Aidspan

Independent observer of the Global Fund

GLOBAL FUND GRANTS' CO-FINANCING USED MORE TO BUY COMMODITIES THAN TO STRENGTHEN HEALTH SYSTEMS, IN PRACTICE

The Global Fund to fight AIDS, TB and malaria aims to provide additional funds to countries facing epidemics of the three diseases. To help ensure that Global Fund monies do not replace beneficiary countries' resources in fighting those diseases, the Global Fund in 2016 put in place the Sustainability, Transition and Co-financing (STC) policy. This policy requires beneficiary countries to increase government expenditures on health to achieve coverage for the three diseases over each Global Fund allocation period, and ultimately help towards achieving Universal Health Coverage. (An earlier version of this policy existed.)

Although sustainability "has always been an element of the Global Fund's work," the December 2019 Guidance note on the STC policy says, the policy "formalized the overall approach to strengthening sustainability, increasing domestic financing and cofinancing, and supporting countries to better prepare for transition from Global Fund financing through national planning."

In other words, countries can use their co-financing to build their health systems while progressively taking over the key costs of their HIV, TB, and malaria programs.

The Global Fund Secretariat includes co-financing requirements in the allocation letters it sends to countries at the beginning of a funding cycle. Information from some of the allocation letters, which Aidspan has analyzed, forms the basis of this article.

Sustainability, Transition and Co-financing policy

The Sustainability, Transition and Co-financing (STC) policy requirements vary according to the country's level of income per capita and the burden of the three diseases. Low-income countries have "the flexibility to demonstrate that their investment is 100% for [Resilient and Sustainable Systems for Health] RSSH interventions." The lower middle-income countries were divided into two categories: the lower lower-middle income countries (Lower-LMICs) and upper lower-middle-income countries (Upper-LMICs). These two categories of LMICs have to spend at least 50% and 75% respectively on key program costs related to the three diseases. Upper Middle-Income countries must focus 50% of their co-financing on key and vulnerable populations.

The possibility for low-income countries and LMICs to invest all or part of their co-financing in building systems for health stems from the Global Fund's recognition of its role in supporting countries to build their health systems. As the Secretariat states, it received a "wake-up" call when the Ebola epidemic in West Africa revealed weak health systems in countries where the Global Fund had by then already been investing for a decade. Examples of RSSH investments vital for the Global Fund programs are procurement and supply chain management, strong data collection and management, human resources for health, and financial and risk management.

Upper Middle-Income Countries often have a concentrated epidemic among key populations. This epidemiological fact explains the requirement that their co-financing focus on them.

The STC policy includes an incentive to encourage countries to meet the Global Fund's co-financing policy requirements. The Secretariat can withhold at least 15% of a country's allocation if the country cannot prove its co-financing expenditures. The country's co-financing commitment should increase with each funding cycle compared to their co-financing in the previous cycle.

Table 1: Requirement from the Sustainability, Transition and Co-financing Policy

Sustainability, Transition and Co-Financing Policy requirements for all beneficiary countries	
Minimum 15% Co-Financing Incentive available when countries increase their co-financing compared to the previous period. Increase at least 50% higher for low-income countries and 100% higher for lower middle-income countries	
Progressive government expenditure on health (all countries)	
Progressive absorption of key program costs (all countries)	
Sustainability, Transition and Co-financing Policy Conditions depending on income category and burden of diseases	
Low-Income Countries	No restriction
Lower-LMI Countries	Minimum 50% in disease programs
Upper-LMI Countries	75% in disease programs
Upper-Middle Income Countries	Focused on disease program and systems to address roadblocks to transition; minimum 50% in key and vulnerable populations

Source: The Global Fund Sustainability, Transition, and Co-financing (STC) policy

Co-financing in the 2020-2022 allocation letters

For the purpose of this analysis, we obtained allocation letters from a dozen countries in Africa and Europe. All letters contain a section on domestic resource mobilization that includes co-financing.

In Annex A of the latest allocation letters, the Secretariat included more details on the co-financing requirements for the upcoming 2020-2022 cycle. The GFO has previously explained the details of the policy, and how the Secretariat calculates and applies the co-financing incentive.

Annex A also contains information on the realization of commitments made for the cycle now ending (2017-2019). This section is especially interesting as it reveals the current co-financing commitments agreed upon by the Secretariat together with the country. Aidspan has previously described the uneven application of this policy, which has sometimes had disastrous consequences. For instance, Guinea, a low-income country committed to purchasing ARVs just after the Ebola epidemic. Due to government budget delays, the country could not purchase the ARVs using government budget on time, which resulted in recurrent stock-outs of the vital medicines.

Co-financing requirements in the coming 2020-2022 allocation period

For all the countries for which Aidspan obtained allocation letters, the co-financing requirements for the 2020-2022 allocation period are in line with the policy (see Table 2 below). The letters clearly stated the percentage and the amount of the co-financing incentive and the minimum of the co-financing incentive.

For example, Benin has an allocation of €94,427,449 and an associated co-financing incentive of 20%, amounting to €18,885,490. (The letter did not explain why the co-financing incentive is 20%.) Benin should spend €9,442,745 more on its health system or on the three diseases during the current allocation cycle 2020-2022 (than in the previous one 2017-2019) in order to obtain €18,885,490.

For low-income countries like Gambia or Benin, the letters mentioned the flexibility to choose the areas of co-financing. For the lower middle-income country Congo, the letter emphasized the need to spend at least 50% of the co-financing on key populations. For Bosnia, an upper middle-income country, that flexibility is not an option: 100% of the co-financing incentive amount should be directed towards interventions targeting key and vulnerable populations.

Table 2: Co-financing requirement in select allocation letters (2020-2022)

Country (Level of income)	Total Allocation/Co-financing incentive	Minimum additional co-financing to access full co-financing incentive	Areas to invest co-financing inupcoming cycle (2020-2022)
Benin (low-income)	€ 94,427,449 20% of total allocation €18,885,490	€ 9,442,745	Full flexibility
Bosnia (uppermiddle income)	€ 1,508,648 25% of total €377,162	€ 377,162	100% for key and vulnerablepopulations
Burkina Faso (low-income)	€ 201,492,553 15%of total allocation € 30,223,883	€ 15,111,942	Full flexibility
Congo (lower-middle income)	€ 54 518 978 15% of the total allocation € 8 177 847	€ 8 177 847	HIV: Purchase ARV tests for viral loadfor • 20% of patients in 2021 • 25% of patients in 2022 • 30% of patients in 2023 HIV: Purchase rapid diagnostic tests (RDT) TB: Purchase first-line medications Malaria: Purchase of medications and RDT for • 30% of needs in 2021 • 40% of needs in 2022 50% of needs in 2023
Gambia (low-income)	US$ 43,242,067 10% of the total allocation 4,324,207	$ 2,162,103	Full flexibility
Mali (low-income)	€ 162,137,776 15% of the total allocation €24,320,666	€ 12,160,333	• Purchase of 1st-line and 2nd-line TB drugs for all patients • Payment for health personnel in the HIV program. • Increase in the national health budget for primary healthcare for community-health reform • Allowances to CHWs in one or two regions.

Source: The Global Fund

Co-financing commitment in the previous allocation period (2017-2019)

The low- and middle-income countries in our sample committed mainly to purchasing health commodities. (see Table 3 below).

Benin committed all its co-financing to the purchase of 40% of HIV commodities needed and 500,000 bednets. Mali committed to purchasing tuberculosis medications in addition to financing some RSSH interventions. Congo, which is a lower LMIC, also committed all its co-financing to the purchase of health commodities.

The letters did not indicate the value of the commodities for any country. Letters to Gambia and Bosnia required that these countries provide evidence of the realization of their commitments. But they do not make those commitments explicit.

Table 3: Co-financing in the 2018-2020 allocation cycle in select countries

Countries (Level of income)	Co-financing in the 2018-2020 allocation
Gambia (low-income)	Should submit evidence of the realization of previous commitments
Benin (low-income)	• 40% of HIV commodities • 500,000 bednets for the 2020 mass campaign
Burkina Faso (low-income)	• Free care for pregnant women and children <5 • Contribution to the cost of TB, • Funding the allowance of Community Health Workers, • Establishing universal national health insurance mechanism (CNAMU)**
Congo (low-middle income)	€ 27,4 million, (30% materialized so far)
Mali (low-income)	• Payment for the community health workers • Payment for TB medications
Bosnia (upper-middle income)	Should submit evidence of the realization of previous commitments

Note: ** In French: Caisse Nationale d'AssuranceMaladie Universelle (CNAMU)

Co-financing can help strengthen Resilient and Sustainable Systems for Health

The co-financing policy provides an incentive to low income and lower middle-income countries to invest more in health, especially on systems for health. Such investment has the potential to improve the performance of the disease programs.

Despite this provision, it appears in practice that both in-country authorities and the Secretariat prefer to direct co-financing towards the purchase of health commodities.

Neglecting to fund RSSH with government co-financing is a missed opportunity: some aspects of a strong

health system are vital for good program performance. For instance, good supply chain management is needed to order the right quantity and quality of commodities at the appropriate time, to store them correctly, and distribute them efficiently.

As Peter Sands, the Executive Director of the Global Fund stated in a June 2019 interview with Devex, the global-development media platform: “To end the big epidemics, you need to have health systems that work. A health system that is not dealing effectively with the big epidemics is not a very effective health system.”

Further reading:

- The Global Fund Sustainability, Transition and Co-financing Policy (GF/B35/04 – Revision 1), Board Decision from the 35th Board Meeting Revision 1, 6-27 April 2016, Abidjan, Côte d’Ivoire
- Global Fund Secretariat report: ‘The Role of the Global Fund Supporting Countries to Build Resilient and Sustainable Systems for Health’, 2015 Geneva, Switzerland.

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