelated to this investigation but in response to the generalized high risk associated with in-country supply chains). In 2018, the Fund also set in motion an Integrated Risk Module to strengthen the integrated risk and assurance framework further.

Executive Director of the Global Fund, Peter Sands, thanked the OIG for this investigation and expanded upon the steps the Fund is taking to reduce the risk of similar occurrences in the future in a Message from the Executive Director posted on the Global Fund's website:

"We have begun by reviewing assurance mechanisms for PSI specifically. We are developing a quality assurance framework to assess the effectiveness of PSI's proposed remedial actions, including an increased focus on controls at implementation level. We are taking steps to strengthen financial reporting, review governance and accountability mechanisms to identify additional safeguards that might be needed, and conduct bi-annual monitoring visits that review financial performance and manage emerging issues. Finally, we are enhancing the Local Fund Agent's scope of work to emphasize fraud prevention, detection and timely escalation to the Global Fund. We will use the same approach for all international nongovernmental organizations that implement Global Fund grants, to make sure that we

have the appropriate assurance that our funds are achieving the impact intended." (See the full message from the Executive Director about the OIG's investigation in DRC.)

(Editor's note: See sections 8.4 and 9.4 of the Risk Management Report and Annual Opinion, presented to the 39th Board Meeting in May 2018, for more detail on the Fund's efforts to address supply chain risks and embed risk and assurance planning.)

Country context

The DRC is the second-largest country in Africa, the 12th-largest in the world, and has a population of 81 million people, 44% of whom live in urban areas and 90% of whom live on less than $3.10 per day. Only 50% of the country can be reached by road or rail transport.

Though DRC once possessed a healthcare system "renowned in Africa," the OIG report says, decades of ongoing conflict and the complex political and economic challenges resulting from the conflict have made the DRC one of the most difficult countries in the world in which to deliver health-care services.

The DRC is a 'high impact' Global Fund country (very large portfolio, mission-critical disease burden) and is designated a 'challenging operating environment' with additional safeguard policy in the Global Fund's differentiation categories for country investigations.

The Global Fund has signed a total of $1.998 billion worth of grants with DRC, of which $1.63 billion has so far been disbursed. Currently (for the implementation period 2018 to 2020) the Global Fund is financing five active grants (see Table 1 above).

Further reading:

- *The Global Fund's news release and full report of the Office of the Inspector General's investigation in DRC*
- *Audit Report - Global Fund Grants to the Democratic Republic of Congo (2016)*
- *Investigation Report on Global Fund Grants to the Democratic Republic of Congo (2014)*
- *Country Audit of the Global Fund Grants to the Democratic Republic of Congo (2010)*

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6. COMMENTARY: Global Fund country coordinating mechanisms are good; they could be better

CCM potential could be fulfilled by strengthening leadership, representation and integration

Ida Hakizinka and Djesika Amendah **19 March 2019**

The Global Fund's Strategy Committee plans to discuss country coordinating mechanism (CCM) evolution next week. These discussions come about three years after the Office of the Inspector General (OIG) published an audit on CCMs (in 2016); and about a year after the Global Fund launched its CCM Evolution initiative (as a pilot project in 18 countries) and adopted a new CCM policy and code of conduct.

The OIG's audit of CCMs enumerated a list of issues, among them: little integration of the CCM into the national systems in several countries; weak governance structure; and a sub-optimal oversight system. The OIG suggested strengthening the capacity of the membership and leadership of the CCMs.

Some of those issues are recurrent and had been highlighted earlier. The Secretariat has tried to address some of them through the CCM Evolution initiative. The initiative aims to improve the performance of CCMs in four main areas: CCM functioning; linkages with other national forums; oversight to maximize grant performance; and engagement.

(See also previous GFO articles on the Tanzania CCM aspiring to be a best practice model and a workshop in Morocco for consultants supporting CCM evolution.)

It is important to maintain a focus on CCMs. This commentary presents a few ideas to deepen the reflection on this critical area.

1. **CCMs have broad representation and a significant role to play**

CCMs are composed of representatives from government, civil society, private sector, persons living with or affected by the three diseases, and multilateral and bilateral agencies. At the time the CCM concept came into being, such broad representation was innovative and particularly important in the context of Global Fund principles, especially those of partnership and country-ownership. CCMs' role, according to guidelines approved by the Global Fund Board, include coordinating the development and submission of national requests for funding; overseeing the implementation of grants; approving reprogramming requests; and ensuring linkages and consistency between Global Fund grants and other national health and development programs.

2. **CCMs have the potential to be real partners of the Global Fund**

The High-Level Review Panel report in 2011 called CCMs "cornerstones of Global Fund architecture" within countries. As such, they should be partners of the Global Fund Secretariat overseeing grants and, when necessary, recommending to the principal recipient (PR) actions that can improve grant performance in countries. Such a role can be effective and efficient if the CCMs truly have broad representation and if they have a capable CCM Secretariat.

Some CCMs members, speaking on condition of anonymity in order to be able to talk candidly, have complained that they are sidelined both by the Global Fund and the PRs after the submission of funding requests and the grant signing ceremony. (Grant agreements are signed between the Global Fund and the PRs.) They explained that during grant implementation, the Global Fund seeks them out only in case of problems, such as a non-performing PR, or to follow-up on co-financing requirements. While such complaints target

the Global Fund Secretariat and the PRs, they also suggest deficiencies in the leadership and functioning CCMs.

3. Strong CCM leadership is necessary to obtain good results

Strong CCM leadership is vital for Global Fund grants' performance and sustainability. Such leadership occurs — not always but often — when the CCM chair holds a recognized leadership position in government, especially in countries where the CCM is not integrated into the national health system. In this way, CCM chairs can bring their influence to bear on issues that are vital for Global Fund grants, such as meeting domestic and co-financing requirements, obtaining tax exemptions, and getting governments to grant privileges and immunities.

Conversely, when the leadership of the CCM is not perceived as influential, the CCMs have a harder time implementing decisions. The CCMs' decisions and recommendations can then be ignored with no fear of repercussions, because its leadership lacks the influence (perceived or real) that come with a position of authority in the government.

This idea of strong leadership often vested in government officials clearly goes against the practice in some countries of excluding government implementers from important CCM discussions on key implementation matters because of a conflict of interest (COI) policy. While all members of the CCM are equal (see CCM Policy) and it is important to ensure they can all speak their mind, such an understanding of the notion of COI is preposterous: The COI requirement is designed to prevent fraud and corruption, as clearly stated in the Global Fund Policy to Combat Fraud and Corruption. The COI requirement does not aim to exclude State PRs from discussions that concern them and decisions that they would ultimately implement. Such exclusion may negatively affect grant implementation.

4. Civil society organizations are vital components of the CCMs

The presence of civil society organizations (CSOs) is vital not only for the proper design and implementation of grants but also to keep government actors accountable. This fact cannot be underestimated given that state PRs administer about 60% of all Global Fund grants.

5. CCMs should be appropriately funded, and represented

Effective, efficient and functional CCMs and their respective Secretariats require competent personnel, in adequate numbers, as well as the necessary working tools. The Global Fund and its partners should invest in the CCMs and their Secretariats human resources and other tools. In particular, the representation and oversight functions of the CCM should be strengthened with adequate staffing considering country context and size of the portfolio.

CCM members are volunteers who represent their original institutions such as CSOs, government, and donors. CCM members' day jobs are to represent their primary employers/institutions – not to represent the CCM or the Global Fund in other instances. For example, in health sector meetings in some countries, rarely do participants discuss the Global Fund strategic policies and how those are aligned with domestic ones, even though many members of the CCM may be present. This weakness in CCM representation could be remedied by the presence of competent professional employees of the CCM Secretariat.

6. CCMs should be sustainable, integrated into the national system and linked with other institutions

In many countries, the CCMs are not integrated within the national health system architecture. Rather, CCMs created for and by the Global Fund serve the purposes of the Global Fund. In that context, the finding in the OIG's 2016 audit of CCMs that in nine countries where the Global Fund withdrew its support, the CCM ceased to exist is not surprising, though it is unfortunate.

Another global health initiative, Gavi, the Vaccine Alliance, has created a structure similar to the CCM called the Inter-agency Coordinating Committee (ICC), which is a national coordination forum in each country with government leadership; and most bilateral donors have steering committees for their own in-country programs. Many representatives of government, CSOs or donors among the CCM membership also hold a seat on the ICC or other, similar, coordinating bodies.

At a national level, it is important to create an entity capable of fulfilling the combined coordination and oversight role that the Global Fund's CCM, Gavi's ICC, and other similar bodies created by third-party funders fulfil seperately for their respective donors. Merging such bodies could create synergies, increase a sense of country ownership, and help build health systems at time when countries are moving toward universal health coverage.

Some countries, such as Rwanda or Chad, have set up unique structures for the management of all donor grants such as those from the Global Fund, World Bank, Gavi and other bilateral donors, to increase efficiency and avoid duplication. It is not a stretch of the imagination to think that if grant management across funders can be successfully merged, so could their coordination mechanisms; and that those coordination mechanisms could become cornerstones of the national health architecture.

Ida Hakizinka is Aidspan's Chief Executive Officer, and Djesika Amendah is Aidspan's senior policy officer.

***Note**: The GFO will publish additional articles relating to the CCM evolution initiative in future issues.*

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7. ANALYSIS: Malawi faces wide-ranging challenges in Global Fund grant implementation

Some relate to Global Fund processes, others to political and economic context

Ann Ithibu **19 March 2019**

Malawi has made significant progress in the fight against HIV, tuberculosis (TB) and malaria since it started receiving Global Fund funding in 2003; more than 90% of people living with HIV knew their status in 2017, 71% were on treatment and 61% were virally suppressed. Malaria incidence and mortality has also reduced significantly.

However, the country faces significant challenges in implementing Global Fund grants, such as weak health systems, low absorption for non-procurement-related funds, and low domestic financial contributions, which together may impede the country's ability to achieve maximum impact.

Malawi is a low-income southern African country with a population of approximately 18 million. The Global Fund classifies Malawi as a 'high-impact' country due to huge Global Fund investments there – approximately $459 million in the 2017-2019 funding cycle alone – and a 'mission-critical disease burden'. Malawi had the ninth-highest HIV prevalence in the world (9.6%) among the adult population aged 15-49 years in 2017; the country is also 'high burden' for both malaria and HIV/TB coinfection. The entire population of Malawi is at risk of malaria: in 2017, there were approximately 4.3 million cases of malaria resulting in 7,000 deaths. Similarly, TB is a serious concern; an estimated 131 people per 100,000 population were infected with TB in 2017, and only 68% of these incident TB cases were put on treatment.

This article analyzes grant implementation in Malawi including challenges faced and lessons learned by the Global Fund and in-country partners such as the Country Coordinating Mechanism (CCM), Principal Recipients and the Global Fund Secretariat. Information for this article comes from publicly available documents, including the funding requests and grant performance reports, two audit reports and one investigation report on the Malawi grants by the Office of Inspector General (OIG) (see 'Further reading' below), as well as interviews with officials in Malawi and within the Global Fund Secretariat.

Global Fund and other partner investments in Malawi

The Malawi health sector relies heavily on funding from external sources. HIV programs especially are almost entirely funded from external resources (95%): The Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR). For the 2018-2020 implementation period, the Global Fund contributes 31% of total available HIV resources; while other external and domestic resources contribute 40% and 1% respectively in the 2018-2021 period, based on an Aidspan analysis on data reported in the 'Funding landscape'.

The 'Funding Landscape' is one of the documents submitted to the Global Fund during the funding application process; it describes the sources of funding for the three diseases relative to the needs and highlight the gaps in funding). The 'unmet need' gap for HIV stands at 28% (Table 1). The Global Fund also financed an estimated 20% and 17% of the TB and malaria responses.

Table 1: Overview of the funding landscape (2018-2021)

	HIV		TB		Malaria*	
Fiscal Year	**Amount ($ million)**	**As % of funding need**	**Amount ($ million)**	**As % of funding need**	**Amount ($ million)**	**As % of funding need**
Estimated funding need	1,092,042,350		76,903,607		379,330,238	
Domestic resources	9,442,679	0.9%	2,800,490	4%	1,482,661	0%
Loans	3,401,354	0.3%	6,000,000	8%	-	0%
External Resources (non-Global Fund)	436,260,201	40%	15,797,997	21%	91,976,139	24%
Total Global Fund resources	339,268,432	31%	15,718,404	20%	65,723,448	17%
Total resources available	788,372,666	72%	40,316,891	52%	159,182,248	42%
Unmet need gap	303,669,684	28%	36,586,716	48%	220,147,990	58%

***Source**: The 'Funding Landscape' is part of a downloadable package of grant application (funding request) documents; it is available on the Malawi Overview page on the Global Fund website. To access the funding request documents, click on 'Applications' under the 'Documentation' section at the bottom of the page. Download both the 'Funding Request Malaria - 2017' and the 'Funding Request HIV/TB - 2017' to obtain the malaria and HIV/TB Funding Landscapes respectively.*

*Note: *Malawi did not include the Global Fund contributions towards malaria for the year 2021 in the funding landscape spreadsheet*

Currently, three Principal Recipients (PRs) implement four active grants in Malawi (Table 1):

- The Ministry of Health (MoH), which implements both HIV/TB and malaria grants focusing on treatment and care; and
- Action Aid and World Vision, two non-state PRs, are responsible for non-biomedical interventions for HIV/TB and malaria respectively; those interventions include community mobilization and demand creation for care and treatment services.

These PRs were unchanged from the 2015-2017 implementation period.

Table 2: Active Global Fund grants in Malawi

Disease component	Principal Recipient (PR)	Grant number	Signed amount
TB/HIV	Ministry of Health	MWI-C-MOH	$364,229,296
	Action Aid Malawi	MWI-C-AA	$29,376,543

Malaria	Ministry of Health	MWI-M-MOH	$25,153,571
	World Vision Malawi	MWI-M-WVM	$40,278,420
		TOTAL	$459,037,830

***Note**: All the grants listed in Table 2 run from January 2018 to December 2020*

Low domestic contributions to the health sector

The government of Malawi spent 10.8% of its total public expenditure on health in 2015, an improvement from recent years – health expenditure was 8.8% in 2014, 8.6% in 2013 and 6.3% in 2012. However, these contributions still fall short of the 15% agreed on by the African Union Heads of States in the Abuja Declaration. To put these proportions in perspective, only two countries – Madagascar and Sudan - actually met the 15% threshold.

Government expenditure on health is just one source of health spending in Malawi and it accounted for 29% of the 'current' health expenditures in 2015. Other sources are development partners (54%) and households and employers (18%). Current health expenditures include expenditures for remuneration of personnel, rent payment, purchase of medications, reagents, and other health commodities.

Malawi has limited fiscal space, which restricts significant increases in government spending on health. The country has turned to loans to fill this gap in funding (Table 1); for instance, in the current 2017-2019 allocation period, the country has committed $33 million in co-financing i.e. domestic investments for the three diseases. Malawi has borrowed $10.5 million from the World Bank to help meet this commitment. The Global Fund's Technical Review Panel, however, warned against the use of loans to fill the funding gaps citing increasing debt levels in Malawi. Indeed, the high levels of debt have been highlighted in the Debt Sustainability Analysis by the International Development Association (IDA) of the World Bank and the International Monetary Fund (IMF).

Most of the current grant funds are for procurement of health commodities

Malawi's portfolio is highly commoditized; the country plans to spend 85% of the total of its current Global Fund grants to purchase health products. The majority of these funds will purchase anti-retroviral medications for HIV and long-lasting insecticide nets (LLINs). Previously, the OIG, in the 2016 audit, had estimated that between 2009 and 2015 Malawi spent 89% of its Global Fund grants on procurement of health products.

Donors finance the procurement of health products to a huge extent, particularly for HIV. In fact, a procurement expenditure analysis by PEPFAR showed that the Global Fund pays for 99% of HIV-related commodities in Malawi, while PEPFAR pays for the remaining 1% (Table 3). The role of the government of Malawi cannot be underestimated, however, as it finances health systems strengthening (HSS), such as human resources, health infrastructure and equipment – 12% of the total HIV-related HSS expenditure - and, to a smaller extent, voluntary medical male circumcision (VMMC) (4%), prevention of mother-to-child

transmission (PMTCT) (2%) and prevention for priority populations (1%). The government of Malawi also purchases essential medicines such as antibiotics. Overall, the contributions of the Government of Malawi are critical for the functioning of the health system although the government does not purchase HIV-related health commodities.

Table 3: Annual procurement profile for HIV-related key commodities

Commodity Category	Total Expenditure ($)	Sources of expenditure		
		Global Fund	PEPFAR	Other
ARVs	69,713,358.09	91.5%	8.5%	0%
Rapid test kits	4,419,939.15	100%	0%	0%
Other drugs	8,922,233.44	100%	0%	0%
Lab reagents & Viral Load Commodities	18,739,435.02	92%	8%	0%
Condoms	3,478,645.97	70.5%	29.5%	0%
VMMC[1] kits & commodities	2,591,461.00	0%	66%	34%[2]
HIV/TB	3,642,349.09	100%	0%	0%
Other commodities [3] (lubricants)	96,000.00	0%	100%	0%
Total	111,603,421.76	99%	1%	0%

Source: Malawi Country Operational Plan (COP) 2018 (Strategic Direction Summary)

Notes:
[1]VMMC - Voluntary Male Medical Circumcision
[2]World Bank
[3]The government does not purchase HIV-related commodities

The Global Fund also invests heavily in programs for key populations, adolescent girls and young women (AGYW), and other priority populations, and health systems strengthening in Malawi (Table 4). During the development process of the 2018-2020 funding request, there were calls by some in-country stakeholders to reduce allocations for procurement and to increase investment in prevention, according to one source. However, the national dialogue attended by all stakeholders and constituencies prioritized the procurement of commodities for three reasons. First, the country implements the "test and treat" policy which increases the number of people on treatment; second, the fact that the Global Fund is the only source of funding for ART, and finally the need to ensure no interruption in treatment.

Table 4: Annual investment profile by program area for 2017

Program Area	Government of Malawi (%)	Global Fund (%)	PEPFAR (%)	Other (%)
Clinical care, treatment and support	0%	75%	21%	4%
Community-based care, treatment and support	0%	0%	83%	17%
PMTCT[1]	2%	23%	75%	0%
HIV testing and counselling	0%	0%	100%	0%

VMMC[2]	4%	0%	89%	7%
Priority Population Prev.	1%	12%	42%	45%
AGYW[3] Prevention	0%	100%	0%	0%
Key Population prevention	0%	28%	59%	14%
Orphans and vulnerable children	0%	0%	100%	0%
Laboratory	0%	0%	100%	0%
Strategic information, Surveys and Surveillance	0%	0%	58%	42%
Health systems strengthening (HSS)	12%	16%	32%	40%

Source: Malawi Country Operational Plan (COP) 2018 (Strategic Direction Summary)
Notes:
[1] PMTCT - prevention of mother-to-child transmission
[2]VMMC - Voluntary Male Medical Circumcision
[3]AGYW – Adolescent girls and young women

Weak supply chain system may undermine gains made in procurement

Malawi's weak supply chain system may undermine efficiencies made by procuring health commodities through the Pooled Procurement Mechanism (PPM). The Global Fund created this mechanism in 2009 to aggregate procurement orders, negotiate lower prices and ensure timely procurement of health commodities for Global Fund recipient countries. Malawi now has access to health products at the national level but inefficiencies in quantification and distribution result in stock-outs of malaria commodities and expiries of TB commodities at local health facilities as highlighted by the OIG in the 2016 audit. Theft and leakage of health commodities, particularly antimalarial drugs, have also been common in Malawi since 2010 prompting the government and other partners to put in place remedial measures. The government, for instance, established the Drug Theft Investigation Unit, revised laws to introduce severe penalties for drug thefts and intensified investigations and prosecutions of those suspected to steal medicines.

In the past, partners established parallel supply chain systems to circumvent these weaknesses in the existing national systems. For instance, the Global Fund Secretariat uses a third-party logistics provider to carry out the last-mile distribution of health products. However, the third-party logistics provider is not a long-term solution. The Secretariat is currently investing in building the capacity of the Central Medical Stores Trust (CMST) - the national procurement agency that procures, provides quality assurance, stores and distributes medicines and medical supplies – as well as integrates the existing parallel supply chains. This is part of the Global Fund's supply chain initiative which includes the development of a supply chain strategy, and work with government and private sector partners to implement supply chain transformation projects. The Secretariat has not yet specified how much funding is available for the implementation of this initiative in Malawi.

Malawi absorbs less than half of the funds for in-country HIV/TB activities

Malawi absorbed 82% of its Global Fund grants in the 2015-2017 implementation period. This proportion is higher than the average for high-impact African countries (69%).

Specifically, for HIV and TB, the Ministry of Health (MoH) absorbed 81% of its HIV/TB grant (grant number MWI-C-MOH, $285 million) in this period. These proportions conceal wide discrepancies in the absorption of funds for procurement, which is through the PPM, in comparison with funds for in-country activities. For instance, Malawi absorbed only 30% of the in-country activities budget for all the grants in the 2009-2015 period as reported by the OIG in the 2016 audit.

Similarly, Malawi underspent funds for in-country activities for the malaria grant in the 2015-2017 implementation period. Overall, Malawi absorbed 68% of the total allocation ($33 million) for malaria. MoH absorbed only 65% of the grant (grant number MWI-M-MOH, $26 million) whereas World Vision Malawi, the non-state PR implementing non-biomedical interventions, absorbed 90% of its allocation (grant number MWI-M-WVM, $6.6 million), according to the Secretariat. To put this in perspective, 75% of the malaria grant was for procurement of health products. According to the Secretariat, the country spent most of the procurement funds. Part of the unspent funds were savings which resulted from significant price reductions in health products; the remaining underspent funds were mostly for in-country activities.

The low absorption rate extends also to funds made available by the government as Malawi used only 30% of the year's co-financing provided by government in the period between July 2015 and June 2016, according to the OIG, in the 2016 audit. However, according to the Secretariat, Malawi absorbed most of the commitment at the end of the grant implementation period (the exact proportion was unavailable).

In the same report, the OIG has attributed the low absorption rate for Global Fund funds allocated to in-country activities, i.e. funds not meant for procurement of health products, to inefficiencies in the country team's management of the portfolio and fiscal agent processes, and limited capacity to implement activities, that are critical to overall success, such as TB active case finding and MDR-TB activities, procurement of malaria rapid diagnostic tests; and expansion of medicines storage infrastructure for priority districts.

In the current grants, Malawi plans to conduct an orientation for PRs and SRs on the Global Fund's budgeting guidelines, operational financial manuals including the role of the fiduciary (fiscal) agent, according to the HIV/TB funding request. The absorption rate for in-country activities for year one of the 2018-2020 grant is not publicly available; the CCM asserts that it has increased 'significantly'. It is noteworthy that the MoH set up a Project Implementation Unit (PIU), in 2016, to manage the MoH grants; the now functional PIU actively monitors and tracks absorption regularly to inform quick decisions.

Inadequate performance by the HIV/TB non-state PR

The performance of Action Aid Malawi, which implements the prevention (non-biomedical) interventions within the HIV/TB response, was inadequate in the 2015-2017 implementation period. The Global Fund's most recent rating for the Action Aid Malawi grant (grant number MWI-C-AA, available on the Global Fund's website) was B2 (inadequate but potential demonstrated) for the period by June 2017. This rating is the second lowest in a five-tier

rating system. By the end of the grant, in December 2017, the performance rating had improved to B1 (adequate), according to the Secretariat. (The Secretariat explained that the latest ratings will be available on the website in the next few weeks).

In contrast, the other two PRs performed well, either or. The Global Fund rated the Ministry of Health (MoH) HIV/TB and malaria grants A2 (meet expectation) and A1 (exceed expectations) , and the World Vision malaria grant A1 in the same period.

Action Aid Malawi also failed to use its total allocation ($29 million); the country absorbed only 64% of the grants in the 2016-2017 period. The OIG attributed the low absorption to delayed grant signing and disbursements, and delayed selection of sub-recipients. Action Aid Malawi also faced challenges such as recurrence of audit queries; incomplete and poor or late reporting for both finance and programs. The Secretariat explained that there has been and continues to be improved oversight from both the Global Fund and the CCM on Action Aid Malawi.

Conclusion

Malawi depends substantially on external funding to finance its health sector. Though the government has stepped up its contribution to the health sector in recent years despite the country's limited fiscal space, a huge funding gap remains. It is noteworthy that despite the scarcity in available resources, Malawi does not fully absorb its domestic and Global Fund funds allocation. Malawi now needs to address the bottlenecks affecting the absorption of funds.

The Global Fund invests heavily in the procurement of health products; in fact, the absorption of funds intended for procurement is very high. Weaknesses in the supply chain have affected the delivery of these health products and services at the various levels of health care. Remedial actions such as integrating and strengthening the supply chain system will address those weaknesses, ensuring the availability of quality-assured drugs and safeguarding against stock-outs, expiries and theft of drugs within the drug stores and health facility.

***Further reading**:*

- *Proactive Investigation into Anti-Malarial Product Theft from Public Health Facilities in Malawi (10 August 2017, OIG report number GF-OIG-17-017)*
- *Audit Report - Global Fund Grants to the Republic of Malawi (11 October 2016, OIG report number GF-OIG-16-024)*
- *Audit of Global Fund Grants to the Republic of Malawi (3 August 2012, OIG report number GF-OIG-10-020)*
- *Malawi Country Operational Plan (COP) 2018 (Strategic Direction Summary)*

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8. OF INTEREST: Other news related to the Global Fund partnership

Civil society's pivotal role, 'Global Health Governance' book review, tips for advocates about PEPFAR cuts

Aidspan Staff **19 March 2019**

Here are a few recent news and media items, of relevance to the Global Fund partnership:

Friends of the Global Fight has published an 'issue brief' called 'Backing Civil Society to End the AIDS, Tuberculosis and Malaria epidemics'. The issue brief highlights the pivotal role in the fight against HIV/AIDS, tuberculosis and malaria played by civil society – all those stakeholders who are neither government bodies nor private sector enterprises, such as NGOs, advocacy groups, and faith-based organizations. "Given the local, national and international knowledge and expertise that civil society groups bring to the table," Friends' news release on the issue brief says, "their engagement in decision-making helps Global Fund programs be more effective and responsive to global health needs." The full issue brief is downloadable as a PDF.

Read more…

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The Governance of Global Health: What needs to change is a book by Devi Sridhar and Chelsea Clinton, looking at the power dynamics in the global health ecosystem. A blog on the Save the Children website by Samy Ahmar calls it "a new, deep and important insight into the world of global health, how power is distributed within it, and why some issues receive lots of funding while others don't". The book looks at the evolving roles of four major international organizations: the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, GAVI, the Vaccine Alliance, and the World Bank.

Read more…

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In the face of several countries funded by PEPFAR facing funding cuts to their 2019 Country Operating Plans (COPs), advocacy organization MPact has published a blog entitled '2019 U.S. PEPFAR COP Reviews: 10 Tips for Advocates'. MPact reports that funding cuts are in many cases "in response to poor performance or an inability to reach performance indicators" set by the State Department's Office of the Global AIDS Coordinator. The blog outlines some of the "persistent structural challenges" undermining countries' HIV responses, why some U.S. policies on sexual health and harm reduction "also undermine countries' efforts to reach the right people, in the right places, at the right time," how the U.S. has taken "a narrow approach to setting performance indicators," and how the proposed funding cuts are happening on the heels of PEPFAR's announcing $100 million in new funding for faith-based organizations.

Read more…

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In the wake of United States President Donald Trump's proposed budget for fiscal year 2020 in which he outlines deep cuts to Medicare, Medicaid, PEPFAR, and the Global Fund, the New York Times has published an article describing some of the challenges the administration faces in its purported attempt to end AIDS in the U.S. within the next 10 years – and what this means on the ground in the southern state of Mississipi.

Read more…

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9. NOTICE: Global Fund Advocates Network calls for video contributions to thank the Global Fund

Aidspan Staff **19 March 2019**

As part of the Global Fund Advocates Network (GFAN) campaign for the Sixth Replenishment for the Global Fund, GFAN is developing short videos thanking donors for their contribution to the Global Fund and implementing countries for their commitments to health. These short videos will show different people, in different settings, saying 'thank you' in different languages, and end with a message in the main language(s) of that country thanking them for their commitment.

GFAN has already collected a number of videos, but is looking for additional short clips of people saying 'thank you' (with enthusiasm) in groups, with varied backgrounds, in particular outside.

If you would like to contribute a video clip, please send your contribution to Tara Hogeterp at th@icssupport.org by March 31, 2019. Videos can have people saying "Thank you" or "Thank you for your commitment to the Global Fund" in any language. Please also provide with your video submission a note with which language was used.

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This is issue #352 of the GLOBAL FUND OBSERVER (GFO) Newsletter. Please send all suggestions for news items, commentaries or any other feedback to the GFO Acting Editor at adele.sulcas@aidspan.org. To subscribe to GFO, go to www.aidspan.org.

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

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GFO Newsletter is now available in English and French. The French-language edition becomes available within one week after the publication of the English edition.

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