Aidspan
Independent observer of the Global Fund

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

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

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

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

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

Co-financing requirements

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

- Increase government expenditure on health (from one allocation period to the next, or progressively) and

- Increase co-financing of Global Fund-supported programs over each funding cycle to take up progressively the key costs of national disease plans.

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

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

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

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

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

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

Kenya, Uganda and Guinea vary in income and disease epidemiology

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

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

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

Kenya: co-financing dedicated mostly to health commodities

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

The funding request also asserts that in the previous funding cycle, the Government of Kenya met 100% of the counterpart funding.

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

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

By government rules, goods are ordered only when there is a budget line for them, and invoices are paid entirely upon delivery. Government budget is allocated annually to different State institutions. Funds that are likely to go unused by an institution can be transferred to another one, towards the last quarter of the current fiscal year; the following year, the institution that failed to absorb its full allocation may receive a lower budget.

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

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

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

Uganda: National Health Accounts as proof of co-financing

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

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

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

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

- Ring-fenced $27 million for the National Medical Stores for procurement of drugs and supplies
- Spent $32 million a year on salaries for health workers
- Spent $58.4 million on infrastructure, utilities, maintenance and other running costs of health facilities.

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

Guinea: a bank account dedicated to the co-financing

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

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

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

Customization and harmonization: the need for an appropriate balance

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

Opening a separate account for the co-financing element demonstrates compliance more easily, but does little to strengthen health systems or – worse – can weaken them. Such bank accounts give undue influence to heads of HIV, TB or malaria programs for which the funds are earmarked. In fact, bank accounts dedicated only to the purchase of commodities in low-income countries with weak systems might inadvertently favor corruption. The reason is that governments use their own systems to procure ARVs or the health commodities funded by domestic sources; the inefficiency of those systems is the 'raison d'être' of the PPM in the first place. In addition, one might question the quality of the commodities procured outside the PPM for countries that use this mechanism for at least 80% of their expenses.

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

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