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NEWSLETTER

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describing the results of the follow-up investigations instead of full investigation reports. The OIG published statements instead of full investigation reports due to "weaknesses of data management in supply chain operations" and missing records in the case of Tanzania, while in Liberia, the OIG's preliminary assessment identified poor record keeping, and not systemic diversion, as the source of the stock reconciliation differences identified during the country audit.

4. ANALYSIS: A 'top 20' ranking of countries with the largest Global Fund 2020-2022 allocations for the three diseases

BY DJESIKA AMENDAH

Using the Global Fund's data service, Aidspan takes a look at which countries received increases in their total allocations of 50% or more, as well as the top 20 countries with the largest allocations for each of the three diseases in this 2020-2022 cycle (Mozambique, India and Nigeria for HIV, TB and malaria, respectively).

5. ANALYSIS and COMMENTARY: Allocations increase of $780 million to West and Central Africa in 2020-2022 funding cycle will speed up progress towards achieving the Global Goals by 2030

BY CHRISTELLE BOULANGER

Allocations for the next cycle will be the largest ever granted to recipient countries. The total amount available for country allocations for the 2020-2022 cycle is $12.71 billion, up 23% from the previous three-year period. This represents a substantial increase for West and Central Africa as the region will receive $780 million more than during the 2020-2022 cycle. How to ensure that these resources are well invested and that they allow for both strengthening health systems and saving lives? The next six months will be crucial to reflection on these questions, and to planning interventions that take into account lessons learned in the past, and recommendations outlined in numerous reports with a view to further improving the effectiveness and efficiency of Global Fund investments.

6. ANALYSIS: Global Fund grants' co-financing used more to buy commodities than to strengthen health systems, in practice

BY DJESIKA AMENDAH

The Global Fund's policy on sustainability, transition, and co-financing allows countries to spend part or all of their co-financing on strengthening their systems for health. A sample of Global Fund allocation letters for the 2020-2022 cycle reveals that countries and the Secretariat prefer to spend co-financing funds to purchase health commodities.

7. OF INTEREST: News for and about the Global Fund partnership

BY ADÈLE SULCAS

This edition's 'Of Interest' focuses on value-for-money resources for applicants to the Global Fund, the Global Fund and Friends of the Global Fund/Japan's participation in the torch relay for the Tokyo Olympics, and the plenary lineup for AIDS 2020, just announced by the International AIDS Society.

TOP

ARTICLES:

1. NEWS: Global Fund Board approves $135.7m and €25.7m of portfolio optimization awards for 23 countries

$2.6m from private sector to be integrated into Papua New Guinea malaria grant

Adèle Sulcas **25 February 2020**

The Global Fund Board has approved additional funding for portfolio optimization, funded from the Register of Unfunded Quality Demand (UQD), in the amounts of $135,666,553 and €25,693,664, for 28 grants in 23 countries. The funds come from $650 million approved by the Audit and Finance Committee for portfolio optimization to fund high-impact interventions from the Register of Unfunded Quality Demand, linked to grants in the 2017-2019 funding cycle. The additional amounts will be integrated into the 28 existing grants through grant revisions that increase each grant's upper-ceiling amount.

The Board's funding decision was approved by electronic vote on 13 February 2020. The Board was acting on the recommendations of the Technical Review Panel (TRP) and the Grant Approvals Committee (GAC).

Table 1: Funding approved for portfolio optimization (UQD) interventions [1]

Applicant	Com-ponent	Grant name	Principal recipient	Previously approved program budget ($ or €)	Recommended additional funding ($ or €)
Afghanistan	Malaria	AFG-M-UNDP	United Nations Development Programme	$25,650,956	$1,092,920
Bangladesh	TB	BGD-T-BRAC	Building Resources Across Communities	$75,722,981	$14,701,807
Bangladesh	HIV	BGD-H-SC	Save the Children Federation, Inc	$12,144,935	$599,568
Bangladesh	Malaria	BGD-M-NMCP	Ministry of Finance [2]	$12,480,383	$1,322,081
Belarus	TB/HIV	BLR-C-RSPCMT	RSPCMT [3]	$16,990,452	$3,400,000
Benin	HIV	BEN-H-PlanBen	Plan International, Inc.	€3,961,196	€196,933
Burkina Faso	Malaria	BFA-M-PADS	Programme d'Appui au développement sanitaire	€96,444,135	€4,722,967
Burundi	Malaria	BDI-M-UNDP	United Nations Development Programme	$41,526,625	$5,300,000
Central African Republic	Malaria	CAF-M-WVI	World Vision Inc.	€27,097,646	€7,844,748

Chad	Malaria	TCD-M-UNDP	United Nations Development Programme	€42,580,391	€12,149,611
Kyrgyz Republic	TB/HIV	KGZ-C-UNDP	United Nations Development Programme	$22,157,492	$3,018,988
Lesotho	TB/HIV	LSO-C-MOF	Ministry of Finance	$55,499,451	$8,544,633
Madagascar	Malaria	MDG-M-PSI	Population Services International	$41,518,651	$24,469,795
Mongolia	TB	MNG-T-MOH	Ministry of Health	$7,724,359	$1,550,000
Mozambique	HIV	MOZ-H-MOH	Ministry of Health	$254,124,911	$37,794,658
Nepal	HIV	NPL-H-SCF	Save the Children Federation, Inc.	$23,200,510	$960,000
Nepal	Malaria	NPL-M-SCF	Save the Children Federation, Inc.	$4,182,557	$408,000
Nepal	TB	NPL-T-SCF	Save the Children Federation, Inc.	$19,017,896	$2,150,000
Papua New Guinea	TB/HIV	PNG-C-WVI	World Vision International	$25,914,590	$2,929,868
Papua New Guinea	Malaria	PNG-M-RAM	Rotary Club of Port Moresby, Inc.	$25,790,597	$2,628,000
Philippines	HIV	PHL-H-SC	Save the Children Federation, Inc.	$9,483,242	$2,500,000
São Tomé and Príncipe	Integrated	STP-Z-UNDP	United Nations Development Programme	€5,088,901	€504,055
Tajikistan	HIV	TJK-H-UNDP	United Nations Development Programme	$12,939,544	$5,324,308
Thailand	TB/HIV	THA-H-DDC	Ministry of Public Health [5]	$23,432,337	$3,559,051
Togo	Malaria	TGO-M-PMT	Primature de la République Togolaise	€31,580,235	€275,350
Turkmenistan	TB	TKM-T-UNDP	United Nations Development Programme	$5,083,665	$1,560,500
Uganda	TB	UGA-T-MoFPED	MoFPED [4]	$23,945,026	$3,000,000
Zambia	Malaria	ZMB-M-MOH	Ministry of Health	$63,711,576	$11,490,376

Notes:

(1) The funding source for all grants in the above table is $650 million approved by the Audit and Finance Committee for portfolio optimization for grants in the 2017-2019 funding cycle. Totals not shown in this table due to mix of USD and EUR denominations, indicated individually per grant.

(2) Economic Relations Division within Nepal's Ministry of Finance.

(3) RSPCMT is the Republican Scientific and Practical Center for Medical Technologies, Informatization, Administration and Management of Health.

(4) MoFPED is Uganda's Ministry of Finance, Planning and Economic Development.

(5) This refers specifically to the Department of Disease Control within Thailand's Ministry of Public Health.

In its report to the Board, the GAC provided comments on the awards, which we summarize in the balance of this article. Given the high number of grants involved, we provide very brief explanations of each, with a small number of others selected for fuller description.

Grant revisions – integration of additional funding from private sector

Papua New Guinea malaria. 94% of the country's population lives in malaria-endemic areas, and PNG has one of the highest malaria burdens outside of Africa. Against this backdrop, PNG's national malaria control program had made what the Global Fund has called a "historical achievement" in reducing the number of malaria cases and deaths through national mosquito-net distribution campaigns. Increasing malaria prevalence in the last three years, however, as a result of a widespread resurgence in malaria, threatens this progress, and PNG is now re-intensifying malaria control.

The $2,628,000, which will be used to fund strengthened vector control, will come from Comic Relief's Red Nose Day Fund. The additional funding will cover the procurement of 245,000 single-size long-lasting insecticide nets (LLINs) for distribution to mothers attending antenatal clinics, as well as the procurement of 138,000 extra-large LLINs for mass distribution. Some funds will also be used to support other aspects of PNGs malaria control program, implemented by the Rotary Club of Port Moresby.

Additional funding awarded for portfolio optimization interventions from the Register of Unfunded Quality Demand

Afghanistan malaria. The additional portfolio optimization investment will support LLIN procurement and distribution through mass campaign and antenatal care services, in order to meet coverage gaps due to underestimation of the population.

Bangladesh TB. The additional funding will support the rollout of a new diagnostic algorithm introduced by the national TB program in 2017, by financing procurement of 132 GeneXpert machines, 40 digital X-ray machines, and 558,555 GeneXpert cartridges, as well as site renovation, infrastructure maintencance, software, training, and project management. This will mean that 469 of the 650 sites targeted in the National Strategic Plan will be equipped with GeneXpert machines by the end of 2020.

Bangladesh HIV. The additional funding will scale up opioid substitution therapy (OST) coverage, which currently is low (5.1% of people who inject drugs).

Bangladesh malaria. The additional funding will cover the cost of LLIN campaigns (703,500 nets) in hotspots in low malaria transmission areas.

Belarus TB/HIV. Belarus has one of the highest levels of rifampicin-resistance/multidrug-resistant TB (RR/MDR-TB) ever recorded; as Belarus has already started to transition towards the new WHO-recommended MDR-TB treatment regimens, the additional funding

will support the treatment transition for all eligible patients between 2020 and 2021. It will also cover the procurement of MDR-TB drugs (including Bedaquiline, Cycloserine, Delaminid and Linezolide) for the treatment of additional pre-extensively drug-resistant TB (pre-XDR) and XDR patients using new regimens.

Benin HIV. The additional investment will pay for 200 peer educators/mediators in 2020 (the same as those supported by the Global Fund in 2018 and 2019) who assist key populations and people living with HIV (PLHIV) with adherence to treatment.

Burkina Faso malaria. The portfolio optimization funding will help cover gaps in Artesunate and Artemisinin-based combination therapy (ACT) for the 6,880,693 confirmed outpatient malaria cases in public-sector facilities and the 1,214,240 confirmed malaria cases in the community.

Burundi malaria. As in many countries, Burundi is experiencing an upsurge in malaria cases; this additional funding will cover the costs of additional antimalarial drugs for 3,445,549 patients and rapid diagnostic tests for 4,586,781 people.

Central African Republic malaria. A population increase, thought to be the result of returning refugee- and internally displaced populations to their villages, has led to increased treatment needs at the health facility and community level. The additional funding aims to provide 752,300 additional LLINs, to complete the campaign in targeted regions.

Chad malaria. The additional funding will fund Chad's 2020 LLIN mass distribution and 2020 Seasonal Malaria Chemoprevention (SMC) campaigns, including 2,906,337 LLINs for six additional regions, and reaching an additional 700,000 children. Current Global Fund grant along with government funding only allows for coverage of 13 out of 19 regions for the mass distribution campaign, and of 39 out of 60 districts eligible for the SMC campaign.

Kyrgyz Republic TB. This additional funding will be combined with a previous portfolio optimization award to support the country's transition to the 2018 WHO MDR-TB treatment guidelines, enabling it to meet the target number of people with RR- and/or MDR-TB who have begun second-line treatment. Kyrgyz Republic is a high MDR-TB burden country, at 30% among new cases and 68% among previously treated cases.

Lesotho HIV. Lesotho has made "noteworthy progress" against HIV but still has a prevalence rate of 25%, the second-highest in the world. This funding will address an emerging gap in availability of antiretrovirals (ARVs), which is the result of an unexpected government budget shortfall for 2019/2020. The funding will be used to procure ARVs, ensure full transition to tenofovir/lamivudine/dolutegravir combination for all patients, and prevent ARV treatment disruption for 275,941 people. Lesotho is on track to reach the UNAIDS 90-90-90 target by 2020.

Madagascar malaria. The additional funding will support the advance procurement of LLINs for the 2021 mass distribution campaign. This will address a misalignment in funding between preparatory activities and the procurement and distribution of nets; Madagascar's LLIN mass campaign previously straddled two allocation periods.

Mongolia TB. The funding will address programmatic gaps by supporting the acquisition of 12 GeneXperts and 11 mobile digital X-ray units – essential for the country's nomadic population (Mongolia has the lowest population density in the world).

Mozambique HIV. The portfolio optimization funding will ensure a continuous supply of ARVs throughout 2020, keeping at least 6 months' stock in the ARV pipeline to ensure continuity of services for people on treatment. The context for this is Mozambique's rapid scale-up of treament from 300,000 people in 2012 to more than 1.2 million by mid-2019. The country has plans to reach 1.69 million people on ART by the end of 2020, which would mean that 72.6% of PLHIV will have treatment coverage.

Nepal HIV. Neither migrants nor prisoners in Nepal receive HIV services, though 75% of new HIV infections in Nepal come from returning migrants and their spouses, and prisoners have been defined as a high-risk group. The additional funding will support the scale-up of HIV prevention services and linkages to treatment and care among migrants and prisoners, starting in 2020.

Nepal malaria. The additional investment will support the coverage of 180,000 at-risk and vulnerable populations with LLINs. Government has committed to eliminating malaria by 2024 but outbreaks recorded in 2018-2019 in previously 'malaria-free' areas emphasized the need for closer surveillance.

Nepal TB. Nepal needs to strengthen TB diagnosis, given the current inadequate access to rapid diagnosis, and a range of issues with sample transportation and quality assurance of laboratory services. The portfolio optimization funds will address identified gaps in RB diagnosis and case finding, aiming to increase case notification by 8,000 (the estimated number of missing people with TB is between 5,000 and 12,000). Survey results due to be published in March 2020 suggest that the overall TB burden is "significantly higher" than previously estimated.

Papua New Guinea TB/HIV. PNG is among the 14 highest triple-high-burden countries in the world, and has high TB/HIV co-infection rates. In 2018, PNG's HIV program and WHO conducted a drug resistance study that showed resistance of 18,4% to first-line drugs. The portfolio optimization funding will support the switch of 29,420 PLHIV on ART to the WHO-recommended dolutegravir (DTG)-based ART regimen.

Philippines HIV. The current Global Fund HIV grant to the Philippines focuses mainly on prevention among key populations, with Government covering ARV costs. The portfolio optimization funding is a one-off investment to support the fast transition to Tenofovir/Lamivudine/Dolutegravir (TLD) ART regimen due to constraints linked to the Government budget cycle. The transition will support treatment for up to 13,000 patients, and provide viral load tests for 40,000, among other program enhancement measures.

Sao Tome and Principe TB. Though malaria transmission here is moving towards elimination, a 31% increase in the annual number of cases was observed from 2016 to 2018. The additional funding will support WHO's recommended indoor residual spraying (IRS) of

the 3 districts where the majority of those cases originated, covering an additional 26,504 households, to reach 85% of households targeted for IRS.

Tajikistan HIV. The additional investment will help cover gaps in HIV prevention and treatment in Tajikistan, by enrolling 1,200 PLHIV on ART and providing counselling and support to increase adherence. In addition, the funding will support the expansion of opioid substitution therapy by 300 people, programs to reduce human rights-related barriers and reduce stigma, and integration of HIV services into the primary health-care system.

Thailand TB/HIV. The additional funding will support Thailand's transition to the new WHO-recommended RR/MDR-TB regimen starting in 2020. It will also be invested in supporting intensified TB case finding, comprehensive treatment and care among migrants/refugees, and comprehensive treatment of TB infection among children in contact with index TB cases, as well as some procurement of GeneXpert cartridges.

Togo malaria. Togo's limited funding resources and shortage of medicines have restricted its scale-up of Seasonal Malaria Chemoprevention (SMC), despite having shown "extraordinary results" in the reduction of malaria incidence, malaria prevention, and reduction in children-under-5 mortality. The additional fundw will be used towards scaling up SMC in 2020, aiming to cover 100% of all children at risk in eligible regions (483,411 children).

Turkmenistan TB. The additional portfolio optimization funding will cover the procurement of Bedaquiline for the country's MDR-TB patients, the procurement of second-line drugs for children (there is an increased number of DR-TB cases diagnosed in children) and of second-line drugs for XDR/pre-XDR cases. This will address the budget gap that now exists due to the initiation of Turkemnistan's transition in 2019 to the new WHO MDR-TB guidelines.

Uganda TB. Uganda's own 2015 prevalence survey showed that it is among the top 20 countries for missing TB cases (40,000 every year). The portfolio optimization additional funding will further support the scale-up of Active Case Finding, procure GeneXpert cartridges, and finding TB cases among PLHIV as well as in key populations such as prisoners. The expectation is that by the end of 2020, the number of notified cases of all forms or TB (bacteriologically confirmed and clinically diagnosed) including both new and relapse cases will increase by 12%.

Zambia malaria. The additional funding will address the gap in Zambia's 2020 LLIN mass campaign in fully covering at-risk populations. The funding will provide 4,872,457 LLINs for the 2020 campaign.

The information for this article was taken from Board Document GF/B42/ER03 ("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: Implementation of Global Fund's Sustainability, Transition and Co-Financing policy, is 'transformative', says thematic review

Commissioned by the Technical Evaluation Reference Group, the review called for better planning for, and management of, transitions in several settings

Andrew Green **25 February 2020**

A thematic review of the Global Fund's Sustainability, Transition and Co-Financing (STC) Policy commissioned by the Technical Evaluation Reference Group (TERG) in 2018 concluded that the Global Fund Secretariat is transforming the work of the organization in line with the Policy, which "should result in countries being better prepared for transition away from Global Fund financing."

The report highlighted the "substantial gains" in helping lower-middle-income countries (LMICs) with non-high disease burdens and upper-middle-income countries (UMICs) to better plan for and manage transitions from external financing, though it emphasized that similar attention and effort were needed to support LMICs with high disease burdens and low-income countries (LICs) "in increasing the sustainability of their disease control efforts."

The report's authors emerged with 14 specific recommendations, including an overall recommendation to further strengthen and operationalize the STC Policy implementation. In its position paper on the review, the TERG ultimately made five high-priority recommendations.

- Scale up efforts to catalyze increased Domestic Resource Mobilization (DRM)
- Strengthen efforts to remove the impediments to scaling up effective HIV, TB and malaria services
- Address health system weaknesses that impact the sustainability of disease outcomes
- Increase attention on sustainability assessment and planning in high-burden, lower-middle-income countries
- Create and ensure access to Global Public Goods, including market shaping for key drugs, diagnostics and commodities.

The Secretariat management, in its response to the review (see page 19 of the report) agreed broadly with the conclusions of the thematic review, but emphasized that "many sustainability and transition challenges depend fundamentally on political will and policy decisions at the national level," which the Global Fund has only a limited ability to influence. While the Secretariat did not respond to each individual recommendation, it concurred with many of the overall conclusions, including that increased efforts are needed to support LMICs and LICs in increasing the sustainability of their disease control.

The report is the first thematic review of the STC Policy, which the Global Fund Board approved in April 2016. The Policy was designed to support the Global Fund's overall

strategy, which includes aligning the Fund's support with increasingly self-reliant national efforts. The STC Policy offers guidance to countries to better prepare them to transition from Global Fund financing as their income status increases and they achieve disease reduction goals. It also seeks to encourage country partners to use domestic resources to take on a greater share of program costs. (See separate article in this issue on co-financing in the 2020-2022 allocation cycle.)

The Fund, in collaboration with country teams and partners, began implementing the policy during the 2017-2019 allocation period. At its March 2018 meeting, the Global Fund's Strategy Committee requested the TERG oversee a thematic review of the STC policy. In turn, the TERG commissioned the Health Management Support Team and the Euro Health Group to conduct the review in 2019, identifying four key objectives:

- Assess the Fund's operationalization and implementation of the STC Policy
- Understand how country programs and stakeholders are incorporating key principles and focus areas of the STC Policy into their national programs and funding requests, including preparing for the transition from Global Fund financing
- Understand the extent to which the STC Policy is helping to foster greater sustainability of national programs
- Document the lessons learned from the ongoing STC Policy implementation to help guide the Global Fund's sustainability efforts

The reviewers examined the operationalization and implementation of the STC Policy at both the corporate and country level. That included ten country case studies, five of which were field-based (Côte d'Ivoire, Kenya, Rwanda, Ukraine and Vietnam) and five desk-based (Dominican Republic, Georgia, Ghana, Namibia and Sri Lanka).

Along with its overall determination that the Global Fund is transforming the work of the organization in line with the STC Policy, the report offers specific insights into the progress made at three review levels: corporate level operationalization and implementation of the Policy; operationalizing, supporting and monitoring implementation at the country level; and results and implications of the STC Policy at the country level.

Corporate operationalization and implementation of the STC Policy

The review praised the clear operational guidance and revised grantmaking processes offered by the Secretariat, highlighting the Secretariat's efforts to prepare for component transitions and implementing co-financing requirements. The reviewers also noted the Global Fund's efforts to revise its partnerships to support STC. However, outside of the Asia, Europe, Latin America and Caribbean (AELAC) countries, the reviewers noted there was not enough attention on strategically operationalizing country-led sustainability efforts.

Operationalizing, supporting and monitoring implementation at the country level

The review found that the Global Fund provides significant STC technical support to countries, particularly around their efforts to assess and plan for the transition, including

expert staff who helped guide the process in the AELAC. The Global Fund has also extended part of its Catalytic Funding and enlisted partners to support country-level STC efforts. The reviewers did call for more sustainability monitoring indicators to offer greater understanding of the integration of services, among other insights.

Results and implications of the STC Policy at the country level

The reviewers based their findings on the evaluation of the 10 case study countries and determined that the implementation of the Global Fund grants is largely aligned with the National Strategic Plans of those countries. For the transitioning programs, there was strong adherence to the focus areas of the STC Policy and all transitioning programs had undertaken a transition assessment and begun transition and/or sustainability planning.

There were several challenges identified, though, which helped inform the recommendations that emerged. Among them, the reviewers recognized that health systems weaknesses are not being adequately addressed to promote sustainability, with Resilient and Sustainable Systems for Health (RSSH) grant activities generally focused on supporting grant implementation instead of systems strengthening. They also cited the risk to services for key and vulnerable populations (KVP) in the transitions, since KVP programs are often funded through external sources. And they raised the concern that countries have limited capacity for domestic resource mobilization.

From these insights, the reviewers identified 14 recommendations, including an overall recommendation that the Secretariat further strengthen efforts to operationalize and implement the STC Policy. That specifically includes prioritizing and monitoring the successful transition of country disease components, while emphasizing sustainability throughout grantmaking and implementation.

In its position paper based on the thematic review, the TERG ultimately selected five of the reviewers' priorities for increased attention:

1. Continue scaling up efforts to catalyze increased DRM.
The TERG suggested prioritizing increases in domestic financing for scale up of KVP services, specifically. The Secretariat agreed with prioritizing efforts to address impediments to KVP service scale up, but noted that "ongoing political, legal and other enabling environment challenges may hinder these efforts in some contexts." The review also called for more support from the Secretariat to country teams in the form of health financing and sustainability specialists.

2. Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services.
This includes a call to intensify efforts to promote domestic or alternate financing for civil society organizations and human rights advocacy that support primary prevention, treatment and compliance adherence activities.

3. Further address health systems weaknesses that impact the sustainability of disease outcomes.
This includes the urgent expansion of efforts to address systems constraints in national procurement and supply chain management, public financial management and integration of programs and systems.

4. Increase attention on sustainability assessment and planning in high-burden LMICs.
The reviewers suggested expanding the successful approach within the AELAC to cover all regions, and modifying the grant application process to encourage greater attention to sustainability.

5. Continue to create and ensure access to Global Public Goods, especially market shaping for key drugs, diagnostics and commodities.
This recommendation called for the Secretariat to maintain a supervisory role after countries transition, to ensure they retain access to Global Public Goods, like market shaping for key drugs, diagnostics and commodities, while continuing to provide access to wambo.org or other pooled procurement mechanisms.

The position paper also listed five recommendations meant to help fine-tune STC operationalization and implementation:

1. Continue and intensify efforts related to efficiency and value-for-money across all Global Fund-supported components.

2. Sharpen focus on tools and processes for prioritization of disease responses at the country level, particularly for high-burden UMICs and LMICs.

3. Continue to evolve the operationalization of co-financing requirements of the STC Policy. This recommendation includes the suggestion that the Secretariat document and replicate successful experiences in leveraging domestic financing for health.

4. Expand country ownership and responsibility for STC efforts and ensure country-centred, demand-driven Global Fund support. The Secretariat noted it is already working to enhance the role of Country Coordinating Mechanisms in STC-related efforts.

5. Consider incorporating additional STC indicators in the Global Fund's Key Performance Indicator Frameworks. This includes ensuring there are indicators to routinely monitor RSSH investments in health systems strengthening, KVP program sustainability and progress on co-financing commitments. The Secretariat said it would review the availability, rigor and quality of potential additional indicators.

Finally, the review listed three additional considerations:

1. Learn from sustainability and transition efforts already underway in Global Fund countries and regions

2. Further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability

3. Consider greater use of on-the-ground mechanisms to strengthen coordination and oversight of STC efforts.

The TERG Position Paper suggested a follow-up review on post-transition outcomes in roughly three years, given that the implementation of the STC Policy is still at an early stage.

***Further reading**:*

- The Technical Evaluation Reference Group's Position Paper on the Thematic Review of the Sustainability, Transition and Co-Financing Policy
- The Global Fund's Sustainability, Transition and Co-Financing Policy
- The article from GFO on TERG priorities
- The primer from GFO on the Global Fund's STC Policy.

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3. NEWS: OIG publishes news updates about Liberia and Tanzania investigations instead of full reports

Investigations closed without formal reports due to lack of data in Tanzania and "no systemic diversion" problem in Liberia

Adèle Sulcas **25 February 2020**

On January 28, the Global Fund's Office of the Inspector General (OIG) published two news updates on the Global Fund website, relating to follow-up investigations by the OIG in Liberia and Tanzania. The investigations aimed to examine more fully issues identified in previous country audits performed in the two countries in 2019 (Liberia) and 2017 (Tanzania). The updates said the OIG was not able to publish a full report for Tanzania, because of a lack of available data in-country, and the lack of concrete proof of fraud. In Liberia, the OIG did not conduct a full investigation as the stock reconciliation differences to be investigated were found to be a result of poor record-keeping.

The OIG's statement about this in the updates said: "The OIG only publishes investigation reports when conclusive findings of fraud and abuse have been made, in line with the applicable professional guidelines. The investigation has therefore been closed without a formal report."

Below we summarize the issues the OIG set out to investigate.

TANZANIA

In the OIG's 2018 country audit in Tanzania (the audit was performed in 2017 but the report was published in 2018), the OIG identified an unreconciled variance of 4.7 million treatments or 'blisters' of anti-malarial drugs (artemisinin-based combination therapy, or ACTs). The variance was found during a comparison of data on ACTs supplied by the country's Medical Store Department (MSD) to health facilities throughout Tanzania over the period of one year (from October 2016 to September 2017), with data from the District Health Information System (DHIS2) that reported those facilities' consumption of ACT treatments over the same period.

MSD recorded having supplied 15.8 million ACT treatments, but the district health system recorded having dispensed only 11.1 million such treatments.

The 2018 OIG audit report attributed the variances in these numbers to three potential issues: the under-reporting of malaria treatments in the district health information system, health facilities' not reporting expiries of some of the anti-malarial drugs, or potential drugs leakages.

Further explanation by the OIG on these three identified causes includes:

1. The National Malaria Control Program (NMCP) erroneously inflates the quantities of ACTs dispensed: The "vast majority" of health facilities did not report data through the district health information system (DHIS2) during the audited period. The NMCP took this into account when quantifying (or estimating) the number of ACT blisters dispensed, and adjusted the reported number from 5.9 million to 11.1 million. However, this did not take into account several other factors negatively affecting ACT consumption data, including reports that used the wrong units of measurement – individual tablets instead of blister packs that can contain 6-24 tablets (see the news release for further detail).

2. Drug expiries are not properly reported: Aggregated data on expired ACTs was not available to the OIG, which meant that the OIG could not estimate the total quantity of expired ACTs during the audited period. After the investigation, the MSD told the OIG that no ACTs had expired during that period, despite information from the Local Fund Agent (LFA) regarding the previous six months, which showed that 12% of ACTs expired in that time at 18% of the health facilities reviewed by the LFA.

3. Possibility of leakages of ACTs from health facilities: The same LFA review revealed that one third (32%) of the health facilities they reviewed had dispensed less than half of the ACTs they had received from the MSD (almost 30,000 ACT blister packs, valued at nearly $16,000). In September 2019, OIG investigators found, through a market survey in north-west Tanzania, that Global Fund-financed ACTs were on sale at 8 out of 56 points of sale reviewed (14%).

In addition, the grant's lead implementer, the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC), could not fully account for more than 2.6 million ACT blister packs of the 15.8 million total supplied by the MSD. The MSD, in turn, had no evidence of how consumption of any of the total volume of ACTs was accounted for. The

risks of this type of data gap (or of over-supply of medicines) include the risk of diversion of medicines into parallel markets and the risk of large volumes of drugs expiring. The Secretariat has undertaken to further trace the unaccounted-for ACTs.

The follow-up investigation by the OIG, which was finalized in December 2019, could not quantify the extent to which the ACTs were (or are) being diverted, nor the specific people or entities involved, the OIG said, because of "persistent weaknesses of data management in supply chain operations". In addition, the investigation pointed out "a series of weaknesses" in Tanzania's Global Fund-financed ACT supply and consumption data; these weaknesses, the OIG news update said, "continue to negatively impact the Global Fund's malaria grant in Tanzania".

The OIG recommends, based on the findings of this investigation, continued follow-up on the implementation of the holistic supply chain review action plan, which was a result of 2015 OIG audit of grants to Tanzania. This involves working with the Ministry of Finance and Planning, the Principal Recipient, the MoHCDEC and the Tanzania National Coordinating Mechanism.

LIBERIA

In a 2019 country audit of Liberia, the OIG had identified a discrepancy in stocks for health products, valued at $1.4 million. Because there were no clear inventory records, the OIG performed a reconciliation of stock movements over a nine-month period, from August 2018 to April 2019. The reconciliation resulted in a difference of $1.4 million between the expected and the actual stock balance. The OIG update says that given the lack of inventory records, the audit had not been able to determine whether the discrepancy identified was the result of incorrect or inaccurate recording of stock movements or transfers, or of misappropriation.

The follow-up assessment by the OIG of this discrepancy found "no evidence of systemic diversion of health products". The OIG said a reporting error due to an incorrect measurement used during stock counts of vials of Artesunate was the most likely conclusion (Liberia's Central Warehouse had reported 1.2 million vials in stock, but the OIG follow-up investigation found that it could have had a maximum of 42,652 Global Fund-financed vials in stock). The OIG also found a more minor discrepancy (6,510 vials not accounted for) within the 42,652 Global Fund-financed vials.

The OIG Liberia country audit had found "significant weaknesses in stock management and record keeping" and some "internal control deficiencies", but because the investigation found no systemic diversion problem, the OIG decided to close the case. The Secretariat will continue to work with Liberia's Ministry of Health to improve supply chain management.

Further reading:

- *The original Liberia audit report: Global Fund Grants in the Republic of Liberia, 14 October 2019 (GF-OIG-19-019).*

- *'First OIG audit of Liberia's grants highlights that financial management arrangements 'need significant improvement'*, *GFO 367, 6 November 2019*
- *The original Tanzania audit report: Global Fund Grants to Tanzania (mainland) – follow-up report, 21 March 2018 (GF-OIG-18-006).*

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4. ANALYSIS: A 'top 20' ranking of countries with the largest Global Fund 2020-2022 allocations for the three diseases

Mozambique, India, and Nigeria received the largest allocations for HIV, TB and malaria

Djesika Amendah **25 February 2020**

The Global Fund has increased funding by an overall 23% to all countries in the coming 2020-2022 cycle compared to the 2017-2019 cycle. (See recent GFO article describing the new allocations.). The Global Fund allocates funds to eligible countries using a formula that accounts for two main variables: the burden of disease and the income per capita. The Global Fund's formula therefore favors low-income countries with high burdens of each disease.

This article highlights countries with increases in their total allocations of 50% or more, as well as the top 20 countries with the largest allocations for each of the three diseases in this 2020-2022 cycle. The data comes from the Global Fund's data service.

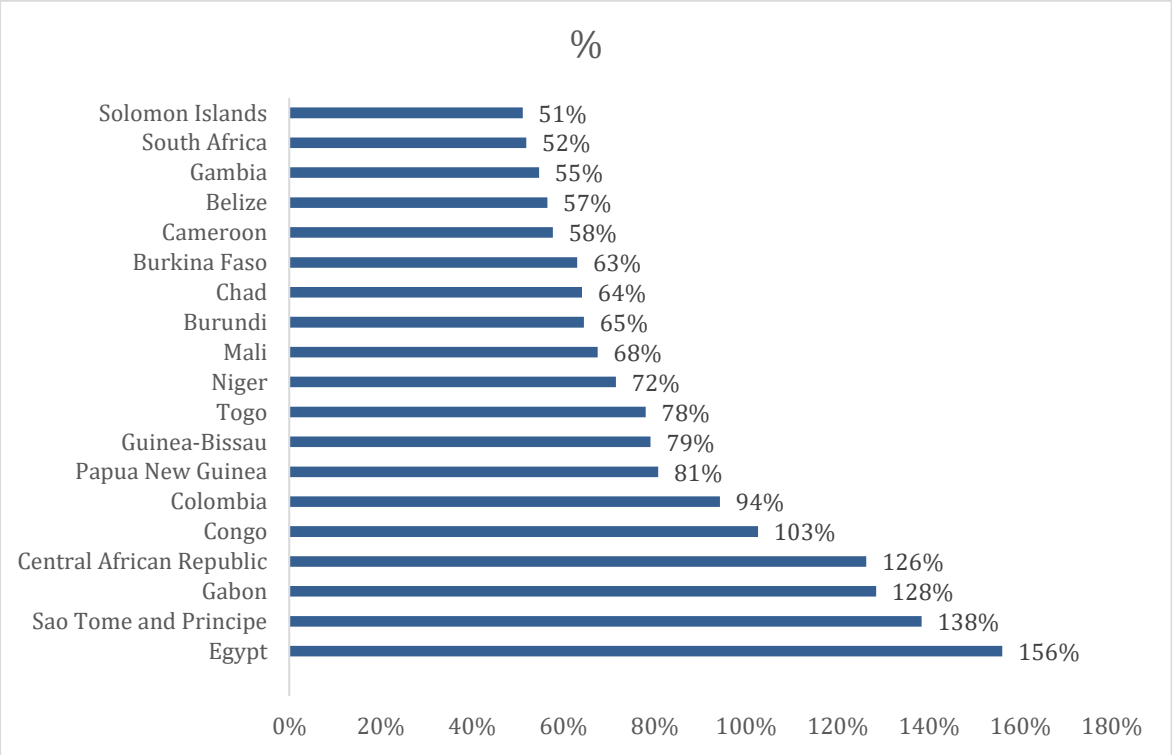
Twenty countries with increased total allocations of 50% and higher

We first focus on countries with an increased total allocation of 50% or more in the 2020-2022 funding cycle, compared to the 2017-2019 cycle, as this represents a substantial increase in available funds to fight those three diseases.

For this section, the data from the following countries/grants were not locatable within the Global Fund's data service: Bulgaria, Fiji, Iraq, Multicountry Americas (an HIV grant for activities in 11 countries in Latin America), Palestine, Russian Federation, Syrian Arab Republic, and Yemen.

Albania received the highest increase in its total allocation, of 490%. Seven countries' allocations have doubled between the two funding cycles (increases of at least 100%) (See Table 1, beneath Figure 1 below). Interestingly, most of those countries have relatively small portfolios: six countries received less than $10 million, nine others received between $10- and $100 million. Only two of these 20 countries (Mali and South Africa) are defined by the Global Fund as 'high impact" – with a "very large portfolio, mission-critical disease burden".

Figure 1: Countries with allocations higher by at least 50% compared to 2017-2019



Source: The Global Fund

Top 20 largest HIV/AIDS allocations

For this section, Aidspan could not locate the data from Bulgaria, Multi-country Americas (CRN+), Palestine, Russian Federation, Syrian Arab Republic and Yemen on the Global Fund's data-service website.

The 20 top HIV/AIDS grants
We rank the top 20 countries in terms of their 2020-2022 HIV/AIDS allocations, excluding catalytic funds, if any.

Among the top 20 countries with the largest HIV/AIDS grants, 17 are African, two are Asian (India and Indonesia) and one is Caribbean (Haiti; see Table 1). Mozambique and South Africa have received the highest absolute allocations in this cycle, of $496.4 million and $491.2 million, respectively. The allocations are in line with their disease burdens, as South Africa has the largest HIV epidemic in the world, with prevalence at 20.4% in 2017. Mozambique is a neighbor to South Africa with an HIV prevalence among adults of 12.6% in 2017, according to UNAIDS. Interestingly, Tanzania and Rwanda, despite a reduction in their HIV allocations by 11% and 21% respectively, are still in the top 20 in terms of allocations. The allocations for India and Myanmar remained essentially the same over the two periods, at $155 million and $123 million respectively.

Table 1: The top 20 highest HIV/AIDS allocations in the 2020-2022 allocation cycle ranked by the amount of the 2020-2022 allocations

Country	Grant Management Division regions	Allocation 2020-2022 US$	Allocation 2017-2019 US$	Difference in allocations between the two cycles	Percentage change %
Mozambique	High Impact Africa 2	496,359,122	289,889,134	206,469,988	71%
South Africa	High Impact Africa 1	491,237,860	317,721,470	173,516,390	55%
Zimbabwe	High Impact Africa 2	425,034,567	406,518,928	18,515,639	5%
Malawi	Southern and Eastern Africa	393,004,813	370,804,766	22,200,047	6%
Tanzania (United Republic)	High Impact Africa 2	364,840,423	408,487,081	-43,646,658	-11%
Nigeria	High Impact Africa 1	329,107,978	239,781,871	89,326,107	37%
Uganda	High Impact Africa 2	289,203,023	255,632,244	33,570,779	13%
Ethiopia	High Impact Africa 2	278,315,505	194,160,288	84,155,217	43%
Kenya	High Impact Africa 2	271,649,197	246,899,292	24,749,905	10%
Zambia	High Impact Africa 2	233,545,183	184,377,140	49,168,043	27%
Congo (Democratic Republic)	High Impact Africa 1	174,093,362	122,678,456	51,414,906	42%
India	High Impact Asia	155,000,000	155,063,624	-63,624	0%
Cameroon	Western Africa	149,772,367	94,644,534	55,127,833	58%
Myanmar	High Impact Asia	122,408,561	123,102,465	-693,904	-1%
Rwanda	Southern and Eastern Africa	121,349,916	154,462,907	-33,112,991	-21%
Indonesia	High Impact Asia	102,717,937	91,934,562	10,783,375	12%
Côte d'Ivoire	High Impact Africa 1	90,998,410	70,216,292	20,782,118	30%
Ghana	High Impact Africa 1	88,833,024	66,436,395	22,396,629	34%
Mali	Western Africa	80,322,830	49,083,927	31,238,903	64%
Haiti	Latin America and Caribbean	72,959,840	66,216,854	6,742,986	10%

Source: The Global Fund data service

Twenty-four countries received allocations increased by at least 50% to fight HIV/AIDS

Eleven countries' allocations have at least doubled (increases of at least 100%). Among these countries, Egypt received the highest allocation increase, of 740%, while Paraguay's allocation increased by 52%. Countries with the highest percentage increases are not the ones with the largest HIV/AIDS grants. For instance, Egypt's HIV/AIDS grant in this cycle is $4.2 million, while that of Paraguay is $6.7 million.

Top 20 Largest TB allocations

For the TB allocations' analysis, we did not have adequate data from the following countries/grants: Bulgaria, Fiji, Iraq, Multicountry Americas (CRN+), Palestine, Syrian Arab Republic and Yemen.

We rank the top 20 countries in terms of their 2020-2022 TB allocations. Among the top 20 countries with the largest TB allocations, 18 are High-Impact Asia and Africa (See Table 2). India and Pakistan have the two largest TB allocations at $280 million and $171.9 million, respectively. India, with a population of 1.4 billion, is home to more than a quarter of the global TB burden, according to the Global Fund. The country also has the world's highest incidence of TB, with 2.7 million cases annually. India has set a goal of ending TB in the country by 2025, five years ahead of the Sustainable Development Goal (SDG) target year. Pakistan, its neighbor, has an estimated 562 000people with TB.

Table 2: The top 20 highest TB allocations in the 2020-2022 allocation cycle ranked by the amount of the 2020-2022 allocations

Country	Grant Management Division regions	Allocation (USD Equivalent) 2020-2022	Allocation funds	Amount	%
India	High Impact Asia	280,000,000	279,929,924	70,076	0%
Pakistan	High Impact Asia	171,981,709	130,163,215	41,818,494	32%
Indonesia	High Impact Asia	150,456,123	102,416,537	48,039,586	47%
Nigeria	High Impact Africa 1	143,595,962	107,495,151	36,100,811	34%
Philippines	High Impact Asia	119,096,167	78,543,887	40,552,280	52%
Bangladesh	High Impact Asia	115,770,502	97,935,663	17,834,839	18%
Myanmar	High Impact Asia	93,126,255	82,947,503	10,178,752	12%
Congo (Democratic Republic)	High Impact Africa 1	76,950,962	56,656,946	20,294,016	36%
Viet Nam	High Impact Asia	59,771,812	47,281,094	12,490,718	26%
Kenya	High Impact Africa 2	56,694,297	45,507,072	11,187,225	25%
Mozambique	High Impact Africa 2	55,152,849	45,122,235	10,030,614	22%
Ethiopia	High Impact Africa 2	50,893,976	51,599,381	-705,405	-1%
Ukraine	Eastern Europe and Central Asia	48,644,568	48,646,090	-1,522	0%
South Africa	High Impact Africa 1	45,528,766	35,599,651	9,929,115	28%
Tanzania (United Republic)	High Impact Africa 2	43,068,093	25,849,887	17,218,206	67%
Uganda	High Impact Africa 2	29,773,958	21,101,922	8,672,036	41%

Somalia	Middle East and North Africa	29,018,030	22,110,931	6,907,099	31%
Uzbekistan	Eastern Europe and Central Asia	26,150,623	21,640,400	4,510,223	21%
Haiti	Latin America and Caribbean	25,422,056	17,896,075	70,076	0%
Zimbabwe	High Impact Africa 2	23,771,855	23,775,807	41,818,494	32%

Source: The Global Fund

Malaria allocation

We ranked the top 20 countries in terms of their 2020-2022 malaria allocations. The top 20 countries in terms of amount of malaria allocations are in Africa (Table 3). India is 21st (not shown in the table). Nigeria has received the largest malaria allocation at about $417.8 million, followed by Democratic Republic of Congo at $393.9 million. Malaria is endemic in these two large countries, which have populations of 206 million and 89 million, respectively. These two countries accounted for 37% of all malaria cases globally in 2018 (See WHO's Malaria report of 2019:).

Table 3: Top 20 countries with highest allocations for malaria ranked by the amount of the 2020-2022 allocations

Country	Grant Management Division regions	Allocation 2020-2022 US$	Allocation 2017-2019 US$	Difference in Allocations between the two cycles	%
Nigeria	High Impact Africa 1	417,893,727	313,409,111	104,484,616	33%
Congo (Democratic Republic)	High Impact Africa 1	393,891,463	347,651,023	46,240,440	13%
Uganda	High Impact Africa 2	260,024,950	188,322,878	71,702,072	38%
Mozambique	High Impact Africa 2	200,001,211	167,870,339	32,130,872	19%
Tanzania (United Republic)	High Impact Africa 2	179,362,012	145,258,808	34,103,204	23%
Burkina Faso	Central Africa	155,188,287	94,868,155	60,320,132	64%
Côte d'Ivoire	High Impact Africa 1	145,592,530	118,139,717	27,452,813	23%
Ghana	High Impact Africa 1	119,665,794	111,531,421	8,134,373	7%
Ethiopia	High Impact Africa 2	115,344,133	129,849,218	-14,505,085	-11%
Cameroon	Western Africa	111,670,203	69,591,080	42,079,123	60%
Sudan	High Impact Africa 1	110,314,123	98,522,995	11,791,128	12%
Niger	Western Africa	107,446,514	53,763,719	53,682,795	100%

Malawi	Southern and Eastern Africa	99,984,069	70,670,374	29,313,695	41%
Mali	Western Africa	90,096,464	53,055,381	37,041,083	70%
Kenya	High Impact Africa 2	86,966,676	63,225,487	23,741,189	38%
Guinea	Western Africa	72,670,272	56,663,302	16,006,970	28%
Burundi	Central Africa	70,849,593	36,656,018	34,193,575	93%
Sierra Leone	Central Africa	68,353,985	43,960,771	24,393,214	55%
Chad	Western Africa	67,614,009	39,986,124	27,627,885	69%
Zambia	High Impact Africa 2	65,131,160	69,000,000	-3,868,840	-6%

Source: The Global Fund

As with HIV/AIDS and TB allocations, countries that received the highest increases in malaria allocations are not among the top 20 in terms of the total allocation in the 2020-2022 cycle. Sao Tome and Principe, and Congo received the highest increases – of 198% (total allocation $11 million) and 156% (total allocation $34 million), respectively.

All countries that received allocation letters must submit their requests for funding to the Global Fund during the three windows for application during 2020. Increases in allocations are associated with an increase in the countries' co-financing commitments – in other words, with an obligation for countries to increase their domestic funding for their respective health sectors and programs for the three diseases. (See separate article in this GFO on co-financing in the latest allocations.)

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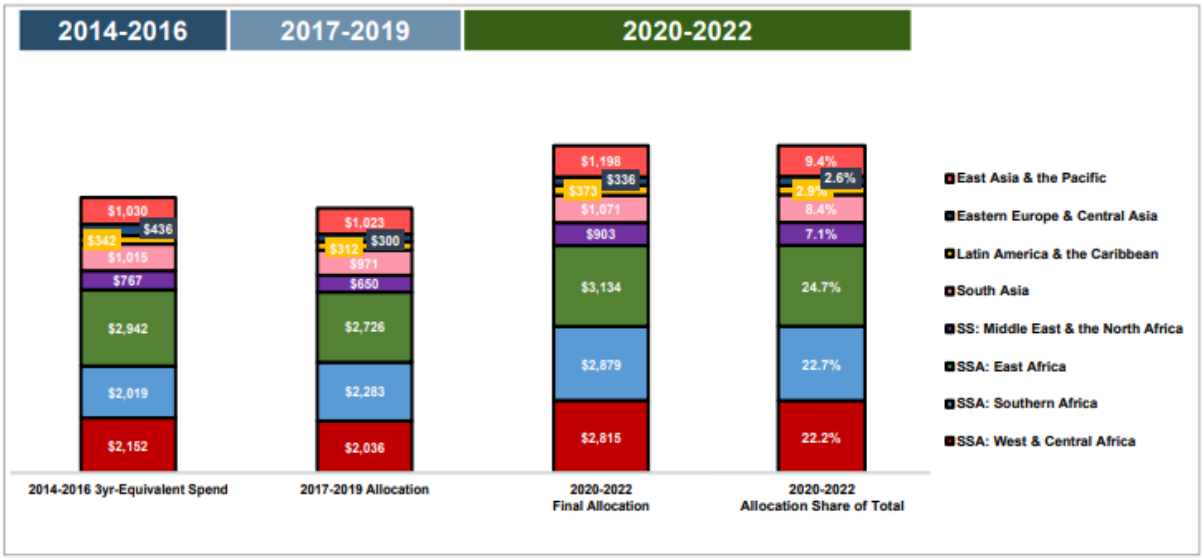
5. ANALYSIS AND COMMENTARY: Allocations increase of $780 million to West and Central Africa in 2020-2022 funding cycle will speed up progress towards achieving the Global Goals by 2030

Level of funding pledged to countries demonstrates the Global Fund 's commitment to speed up progress towards ending epidemics by 2030

Christelle Boulanger **26 February 2020**

As the Global Fund announced in a press release published on their website, funding allocations for the next cycle will be the highest ever made to recipient countries. The total amount available for country allocations in the 2020-2022 cycle is $12.71 billion, including $890 million for catalytic investments for the period, beginning in January 2020. This represents a 23% increase compared to the previous three-year period.

Figure 1: Geographic distribution of Global Fund allocations



The allocation for West and Central Africa represents a substantial increase as the region will receive $780 million more during the 2020-2022 cycle compared to the previous one. The table below shows that 10 out of 23 countries in the region have seen their allocation increase by more than 60%, with some significant increases exceeding 100%: The Central African Republic (126.3%), Congo Brazzaville (102%), and Gabon (128.4%).

Figure 2: Francophone countries' allocations comparison between 2017-2019 and 2020-2022 funding cycles

Country	Allocations	Matching funds	Total allocations USD 2017-2019	Allocation (USD equivalent) 2020-2022	Total	%
Benin	71,257,241	3 031 736	74 288 977	104,149,836	**29,860,859**	**40.2%**
Burkina Faso	136,327,672		136,327,672	222,238,520	**85,910,848**	**63.0%**
Burundi	72,300,822		72,300,822	118,944,175	**46,643,353**	**64.5%**
Cameroon	174,851,831	8,053,049	182,904,880	275,735,837	**92,830,957**	**50.8%**

Cape Verde	3,831,729		3,831,729	4,722,689	**890,960**	**23%**
Central African Republic	59,367,810		59,367,810	134,348,533	**74,980,723**	**126.3%**
Chad	78,896,585		78,896,585	129,470,416	**50,573 ,831**	**64.1%**
Comoros	6,431,994		6,431,994	7,032,457	**600,463**	**9.3%**
Congo	29,676,990		29,676,990	60 132 331	**30,455,341**	**102.6%**
Congo (Democratic Rep)	526,986,425	13,000,000	539,986,425	644,935,787	**104,949,362**	**19.4%**
Côte d'Ivoire	201,545,202	6,063,472	207,608,674	255,317,349	**47,708,675**	**23.0 %**
Djibouti	8,515,920		8,515,920	10,896,526	**2,380,606**	**28.0%**
Gabon	1,326,385		1,326,385	3,029,880	**1,703,495**	**128.4%**
Gambia	27,959,582		27,959,582	43,242,067	**15,282,485**	**55%**
Guinea	104,012,364		104,012,364	136,224,099	**32,211,735**	**31.0%**
Guinea-Bissau	31,484,274		31,484,274	56,382,745	**24,898,471**	**79%**
Madagascar	76,785,534		76,785,534	88,824,081	**12,038,547**	**15.7%**

Mali	106,738,428		106,738,428	178,831,717	**72,093,289**	**67.5%**
Mauritania	16,349,941		16,349,941	19,591,501	**3,241,560**	**19.8%**
Mauritius	2,487,917		2,487,917	2,265,213	**-222,704**	**-9%**
Morocco	14,573,417		14,573,417	17,578,908	**3,005,491**	**20.6%**
Niger	79,858,136		79,858,136	136,957,189	**57,099,053**	**71.5%**
Rwanda	210,078,156		210,078,156	190,161,352	**-19,916,804**	**-9.5%**
Senegal	69,079,236	2,368,544	71,447,780	76,789,727	**5,341,947**	**7.5%**
Togo	61,239,475		61,239,475	109,034,533	**47,795,058**	**78%**
Tunisia	4,060,055	1,000,000	5,060,055	4,798,985	**-261,070**	**-5.2%**

Only 3 countries within the Global Fund francophone countries have seen a decrease in their grants: Mauritius, Rwanda and Tunisia.

When allocations are broken down by disease, it is clear that increases have been primarily allocated to the malaria response, particularly in high-incidence countries such as those in the Greater Sahel (Chad, Mali, Burkina Faso, Mauritania, Niger and Senegal). Allocation letters for countries with large increases in grant size contain specific recommendations from the Global Fund in terms of activities to be funded: expanded coverage of seasonal chemoprevention for Sahel countries, as well as programs that take a regional approach and strengthen coordination between ministries and programs in the countries concerned. In addition, the Global Fund highlights the need to strengthen health systems throughout.

In order to achieve this, the allocation letters outline the Global Fund's preference for “integrated and focused actions (including activities that treat co-infection and provide a full

and consistent range of services, such as prenatal care).” Finally, the Global Fund recognizes that “investments supporting the capacity of systems necessary to obtain impact and guarantee sustainability (in terms of laboratory, supply chain, health information systems, community-based monitoring, community mobilization, advocacy and human resources for health at community level”) are a priority which must be reflected in proposals submitted by recipient countries.

Necessary (but not necessarily sufficient) conditions for concept notes to achieve success

The 2020-2022 cycle is the third round of the new funding model, which is based on: a transparent and inclusive dialogue open to all actors involved in the response to epidemics (and beyond, where possible), taking into account barriers to access to health care (in particular discrimination linked to gender and human rights), with gradual commitment of recipient countries to fund national budgets.

The pace and requirements of this exercise make the process very difficult to carry out. The TRP noted various recurring shortcomings in its report on the 2017-2019 period: analysis of the epidemiological situation is often too weak, a lack of methodology for identifying priorities and justifying them in the concept note, too little focus on integrated interventions, even though many joint HIV-TB concept notes were submitted in the last cycle. For these reasons, the 2017-2019 TRP made recommendations for the current period:

- **Improve priority setting** by increasing focus on prevention and reducing incidence;
- **Strengthen cross-cutting programming for resilient and sustainable systems for health** (RSSH);
- **Strengthen community systems**; and
- **Place more emphasis on program sustainability, mobilization of national resources** and preparing for the transition from Global Fund support

This is of course extremely wise advice and has been informed by weaknesses in previous requests. However, a certain number of changes are required to achieve this, some at intellectual-paradigm level, others in terms of form and method, which are useful to outline here, as these changes are not always visible in the current process of developing requests.

Improving priority setting

TRP members concluded (in a report after the 2017-2019 term) that they did not always have a strong sense of the scientific and evidence-based logic behind the selection of particular

activities over others, and did not observe the link between the priorities set out in the country's national strategic plan (NSP) and those of the funding request.

This raises questions about the content and format of certain NSPs, which should allow for a hierarchy of priorities, as well as providing budget estimates to allow the plan to be financed in its entirety by health donors. The structure of funding cycles requires that NSPs are updated or newly developed before funding requests are written, and that some of the same stakeholders are involved to ensure the logic and continuity of discussions. Subsequently, it is useful for members of the committee drafting the request to have a methodology for discussing and deciding priorities. It is important to agree on the criteria underlying what is selected and what is left out.

The investment case and the allocation letters are clear on this: it is about optimizing resources and maximizing impact with the investments made. In other words, countries must set out to minimize the effects of epidemics in order to eliminate them within a limited budget. The implication of this statement is twofold: costs must be minimized (integrating actions to meet several health objectives at the same time, reducing operating and coordination costs (particularly in countries where grants are managed by international organizations, which the Office of the Inspector General's May 2019 Advisory Review on West and Central Africa showed had lower long-term impact than national/state implementers), and increase the output of activities implemented through a more targeted approach (better suited to the target group and the regions covered).

Focusing on prevention and reducing incidence

TRP members recommend focusing more on prevention and incidence reduction. They believe that this is the most effective approach to move towards ending the epidemics by 2030. We know that the number of people newly infected with HIV is double the number on treatment; we also know the frightening number of people with latent tuberculosis (one third of the world's population). Finally, the number of malaria-related deaths has increased over the past three years, demonstrating that prevention strategies, in particular chemoprophylaxis campaigns, have not been carried out effectively.

This emphasis on prevention and on reducing incidence, however, presents methodological limitations, which one must be aware of in order to overcome them quickly. In fact, it is traditionally difficult to attribute a drop in incidence to a particular prevention activity, particularly in terms of HIV, which is linked to behavioral factors, perception of one's vulnerability to the virus, as well as various other recognized factors. Given the impact indicators selected by the Global Fund, and the need to provide quantified results to show the direct impact of investment, it is to be expected that measuring the effect of prevention strategies will be difficult.

Strengthening cross-cutting programming for resilient and sustainable systems for health and strengthening community systems

The Global Fund is asking countries to move from supporting the system (notably through payment of salaries) to strengthening it in a sustainable manner. Cross-cutting programming for the three diseases, and beyond, therefore requires a preliminary knowledge of the weaknesses of the system, a detailed study of the potential cross-cutting sectors, as well as multisectoral and multi-donor dialogue. These are areas that are still rarely covered. The Global Fund RSSH roadmap presented to the Board of Directors in May 2019 sets out priorities that appear to be relevant to the institution but are not necessarily reflected at country level. However, this step is crucial for coherent and sustainable programming.

The most obvious example of cross-cutting programming today is the development of integrated strategic plans and cross-cutting community strategies. Several countries have produced, or are in the process of developing, integrated NSPs, such as Benin and Mali. 13 community strategies have also been developed since NFM1, reflecting the integration of types of activities and epidemics: community health workers are involved in all activities (prevention, awareness, screening and sometimes dispensing treatment) and in all health disciplines (HIV, TB, malaria, vaccinations, maternal and newborn health, etc.).

Integration can also take the form of cross-cutting planning for the supply of health products, laboratory capacity, or human resources training. This requires "systemic" planning and thinking, which is still far removed from the current siloed approach to management. Finally, there is a need to ensure that this work is funded (through cross-donor dialogue, given that these areas are funded by the Global Fund, GAVI, Unicef, UNFPA, the Bill & Melinda Gates Foundation), which appears to be more complex than initially envisaged.

Increasing the focus on sustainability of programs and mobilizing national resources

The majority of donors now operate co-financing policies by asking beneficiary countries to participate in funding programs. There are various approaches taken (some donors ask the country to honor its commitment before releasing the funds, others are prescriptive about what should be co-financed), and the pressure that these commitments place on countries is rarely calculated. However, without carrying out an exhaustive inventory of the current share of health financing by the state budget, the level of debt, commitments with various partners, as well as an assessment of what has been financed in NFM1 and 2 and to what extent commitments have been respected, we do not have a clear picture of the situation. We know that the commitments given by African states do not meet the need (and are far behind the Abuja commitments) but we do not know what this commitment to co-financing represents and the pressure it places on national budgets. This is why before any discussions around the commitment of beneficiary countries to cover co-financing, it is necessary to assess in depth

the landscape of health financing in each country, to identify the sectors or activities that will be most effective in terms health indicators.

Conclusion

The challenges around improving the effectiveness and efficiency of health systems are huge, and this weighs heavily on the impact achieved in the response to epidemics. The two go hand in hand, to the extent that we must now consider health system efficiency to get closer to meeting Sustainable Development Goal 3. Will it be possible, as the TRP recommends, to meet this challenge through the next allocation cycle?

This is Executive Director Peter Sands' wish, as he wrote in his report to the Global Fund Board in November 2019: “As we start thinking about refreshing our strategy, we must recognise that the context has changed. In the SDG era there is far more focus on the interdependence between different goals, and on the need to build the systems that underpin sustainability. We have already transitioned from the Global Fund’s original mandate of simply saving lives to one of saving lives and ending epidemics. Now we must be prepared to frame our goals of ending the epidemics of HIV, TB and malaria within the broader agenda of delivering health and well-being for all. There are opportunities and risks in this evolving context. The opportunities lie in the recognition that ultimately we won’t defeat the epidemics unless we help countries build strong systems, particularly for primary health care, and in the way we can collaborate more effectively in supporting countries and communities. Equally important are our efforts to deepen our partnerships with key bilateral partners to ensure we maximise our collective impact.”

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6. ANALYSIS: Global Fund grants’ co-financing used more to buy commodities than to strengthen health systems, in practice

In low-income countries co-financing should focus more on building self-sustaining health systems

Djesika Amendah **25 February 2020**

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 in upcoming cycle (2020-2022)
Benin (low-income)	€ 94,427,449 20% of total allocation €18,885,490	€ 9,442,745	Full flexibility
Bosnia (upper middle income)	€ 1,508,648 25% of total €377,162	€ 377,162	100% for key and vulnerable populations
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 load for** • 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'Assurance Maladie 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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7. OF INTEREST: News for and about the Global Fund partnership

Adèle Sulcas **26 February 2020**

GLOBAL FUND PUBLISHES 'VALUE FOR MONEY' TECHNICAL BRIEF

The Global Fund website's 21 February news update, 'Value for Money Resources for Applicants', describes how value for money – maximizing and sustaining equitable and quality health outputs, outcomes and impact for a given level of resources – is key to Global Fund investments. The update says that while the concept has long been an integral part of the Global Fund's operations, "from the 2020-2022 funding cycle onward applicants are encouraged to consider it from funding request development through grant closure".

To this end, the Fund has published a technical brief designed to help applicants focus on key value-for-money elements in their grant applications. The brief was developed in close consultation with the Technical Review Panel and the Fund's development partners, and spells out "key elements of value for money for applicants to consider when developing funding requests". It is also intended to support implementing partners as they develop disease-specific and health-sector national strategic plans.

The technical brief is available on the Fund's website in English, French, and Spanish.

See the Global Fund's update on 'Value for Money Resources for Applicants)...

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GLOBAL FUND/FRIENDS JAPAN IN TOKYO 2020 OLYMPIC TORCH RELAY

The Global Fund's Executive Director, Peter Sands – along with other global health advocates and leaders making up a Global Fund team – has been selected as a torchbearer for the Tokyo 2020 Olympic Torch Relay. The team "will carry the torch for everyone involved in the fight to end epidemics" in Okinawa, the site of the 2000 G8 Kyushu-Okinawa Summit, where Japan introduced infectious diseases to the meeting's agenda. This began the process for the establishment of the Global Fund in 2002, strongly supported by Japan, which has remained the Global Fund's fifth-largest contributor.

Most of the nine delegates who make up the torch team are affected by HIV, TB or malaria. In addition to Peter Sands, they are: Maureen Murenga (Lean on Me Foundation, from Kenya), Jeffrey Acaba (APCASO, from Philippines), Erika Castellanos (Global Action for Trans*Equality, from Belize), Noriyuki Ishiyama (Japan Center for International Exchange/Friends of the Global Fund, from Japan), JOY (Stop TB Volunteer Ambassador, from Japan), Zolelwa Sifumba (St Andrews Hospital, from South Africa), Morimitsu Touma (Yaeyama War Malaria Bereaved Family Association, from Japan), Saw Winn Tun (Malaria Community Worker, from Myanmar).

See the Global Fund's full news release on the Tokyo Olympics torch relay...

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IAS ANNOUNCES 'AIDS 2020' CONFERENCE PLENARY LINE-UP

The International AIDS Society (IAS) announced on February 24 the lineup for the 23rd International AIDS Conference, to be held in San Francisco and Oakland, United States, on 6-10 July 2020. The conference's International Chair, Anton Pozniak, said the plenary "features this year's most critical issues in the global HIV response". The plenary programme will feature issues including biomedical HIV prevention strategies, vaccine and cure research, advances in treatment, a global perspective on 'U=U' (undetectable equals untransmissible), paediatric HIV, resilience among women living with HIV, HIV-related inequities, social factors driving HIV, interventions for people who inject drugs, aging with HIV, funding the response, and progress towards global targets.

Global Fund Executive Director Peter Sands will address the plenary on Tuesday, 7 July, on 'Doubling down: Our X-billion dollar challenge to end AIDS'.

See the AIDS 2020 website's full plenary lineup...

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