Aidspan
Independent observer of the Global Fund

Ambitious national targets for getting people on treatment often not reflected in grant performance frameworks, GAC says

In its report to the Board on the third batch of grants it recommended for approval, the Grant Approvals Committee (GAC) said that it was very concerned that national programs have ambitious goals to continue scaling up antiretroviral therapy (ART), with the aim of achieving the 90-90-90 targets or even treating all patients diagnosed with HIV – but that these goals are not necessarily reflected in performance frameworks because of "limitations of budgets in the 2017-2019 allocation period."

The GAC said that the technical partners who sit on the committee believe that countries will need to continue to enroll new patients onto ART (including newly diagnosed HIV-positive pregnant women, individuals with advanced disease, pediatric and TB/HIV patients) as part of the standard of normal care, regardless of available budgets. "This approach presents a significant risk for Global Fund–supported programs," the GAC stated.

The pressure on Global Fund–supported budgets and the likely trend that countries will continue enrolling patients on ART beyond planned targets and budgets, the GAC said, has been observed in high-burden countries with mature national ART programs; in contexts where there are low ART coverage levels compared to regional averages (e.g. in Central and West Africa); and in countries identified for paced reductions of Global Fund allocations.

(Countries with components that were identified as over-allocated or significantly over-allocated at the time of the 2014-2016 allocations were advised that they should expect gradual [or "paced"] reductions for these components in future allocations, until such time as the components were no longer over-allocated.)

The GAC said it was concerned that continued enrolment of patients in line with the ambitious national

targets, but without sufficient domestic, Global Fund or other external resources, will potentially reduce treatment retention, and increase the risk of stock-outs and drug resistance. It said that ambitious targets to put ever increasing numbers of people on treatment is stretching existing budgets and that the situation could impact future support for prevention and health systems.

The GAC is made up of senior management officials at the Global Fund, who are voting members, plus representatives of technical, bilateral and multilateral partners, who participate in a non-voting capacity. The Global Fund Secretariat told Aidspan that the technical partners include the World Health Organization (the HIV, TB, malaria and RSSH departments), UNAIDS, the Stop TB Partnership and Roll Back Malaria. They also include a representative from civil society "with relevant technical expertise." Development partners – i.e. bilateral and multilateral donors – may also be invited to participate in GAC meetings, also in a non-voting capacity. The GAC has an Executive Committee made up of the GAC's voting members.

The GAC identified three TB/HIV grants in this batch of approvals – in Ethiopia, Kenya and Mozambique – as being particularly problematic.

Ethiopia

Table 1: Allocations for Ethiopia in 2014-2016 and 2017-2019 ($ million)

	2014-2016 allocation				2017-2019 allocation	
Comp.	Existing funding	Additional funding	Incentive funds	Total	Base allocation	Matching fu
HIV	150.9	226.5	0	374.4	194.2	0
TB	56.5	3.0	0	59.5	51.6	0
Malaria	22.6	127.9	0	150.6	129.8	0
HSS	3.6	0	0	3.6	0	0
TB/HIV	0	0	10.2	10.2	N/A	N/A
Total	233.7	357.5	10.2	601.4	375.6	0

Note: The amounts shown in the table for 2017-2019 are the amounts communicated to Ethiopia when the base allocations were announced. The split among the components was "indicative." The final program split was as follows: HIV $194.2 million, TB $45.6 million, malaria $111.8 million and RSSH $24.0 million – excluding matching funds.

PLEASE READ CAREFULLY: We hesitated about including this and the other two tables in this article because the 2014-2016 and 2017-2019 allocation periods are not really comparable – for reasons we explained at great length in a GFO article. The 2014-2016 allocations were unique in that they represented a transition between the rounds-based period and the new funding model. As such, the 2014-2016 allocations contained money from both existing grants and additional funding. Also, the Global Fund has said that the 2014-2016 allocations were meant to cover four years rather than the usual three. It is only natural that grant recipients will want to compare what they received in 2017-2019 against what they got "last time." But we caution against reading too much into this comparison.

The GAC said that Ethiopia has set ambitious targets for its national programs for the 2017-2019 allocation period – i.e. an increase in the number of people on ART from 423,000 in 2017 to over 626,000 by 2021; and an increase in annual enrolment of patients receiving MDR-TB treatment from 730 in 2017 to 1,590 by 2021. The GAC said that given the paced reduction in Ethiopia's allocation, and the fact that

the Global Fund currently supports 100% percent of the budgets for both ARVs and first- and second-line anti-TB drugs – there is a risk that funding for ART and MDR-TB treatment will not be sustainable beyond the current implementation period "without increased country ownership and significant additional domestic contributions targeted towards treatment and other key commodities."

The GAC said it was also concerned about the fact that while the Global Fund–supported budget could cover up to 500,000 patients on ART by 2021, the national target is 626,000 patients. Should the national program continue to enroll new patients on ART and MDR-TB treatment, the GAC said, there are potential risks that further scale-up would create financial gaps in Years 2 and 3 of the program. (The TB/HIV grants have a proposed start date of 1 January 2018.)

Kenya

Table 2: Allocations for Kenya in 2014-2016 and 2017-2019 ($ million)

	2014-2016 allocation				2017-2019 allocation	
Comp.	Existing funding	Additional funding	Incentive funds	Total	Base allocation	Matching fu
HIV	292.2	45.1	0	337.3	246.9	18.8
TB	24.0	21.0	0	45.0	45.5	6.0
Malaria	88.1	25.0	0	113.1	63.2	0
HSS	0	0	0	0	0	0
TB/HIV	0	0	34.3	34.3	N/A	N/A
Total	404.3	91.1	34.3	529.7	355.6	24.8

Note: The amounts shown in the table for 2017-2019 are the amounts communicated to Kenya when the base allocations were announced. The split among the components was "indicative." The final program split was as follows: HIV $216.3 million, TB $40.0 million, malaria $60.1 million and RSSH $39.1 million – excluding matching funds.

The GAC noted that while Kenya is planning to continue scaling up the number of people on ART, available resources from the 2017-2019 allocation period are under extreme pressure. With the Global Fund's contribution, the GAC said, available resources "are sufficient to cover the continuation of the ART program target of 1.1 million (79%) patients on treatment." However, the GAC said, the constraints of the allocation "potentially limit" starting new patients on treatment. The GAC noted that an ART funding gap in the amount of $65 million has been registered as unfunded quality demand (UQD).

Mozambique

Table 3: Allocations for Mozambique in 2014-2016 and 2017-2019 ($ million)

	2014-2016 allocation				2017-2019 allocation	
Comp.	Existing funding	Additional funding	Incentive funds	Total	Base allocation	Matching fu
HIV	235.6	3.6	0	242.2	289.9	10.7
TB	33.1	18.3	0	51.4	45.1	6.0
Malaria	92.4	48.3	5.9	146.6	167.9	0
HSS	15.9	0	0	15.9	0	0

TB/HIV	0	0	43.6	43.6	N/A	N/A
Total	380.0	70.2	49.4	499.7	502.9	16.7

Note: The amounts shown in the table for 2017-2019 are the amounts communicated to Mozambique when the base allocations were announced. The split among the components was “indicative.” The final program split was as follows: HIV $258.5 million, TB $45.1 million, malaria $167.9 million and RSSH $ 31.4 million – excluding matching funds.

In the last four years, the GAC said, Mozambique has gone through a rapid acceleration of its HIV response and is planning on reaching one million patients on ART in December 2017. Referring to “the highly commoditized nature of the MOZ-H-MOH grant,” the GAC acknowledged that the Global Fund–supported ART budget from the 2017-2019 allocation is not sufficient to support further scale-up. The ART funding gap for 2019 and 2020 is currently estimated at $67.7 million.

The GAC acknowledged what it called “the emerging challenges and potential risks of implementing program scale-up amidst resources constraints.” It referred to the risks of funding gaps and stock-outs faced by programs “aiming to align with normative guidance.”

How to respond?

There was a difference of opinion among the GAC partners concerning what to do about this situation. According to the GAC, most partners argued that the Global Fund should continue “business as usual” while monitoring the situation. They believe the risk of continued enrolment of new patients leading to treatment gaps is low, based on a number of beliefs and assumptions, including the following:

- ART-related targets in national programs may not be reached;
- we haven’t yet seen countries running out of funds; and
- the pace of scale-up will likely slow as programs face the more difficult process of expanding ART to hard-to-reach rural areas and populations.

However, other partners were more cautious. Citing the resource constraints, they argued that continued scale-up in a situation of uncertain future resources would not be a reasonable approach if there is no “shared responsibility” – i.e. a commitment by all parties – to work together to develop concrete solutions.

In the end, the GAC Executive decided that the issue should be brought to the Board’s attention, and that there should be shared responsibility and a strong commitment to developing collective strategies and mitigation actions to address the identified risks. The GAC said that these strategies and actions should include the following:

- an urgent high level inter-agency discussion, with the involvement of donor governments, to fully map out the programmatic and financial risks, define technical support needs, and agree on unified approaches;
- precise periodic monitoring of key information including (a) ARV stock levels; (b) data on forecast and projections of national ART consumption; (c) number of new patients enrolled on ART; and (d) retention rates (because improvements in retention would also increase demand for ARVs);
- engagement of technical partners in further analysis across the Global Fund HIV portfolio to provide concrete data on the scope, scale and costing of the potential risks; and
- regular check-in with the GAC to assess the probability of identified risks materializing and to

anticipate and implement timely course corrections as needed.

The GAC said that the Global Fund may be able to utilize efficiencies and portfolio optimization to ameliorate a portion of this issue, but that the scope of the problem requires a full country and partner response.

In addition, the GAC recommended that the Secretariat and partner organizations further their engagement and collaboration with Ethiopia, Kenya and Mozambique to explore ways to address funding gaps, to increase sustainable financing of commodities, and to sustain prevention programs – including through domestic funding, contributions from other donors, and efficiencies in programs supported by the Global Fund.

In the case of Ethiopia, the GAC noted that the country has significantly increased its health expenditures, and it called for a similar increase in domestic funding for commodities.

This issue is not new

The increasing commoditization of Global Fund grants, and its implications for prevention and other programming, are not new issues. But they have received growing attention in 2017.

On 27 April 2017, GFO reported that in Window 1 of the current funding cycle, Zimbabwe submitted a TB/HIV funding request for $629.0 million, of which $432.0 million was within Zimbabwe's allocation and $197.0 million was for a prioritized above-allocation request (PAAR). The article explained that 70% of Zimbabwe's allocation for TB and HIV was dedicated to the procurement of essential health products, and that a further 20% was devoted to covering the costs of critical human resources – leaving little room for other programs.

Although the funding request included activities to strengthen health systems and to deliver services to key populations, the article stated, the CCM was not able to devote as much money to these interventions as it would have liked. The article said:

"In an effort to 'make everyone happy,' the CCM tried to come up with a funding request that was 'balanced' between prevention and health systems strengthening, on the one hand, and treatment on the other. But the amounts budgeted in an initial draft of the funding request for prevention and health systems strengthening had to be scaled back when a team from the Global Fund Secretariat pointed out that the proposal would create a treatment gap – a gap that reached 100% in Year 3. The team said that not only would this not be acceptable to the TRP, but it would of course also not be in the best interests of the country.

So, the proposal had to be re-shuffled to ensure there was no treatment gap. Hard choices had to be made. The RSSH interventions were reduced by about 50%, from representing 16% of the total budget to representing 8%.

The CCM opted to prioritize HIV prevention for adolescent girls and young women, sex workers and men who have sex with men by including interventions targeting these groups in the within-allocation portion of the final proposal. HIV prevention for the general population, prisoners, transgender people and people with disabilities was moved to the PAAR portion of the proposal.

In a discussion paper published in June 2017, ICASO and EANNASO (Eastern Africa National Networks of AIDS Service Organizations) said the Global Fund's HIV prevention investments appear to be decreasing over time. In order for the Global Fund to achieve its HIV prevention targets enshrined in its

new strategy, the authors said, its investments in HIV prevention in Africa need to increase from current levels (approximately 15%) towards the UNAIDS benchmark of 26%. “The authors emphasize that any comparison of current and historical HIV prevention spending must acknowledge that millions more people now require sustained antiretroviral therapy (ART), much of which is procured through Global Fund grants.” (See GFO article.)

ICASO Executive Director Mary Ann Torres told Aidspan that

“ICASO and EANNASO’s discussion paper draws attention to the fact that in many African countries, Global Fund grants are often highly commoditized, limiting the opportunities for prevention scale-up within country allocations. Our research shows that wealthier African countries – such as Botswana, Mauritius and South Africa – are able to support more of their treatment liability with domestic funding, freeing up their Global Fund allocation to be spent on other priorities, including prevention. We encourage civil society and community groups to advocate for their governments to increasingly absorb critical aspects of their HIV response – especially ART. This is important from a sustainability perspective, but it also enables more balanced Global Fund–supported programs.”

In its report on Windows 1 and 2 of the current funding cycle, the Technical Review Panel (TRP) said:

“Prevention programs are often constrained by budget requirements to cover the high number of patients already on, or planned to be enrolled on, treatment…. While much more effort and resources will be required to achieve the 90-90-90 treatment targets, it is just as important to maintain, adapt, and expand prevention programs.”

The TRP said that there are gaps in coverage across the prevention and treatment cascade deriving from structural, political and cultural reticence to addressing and scaling-up prevention activities among key populations, as well as for young women and girls. “These issues are further compounded by the shrinking fiscal space, including reduced budgets and [the] need to cover treatment costs.”

Speaking on behalf of the secretariat of the Global Fund Advocates Network (GFAN), Peter van Rooijen told Aidspan:

“The $12.9 billion from the Fifth Replenishment in 2016 represented a modest increase compared to the $12.0 billion from the Fourth Replenishment in 2013. Yet, in the interim the number of people that the Global Fund has supported on ART has nearly doubled – from 6.1 million in December 2013 to 11.0 million in mid-2017. This development, combined with funding constraints in individual countries, suggests that increasing tensions between commodities and other interventions appear almost inevitable. However, the way that these tensions are dealt with will be critical. If we retract to the archaic and false dichotomy of treatment versus prevention, we risk losing years of hard won gains.”

Some of the information for this article was taken from Board Document GF-B38-ER02, Report of the Secretariat’s Grant Approvals Committee. This document is not available on the Global Fund website.

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