House of Commons
International Development Committee

DFID’s contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria

First Report of Session 2012-13

Volume II

Additional written evidence

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The International Development Committee

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## List of additional written evidence

(published in Volume II on the Committee’s website www.parliament.uk/indcom)

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Written evidence

Written evidence submitted by the All-Party Parliamentary Group on Global Tuberculosis and the All-Party Parliamentary Group on HIV and AIDS

The All-Party Parliamentary Groups on HIV and AIDS¹ and Global Tuberculosis² (TB) were formed to raise awareness within Parliament about the significance and importance of addressing these diseases. Together the groups have over 150 Parliamentarians from all political parties amongst their membership, including former ministers from the Department for International Development and Department of Health.

Since its inception in 2002, programmes supported by The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) have saved an estimated seven million lives, disbursed anti-retroviral drugs to over three million people, treated 8.6 million cases of TB and distributed 230 million insecticide-treated bed nets.³ As Parliamentarians who care deeply about the impact of the three diseases on the developing world, we are greatly concerned about how the current funding crisis at the Fund will affect both the global response to the AIDS, TB and Malaria epidemics, and DFID’s efforts to achieve long term poverty reduction.

THE CURRENT FUNDING SITUATION OF THE GLOBAL FUND AND DFID’S CONTRIBUTION TO THE FUND

1. We welcome the strong support that DFID has shown to the Global Fund since its inception in 2002. DFID have maintained the previous Government’s commitment of £1 billion to the Fund (2010–15), paying annual contributions in line with this pledge.

2. The Fund was rated as being “Very Good value for money” in DFID’s Multilateral Aid Review (MAR) in 2011, receiving the highest possible rating, the same as the Global Alliance for Vaccines and Immunisation (GAVI), which received a substantial increase in investment from the UK Government in 2011. Since the publication of the MAR, DFID has repeatedly stated that the UK will “significantly increase” its contribution to the Fund, but we still await the UK’s increased pledge 12 months after the publication. DFID have cited a desire to see reforms at the Fund as a reason for the delay.⁴

3. The unprecedented decision to cancel round 11 funding grants, effectively postponing scale up of interventions until 2014, is a cause for grave concern. The Global Fund replenishment meeting held in New York in 2010 aimed to raise $20 billion, with a minimum of $13 billion, but only raised $11.7 billion. If the Global Fund is to sustain progress and ensure investments made to date are not rolled back it is essential that the UK Government makes its future pledge as soon as possible to solidify confidence in the Fund and ensure the financial sustainability of the organisation. We welcome the assurances from the UK Government that it stands ready to make a new commitment, above and beyond its existing pledge,⁵ and ask that the increased amount is released as a matter of urgency.

THE PROSPECTS FOR DFID ACHIEVING ITS DEVELOPMENT OBJECTIVES IF CURRENT FUNDING SHORTFALLS AT THE FUND ARE NOT ADDRESSED

4. DFID’s bilateral aid spending on HIV and AIDS has decreased by over 30% since 2010.⁶ In response to criticism of this decision, DFID has confirmed that this does not represent a reduction in its spending, as funding will be channeled through multilateral institutions—primarily the Global Fund. HIV remains the leading cause of death for women of reproductive age Worldwide⁷ and TB is among the three greatest causes of death among women aged 15–44.⁸ Efforts to improve maternal and child health cannot be met without tackling the HIV and TB pandemics. A further delaying of DFID’s contribution to the Global Fund will have a detrimental impact upon DFID’s own efforts to tackle maternal and child mortality, including Millennium development Goals (MDG’s) 4, 5 & 6,⁹ as well as upon its commitment to reduce HIV infections.¹⁰

5. TB remains the leading cause of death for people living with HIV and AIDS Worldwide and with the cancellation of round 11, potential gains in TB and HIV control will be lost. The WHO Stop TB Partnership estimates that over the next five years, 3.4 million people will go untreated for TB. 1.7 million people will lose their lives to this disease, that is both treatable and curable.¹¹

¹ http://www.appghivaid.org.uk/
² http://appg-db.org.uk/
³ About the Global Fund, who we are—http://www.theglobalfund.org/en/about/whoweare/
⁴ http://www.theyworkforyou.com/debates/??ds=2012-03-14a.243.5&sf=global+fund#g244.1
⁵ DFID response to Parliamentary question (94889) from Ivan Lewis MP—http://bit.ly/H0GE4E
⁹ DFID response to Parliamentary question (101685) from Andrew George MP—http://www.publications.parliament.uk/pa/cm201112/cm翰ansrd/cmn120326/text/120326w0002.htm#120326w0002.htm_ssbhd62
The Impact on People in Developing Countries from the Delay in Funding of New Grants

6. The Global Fund is the largest international financier of the three diseases. It supports 83% of international financing provided to fight TB, two thirds for malaria and half of all Anti-retroviral drugs to people living with HIV and AIDS. It also funds health systems strengthening, as inadequate health systems are one of the main obstacles to scaling up interventions to secure better health outcomes for HIV, TB and malaria.12

7. Assurances from DFID that the impact of the absence of Round 11 will not be felt on the ground are contradicted by evidence from civil society organisations who are working in the field. MSP13 have reported that in the Democratic Republic of the Congo, the number of patients starting on Anti-retroviral therapy in 2011 was 80% lower than in 2010. Uganda will not be able to implement its plans to double the number of people newly initiated onto ART to 100,000 per year, as it had planned to do. The International HIV and AIDS Alliance predict that ART shortages could affect 112,000 patients in Zimbabwe by 2014, and plans to expand TB screening to people living with HIV in Zambia will suffer.

8. Approximately 157,286 patients in Africa are at risk of TB due to the funding crisis. In Tanzania where the Fund provides 39% of the TB budget, 45,637 TB patients are at risk of not receiving treatment. 68,000 people will go undiagnosed, 6,000 of these will be children. Tanzania’s TB grant runs out in November 2012 and although Tanzania is eligible for the TFM, they will not be able to scale up any services, or reach new patients.14

9. Critically, the Transitional Funding Mechanism created by the Fund to cover essential services following the cancellation of round 11 to prevent disruption of existing programmes does not cover any scale up of treatment at a time when scientific evidence15 and tools16 are available to make significant headway in combating HIV, TB and Malaria. To scale back from the global response to these diseases would not only reverse these incredible gains, but also increase future costs.

The UK’s Role in Influencing other International Donors

10. The UK can play a pivotal role in influencing other donors to respond to this crisis. Historically the UK Government has played a significant role in leading global efforts on International Development, as witnessed at the 2005 G8 summit, and in 2011 with its galvanizing of international support for GAVI. Such leadership should be applauded, and should continue.

11. We welcome the role that the UK has hitherto played in encouraging international donors to release and increase their contributions to the Global Fund following the cancellation of round 11,17 and recognise that much work has been done behind the scenes in encouraging other donors to pay on time.

12. However, we feel that more urgent efforts are required to leverage additional resources, and recommend that the UK Government should support calls for an emergency replenishment conference at the G20 in Mexico. By supporting such a replenishment moment which brings together a broad range of nations, the UK could help to leverage additional resources from other governments including Australia, Spain and Germany as well as emerging economies who could bear a greater proportion of the response to the three diseases.

13. In short, if the UK Government was to support a specific replenishment moment like the G20 there would be a greater opportunity to generate the pressure and scrutiny needed to secure additional resources from other governments.

Reforms Undertaken by the Global Fund to its Management and Business Model, and Improve Risk Management

14. It is essential to ensure that funds are handled appropriately. We welcome the highly transparent approach taken by the Global Fund, and the steps it has taken to quickly investigate allegations of indiscrepancies in its country programmes.

15. Following an independent high level panel report on the Global Fund, which outlined that the Fund needed to focus more on its core business of managing grants to save and protect lives, a Consolidated Transformation Plan18 was put in place by the Fund to implement the panel’s recommendations.

16. We understand that significant progress has been made with the plan. The appointment of Gabriel Jaramillo as General Manager, who was on the independent high level panel ensures that reforms are at the heart of GFATM going forward. We note that with a British senior civil servant, Simon Bland chairing the board at the Global Fund, the UK is in a very strong position to ensure that these reforms are implemented with rigour.

17 DFID response to Parliamentary Question (98536)—http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120312/text/120312w0004.htm#120312w0004.htm_sbd40
18 http://www.theglobalfund.org/en/board/meetings/twentyfifth/
17. We also note that, in contrast with other multi-lateral institutions, the Global Fund has been ranked by DFID as performing very highly on transparency and accountability:

“The global funds’ generally good performance on accountability is more than matched by their high degree of transparency. All of them have a disclosure policy with a presumption of openness, and in most cases policy and project documentation”\textsuperscript{19}

18. Whilst recognising the utmost importance of ensuring that the Global Fund is managing its resources appropriately, we do not think that these bureaucratic reforms should detract from the urgency of the financial situation at the Fund. The impact that the Global Fund’s programmes are having upon the world’s poorest people in developing countries cannot be understated. We must ensure it continues to have the resources available to continue the fundamental progress that has been made in recent years in the fight against the three diseases.

May 2012

Written evidence submitted by the Bill & Melinda Gates Foundation

1. \textbf{IMPACT OF THE GLOBAL FUND}

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has emerged as one of the single most important financing mechanisms for global health. Its impact on the lives of millions who might otherwise not have received life-saving health interventions has been both swift and tangible. Since 2002, investments in the Global Fund have financed innovative preventive and treatment programs in 150 countries with high burdens of disease. The Global Fund has provided antiretroviral treatment to 3.3 million people, detected and treated 8.6 million people with tuberculosis, and provided 230 million bed nets to families to prevent malaria, which have been key to the 20% decline in malaria deaths over the past decade. Most importantly, the Global Fund’s impact continues every day; its efforts save 100,000 lives per month and could save millions more by 2016.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{gates_fund_infographic.png}
\caption{A DECADE OF SAVING LIVES}
\end{figure}


The Global Fund operates as a multilateral organization and public-private partnership, which gives it a particular comparative advantage. At the Bill & Melinda Gates Foundation (the foundation), we have been particularly strong supporters of the multilaterals engaged in global health, as have the UK and other governments. We believe these organizations can be a highly effective way of coordinating aid and reducing duplication for all donors. We value greatly the cooperative relationship we have with DFID and other governments in regard to the Global Fund. The UK’s thinking has influenced our actions significantly.

2. \textbf{FUNDING SITUATION FOR THE GLOBAL FUND}

Between 2008 and 2010 the Global Fund invested $8 billion to fight AIDS (57%), malaria (29%), and tuberculosis (14%). Other than the bi-lateral U.S. PEPFAR program for AIDS, the Global Fund is the biggest single donor for all three of these diseases worldwide. Between 2011 and 2013, assuming that all donors honor their commitments, the Global Fund will disburse $10 billion. This will mark a $2 billion increase, but it will...

\textsuperscript{19} DFID Multilateral Aid Review (p 55) http://www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf
still fall short of the $12–$14 billion that is needed for the Global Fund to keep pace with its progress to date. Whilst the recent cancellation of a new Round of funding, replaced by a Transitional Funding Mechanism, will help to prevent life-saving programs from collapsing, it will not help us maintain momentum in tackling the epidemics.

Disruptions in funding have, in part, been a result of the Global Fund’s unique level of transparency. Fraud allegations that surfaced in news reports last year referred to only a small portion of the Global Fund’s total resources, but the allegations pushed some donors to delay payments. While headlines suggested that two-thirds of specific Global Fund grants were being misdirected, the evidence showed that less than 5% of Global Fund money was misused (affecting four of 145 countries and $34 million out of a total disbursement of $13 billion). Crucially, this fraud was discovered and reported publicly by the Global Fund itself, which has had a rigorous audit and investigation system in place since its grant-making began. The Global Fund’s commitment to efficiency and transparency, and its zero-tolerance for fraud, led to these problems being discovered and decisive actions to change the way it handles the grants in question.

Further reforms in grant management, oversight, and governance implemented by a maturing Global Fund, will continue to lead to improvements in performance. The adoption of these reforms has already resulted in increased donor confidence, including the Japanese government’s renewed commitment to fulfill its earlier pledges (despite the impact of the Tsunami), and a proposed U.S. pledge in 2012 to increase its own commitments. However, much remains to be done to keep the Global Fund financially secure.

3. OUR CONTINUED COMMITMENT TO THE GLOBAL FUND

The foundation invests approximately half of its resources in the area of global health, and it has been the largest non-governmental supporter of the Global Fund. We were also among the Global Fund’s earliest supporters, committing more than $650 million during its first decade. At this year’s World Economic Forum, we underscored our belief in the Global Fund and its work by announcing a new commitment of $750 million. This represents our largest single current grant foundation-wide and demonstrates our confidence in the Global Fund as a sound investment. However, while these funds are significant, they cannot come close to the billions needed from donor governments to sustain the Global Fund; OECD donors significantly outweigh Foundations as a whole in funding to any of the major multilateral organizations.

When he announced our new financial commitment to the Global Fund, Bill Gates continued to challenge global leaders to invest in innovations that are accelerating progress against poverty and disease—or risk a future where millions will needlessly die. He noted that while the world has made tremendous progress against AIDS, TB and malaria, much more must be done to achieve lasting progress. In his annual letter released in January 2012, Mr. Gates underscored his belief that donor governments should not turn their backs on the Global Fund, describing the stakes in human terms:

Citizens of donor countries should know about the difference their generosity has made. The cost of keeping a patient on AIDS drugs has been coming down, and it looks like getting it to $300 per patient per year should be achievable. That will mean every $300 that governments invest in the Global Fund will put another person on treatment for a year. Every $300 that’s not forthcoming will represent a person taken off treatment. That’s a very clear choice. I believe that if people understood the choice, they would ask their government to save more lives. (Bill Gates, 2012 Annual Letter, Bill & Melinda Gates Foundation)

4. DFID’S PROMINENT ROLE IN GLOBAL HEALTH AND THE GLOBAL FUND

DFID has long championed the Global Fund and, along with France and Japan, is among its largest contributors after the United States. The UK government has also led the way in evaluating the Global Fund and other global aid organizations for their effectiveness and efficiency. Aside from monetary support, the UK government’s consistent vocal public support for the Global Fund has encouraged other donor governments and has increased international confidence in the Global Fund’s work. This continued leadership, including the key role of Simon Bland as the Chair of the Board, provides us with continued confidence in the effective stewardship of our joint investment.

Bill Gates noted this year that our work with the Global Fund is “one of the most effective ways we invest our money every year” and asked other funders to join in getting so much “bang for our buck”. We know that the Global Fund (and other aid programs) face challenges in dealing with populations and places that are hard to reach, but we believe that to pull back on our collective commitment to reaching them is unacceptable.

APPENDIX

RELEVANT WEBLINKS

2012 Annual Letter from Bill Gates:
http://www.gatesfoundation.org/annual-letter/2012/Pages/home-en.aspx#global-health
Press Release on Gates Foundation’s 2012 Donation to the Global Fund:
May 2012

Written evidence submitted by the British HIV Association (BHIVA) and the Royal College of Physicians (RCP)

Comments
1. The Global Fund to Fight AIDS, Tuberculosis and Malaria supported by its international partners (including DFID) has been at the forefront of the global battle against HIV. Since its inception, it has funded and supported over 3.3 million people to receive life-saving Antiretroviral treatment (ARV). In addition, many more programmes have been in readiness to expand HIV testing and access to ARVs in Round 11 of the funding process. This has now been suspended and an interim Transitional Funding Mechanism has been proposed whilst the Global Fund reviews its financial position and future funding.

2. As a result of this, there are a number of issues about which we have critical concerns. As organisations representing healthcare professionals our concerns focus on the impact of the current situation on individuals and communities living with HIV in the developing world and on the global public health impact of these measures:

(a) ARV treatment is treatment for life; any interruption in therapies for individuals would have a devastating effect not only on the health of the individual but also within the wider community. The SMART study (Smart Study Group, New England Journal of Medicine, 2006) a study that examined interrupted ARV versus continuous ARV as a strategy for managing HIV was stopped early because of an alarming increase in death rates in the interruption arm. This is now universally regarded as bad practice. Moreover, interruption of ARV will lead to development of resistance to ARV in some individuals. Transmission of resistant viruses will have a significant impact on future therapy options for the community. Increase in HIV virus resistant to first-line treatment has already been seen in Africa and Asia (Fentz D, AIDS Review; 14: 17–27: 2012).

(b) Many of the Global Fund and PEPFAR funded ARV programmes in the developing world have been using “older”, cheaper first-line therapies (eg zidovudine and stavudine). Stavudine has recently had restrictions imposed on its license for use in Europe by the EMA that have an increased propensity to significant side-effects. Recent WHO HIV treatment guidelines (http://www.who.int/hiv/pub/arv/adult2010/en/index.html) suggest using tenofovir-based first line therapy. Many national programmes in sub-Saharan Africa, in particular, have been slow to adopt these and switch therapies appropriately primarily due to funding constraints. Freezing of round 11 of funding will have a further impact in that many more patients will remain on potentially toxic medication.

(c) There is increasing evidence that patients on long term first-line ARV therapy in the developing world are beginning to develop failure (see El-Khatib, AIDS 2010; 24: 1679–87, for data from South Africa) and are in urgent need of more expensive second-line therapies. Furthermore, there is a need to increase investment in infrastructure to support adherence to treatment regimens, early identification and treatment of co-morbidities, particularly TB and early and cost-effective identification of treatment failures. This is a time for increased investment to consolidate the gains achieved by ARV rollout in the developing world.

(d) There are a number of key strategies in preventing the spread of HIV infection currently being discussed and researched (see WHO Consultation November 2011, http://www.who.int/hiv/pub/meetingreports/consultation_20111116/en/index.html). These include the strategic use of ARV “treatment as prevention”, oral and topical pre-exposure prophylaxis, and universal access to ARV as prevention of Mother-to-child transmission of HIV. Technical updates and rapid advice for HIV treatment and testing will be released shortly by the WHO. National programmes will need to be in a position to respond to this. It is therefore crucial that the impetus created by the Global Fund and its partners is not lost at this stage.

3. For all the above reasons, and many more, we believe that the current funding hiatus within the Global Fund to fight against AIDS, Tuberculosis and Malaria will not only have a significant impact on individuals living with HIV/AIDS but may well have a deleterious effect on the global war against HIV/AIDS.

British HIV Association (BHIVA)

BHIVA has become the leading UK professional association representing professionals in HIV care. Founded in 1995, it is a well-established and highly respected organisation with national influence committed to providing excellence in the care of those living with and affected by HIV.

BHIVA acts as a national advisory body to professions and other organisations on all aspects of HIV care. BHIVA also provides a national platform for HIV care and contributes representatives for international, national
and local committees dealing with HIV care. In addition, BHIVA works to promote undergraduate, postgraduate and continuing medical education within HIV care.

The current membership of the association is over 1,000 across a wide range of healthcare professionals and other HIV healthcare workers. Membership benefits include subscription to the key journal HIV Medicine, BHIVA E-Newsletter, BHIVA National Audit Report and BHIVA Treatment Guidelines.

May 2012

Written evidence submitted by the Eurasian, Harm Reduction Network

PRELIMINARY ANALYSIS OF POTENTIAL IMPACT ON THE HIV/AIDS SITUATION IN SOME EECA COUNTRIES RESULTING FROM CHANGES IN THE GLOBAL FUND’S GRANT POLICIES

This preliminary analysis is based on the information received from representatives of EECA countries who participated in the regional consultation “Responding to the Global Fund’s Financial Crisis in Eastern Europe and Central Asia”, organized by EHRN in Vilnius on 26–27 January 2011.

ARMENIA

Information below on Armenia is provided by a number of Global Fund sub-recipients:

“AIDS Prevention, Education and Care” NGO.
“AIDS Prevention Union” NGO.
“ATV” NGO.
“Education in the name of Health” NGO.
“Family Benefactor” NGO.
“New Generation” NGO.
“Positive People Armenian Network” NGO.
“Public Information and Need for Knowledge” NGO.
“Real World, Real People” NGO.

During the recent CCM meeting, held on 6 March 2012, the NGO PR representative, presenting the final version of the budget, declared that a meeting with sub-recipients had been organized earlier and all the budget amendments were coordinated with them. We assert that no such discussion was held. Only overall figures were represented to us, ie the amount of reduction that would be made for each SDA (Service Delivery Area). What is more, the letter from NGO PR sent to all sub-recipients on 23 February 2012, contained no financial information, it only informed on the place, date and time of the meeting. The minutes of the meeting with the sub-recipients, held on 29 February 2012, contain the following record: “Yelena informed that if the RCC Grant Phase 2 Proposal is approved by the Global Fund, NGO PR will start discussing the budget of each SR (Sub-recipients) separately to make the reductions within the SRs budgets.” (See the attached minutes).

The document “NGO_PR_CCM Request for RCC Continued Funding_Mar01_2012” presents the made reductions, however without any explanations. In particular, on page 33 there is a short list of budget cuts for the projects aimed at the key populations at higher risk, including care and support projects.

— Reduced activities for SWs (SDA1.2.3) 40,434 Euro.
— Reduced activities for MSM (SDA1.2.3) 31,108 Euro.
— Reduced activities for IDUs (SDA1.2.3) 450,062 Euro.
— Reduced harm reduction activities (SDA1.4) 600 Euro.
— Reduced activities for youth (SDA 1.5) 805,070 Euro.
— Reduced activities for care and support (SDA 2.2) 95,936 Euro.
— Reduced activities for NGO capacity building (SDA 3.1) 571,859 Euro.

The minutes of the meeting with the sub-recipients held on 24 February 2012, contain the record: “Yelena told that reducing the budget NGO PR applied a unified approach to all SRs while cutting both programmatic and administrative expenses of the projects with an ultimate goal to reach more beneficiaries with limited funding. This is the requirement of GF in light of current resource constraints and the changes require efforts from all stakeholders involved in the project.”

If so, the question arises, while the programmatic and management costs for important services provided by the sub-recipients to the vulnerable groups are reduced, why the PR management cost is increased by EUR 160,020. In what way this only increase in all the budget lines could improve accessibility to the necessary services for vulnerable groups?

It is not clear either how the increase of PR budget alongside with reduction of program expenses of the sub-recipient could contribute to the maintaining the coverage of the vulnerable populations by the services. Why the management budget has been increased while the number of sub-recipients has been reduced? Thus,
the funding of “AIDS Prevention, Education and Care” NGO (carries out HIV/AIDS prevention among youth), and of the Armenian National AIDS Foundation (deals with information materials development, contributes to the functioning of User Friendly Clinic for key populations at higher risk, provides trainings on NGO capacity building) has been cut off.

The only explanation regarding the increase in the NGO PR’s management budget, given in the “NGO_PR_CCM Request for RCC Continued Funding_Mar01_2012” document, is that “this increase was discussed with the Portfolio Manager”.

As a result of the budgets reduction, which was not coordinated with NGOs, the implementation of the whole RCC grant is under the threat. We are concerned about reducing the mass media campaigns. The Global Fund has not set such requirement for the programs as to stop the mass media campaigns. The mass media campaigns, requiring low costs (1% of the NGO sector budget, about AMD 3 per beneficiary, at the rate of EUR 1=AMD 500), are one of the key components of the HIV prevention at the national level, and they help to coordinate the HIV awareness of the general population, to form the same constructive attitude towards vulnerable populations and PLHIV. However it is suggested cutting of funding the mass media campaigns.

Another example—NGO PR requires increasing workload for outreach workers by 70% (85 beneficiaries per one outreach instead of former 50 beneficiaries). That is impossible, since to maintain the quality of the performed activities, when there is such a considerable workload increase, it would be necessary to provide additional training for the outreach workers and psychological support to prevent professional burnout. But the PR requires only increasing productivity against reducing the costs for development.

Belarus

What was included in the Round 11 country proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

According to WB, Belarus belongs to the category of Higher Middle Income countries, so the country could (and was planning to) apply with a proposal to support activities targeting IDUs only (HIV prevalence is 13.3%, according to 2011 sentinel surveillance data); therefore, the budget cannot exceed 12.5 million for five years. According to the UNDO representative (GF grants PR in Belarus) no any specific activities were developed and included into the application before the cancellation of the Round 11 was announced.

Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

Round 10 proposal from Belarus did not pass prequalification because of a violation of the CCM voting procedure.

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and the budget? What impact would this have?

According to the respondent, within Phase 2 of Round 8 grant cuts were made to the budget line “Pharmaceutical Drugs”—the budget was reduced by €1,151,358 due to the reduction in GF funding of the procurement of ARV drugs for 2012–14 (initial budget of the second phase was €12,841,716). This was done based on Belarus commitments to begin funding 40% of the need for ARV drugs in 2012 that the country made in the framework of the initial Round 8 proposal approved by the Global Fund.

At the same time, according to a dialogue between Belarus CCM members and representatives of the Global Fund “in case of overspending in the state budget and the grant budget on ‘ARV drugs’ we will procure a realistic number of treatment courses from the grant money, less the amount of procured drugs that will be purchased using the state budget; the overspending will be covered from other grant budget lines, on agreement with the CCM and the Global Fund. Particularly, in 2010–11 the budget for ARVs and opportunistic infections treatment exceeded the budget by €460,994, which became possible due to cutting the costs of other activities”. The same strategy is being planned for Phase 2, ie compensate “overspending” for treatment by making cuts to the budget for other activities.

On 16 January 2012 CCM received a letter from the Global Fund with the invitation to apply for the second phase within RCC and also informing about the 25% reduction in Phase 2 RCC funding and the need for the reprogramming of grant activities in order to focus the 100 % of proposal funding on vulnerable groups and specific services for them. This change could lead to the slowdown of the HIV prevention programs in country and could force the country to discontinue the programs that target rural youth, university students, and the general population. Vulnerable groups are understood as those groups that have epidemiological significance—for Belarus they are IDUs, CSWs, MSMs and prisoners. This change will have a significant impact on the activities of organization such as BelAU, ABG, Alternativa, Association BelSet AntiSPID and others SRs.
**Ev w8  International Development Committee: Evidence**

Is it expected that the current grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

The reprogramming of the program activities within second phase RCC is planned in accordance with the GF requirements—100% of activities will be targeted on vulnerable groups. As it was mentioned earlier this may lead to the slowdown of the HIV prevention programs in country and could force the country to discontinue the programs that target rural youth, university students, and the general population.

Belarus CCM asked GF Secretariat to shift the deadline for RCC application from 15 March to 15 April and this was approved.

According to the respondent, there are no plans as of yet regarding the reprogramming of the active grants and submission of grant proposals in the framework of the Transitional Funding Mechanism. According to the results of EHRN analysis confirmed by GF Secretariat staff, Belarus cannot apply in the TFM framework.

**Kyrgyzstan**

What was included in the country’s Round 11 proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

Kyrgyzstan could not apply for HIV funding because of the “recent funding” policy (countries cannot submit their proposals if their recent application for the same component was approved by the Global Fund Board, and less than 12 months have passed between the beginning of grant implementation and the submission of the new proposal). They were planning to submit a TB proposal which did not entail an expansion of current services, focusing on treatment.

Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

No information is currently available.

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and budget? What impact would that have?

According to the respondent, no cuts have been made to the HIV component funding yet, but there are ongoing delays of funding for sub-recipients, which has an extremely negative impact on the implementation of the projects that target MARPs.

Is it expected that the current grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

Kyrgyzstan cannot submit a proposal for TFM, neither for HIV nor for TB.

**Moldova**

What was included in the country’s Round 11 proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

Moldova was preparing a proposal in the framework of the second wave of the national strategy applications.

Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

Moldova does not have any Round 10 grants.

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and budget? What impact would that have?

Currently Moldova is implementing two HIV grants (Rounds 6 and 8); those were consolidated according to the Global Fund’s new funding architecture and the Single Stream of Funding mechanism.

All activities and services related to HIV treatment (ARV treatment, testing systems, prevention of vertical transmission—from mother to child, treatment of opportunistic infections, etc.) as well as the set of HIV prevention services targeting vulnerable groups (needle exchange, substitution therapy with methadone, condoms) were included in the Round 6 proposal which comes to an end on 31 December, 2012, which indicates the threat of cuts to lifesaving services.

The Round 8 grant does not include funding for treatment and prevention among vulnerable groups, but the project practically includes a full list of psychosocial support services to ensure access to quality treatment and increase adherence to treatment through case management, including material aid and food aid.
According to the Global Fund requirements, before submitting a TFM proposal (this means addressing funding of those activities that may be finished once the Round 6 grant ends through the TFM), a country must confirm that those funding needs cannot be addressed through other sources of funding, including through reprogramming the budgets of the Global Fund's active grants. That is why civil society representatives in Moldova are worried that all those services and activities that will not be considered “essential” (for instance, the work of social regional centers for PLHIV, psychosocial support for PLHIV and their family members in the regions of Moldova (outreach work in the territories), psychosocial support for IDUs and OST clients (the work of four centers for drug users, including in the penitentiary system), material aid to children, etc) may be cut, and relevant budgets may be reprogrammed towards the “essential” needs.

Is it expected that the current grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

Moldova is eligible to apply for HIV funding in the TFM framework, because on one hand it is the only EECA country that prepared its proposal for the second wave of NSA (and according to the Global Fund TMF newsletter, countries that participate in the second wave of NSA are also subject to the Global Fund Board’s decision to establish the TMF. Proposals submitted in the framework of the second wave of NSA must conform to all TMF eligibility criteria; in particular, they must be aimed at receiving funding for the continuation of core prevention, treatment and/or support interventions).

On the other hand, Moldova is implementing Round 6 and 8 HIV grants. In summer of 2011, those grants were combined into a single grant in the framework of the Single Stream Funding approach. The date of finalization of that grant is beyond the agreed-upon period: 1 January 2012 to 31 March 2014. Yet, funding to procure ARV drugs will be depleted in 2012. This is another reason why Moldova may be eligible for TFM funding.

RUSSIA

What was included in the country’s Round 11 proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

Russia could apply for Round 11 HIV funding only within the “NGO Rule”: those countries with Higher Middle Income level that are not part of the OECD list of the Development Assistance Committee cannot apply for HIV funding, except when a proposal is submitted by non-governmental organizations in the country where the implementation will take place.

In addition, it was possible to apply only for funds from the targeted budget (five million USD for the first two years, 12,5 in total for five years), and the proposal had to target vulnerable groups.

Several NGOs from Russia were planning to apply for Round 11 funding independently of each other (OHI, ESVERO, AIDS Infoshare + ARF, PSI, AFEW, possibly others). In the GLOBUS framework the Consortium was working with all target groups, but since the funding levels and conditions for proposal submission had changed, OHI were preparing to submit a proposal that only targeted IDUs, for $12.5 million for five years, with planned coverage of over 21,000 IDUs in 25 Harm Reduction projects. ESVERO and AIDS Infoshare + ARF were planning to submit proposals focusing on the same target group. PSI was planning to focus on MSM, and AFEW on the penitentiary system.

Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

Russia could not apply for an HIV grant in Round 10. A grant on TB was approved but it has not been signed yet. And there is a possibility that it will not be signed at all—in its letter of 21 December 2011 (Ref: EECA/NC/406–21/12/2011) the Global Fund informed the CCM in the Russian Federation of its decision to provide an extension until 15 March 2012 of the deadline to complete the Round 10 TB Grant negotiations and signing. This exceptional extension was granted on the condition that national stakeholders utilize the extension period to finalize grant negotiations by defining appropriate ways and consensus among all CCM constituencies, national stakeholders (with the assistance of the WHO) to implement the Grant. Consequently, the CCM had to define appropriate ways and reach the necessary meaningful consensus among all the CCM constituencies and stakeholders involved in TB control in the Russian Federation to implement the Round 10 TB proposal. However, no any substantial progress has been achieved yet. What will be the final decision of the Global Fund Secretariat on this issue is unclear now (as at 20.03.2012).

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and budget? What impact would that have?

Russia does not have Round 8 and 9 grants for HIV or TB.
Ev w10 International Development Committee: Evidence

Is it expected that the current grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

Russia does not have active HIV grants. Round 3 grant (OHI) was finished on 31 December 2011, and Round 4 (RHCIF) and 5 (ESVERO) were finished on 31 August 2011.

According to the Global Fund Secretariat, however, Russia can apply for funding in the TFM in accordance with the “NGO Rule” to continue the services that were implemented in Round 3.

NGO ESVERO, whose grant has officially came to an end but in reality is still being finalized, has managed to successfully advocate for being eligible to apply for the continuation of funding for Round 5 HIV project within the TFM. The Board approves, on an exceptional basis, for the RUS-506-G05-H grant that an application may be submitted for funding under the Bridge Funding Mechanism in the context of the Transitional Funding Mechanism (“BFM”), as well as to the Transitional Funding Mechanism (“TFM”).

In the case the applications will not submitted or approved, this would mean the end of harm reduction programs in Russia for the coming years, because according to a 2011 OHI survey “Potential sources of funding of the Foundation”, the Global Fund is currently the only possible source of funding for network programs that focus on HIV/AIDS prevention among IDUs in Russia.

Altogether, about 75 projects focusing on HIV prevention among IDUs were discontinued at the same time as the HIV grants from the three rounds were finished. In addition, services for other groups were discontinued as well (17 projects for MSM, about 30 for CSW, etc.) ESVERO alone covered 143,000 IDUs during five years.

UKRAINE

What was included in the country’s Round 11 proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

Ukraine was not eligible to submit a proposal for Round 11 in accordance with the “recent funding” criteria: its Round 10 HIV proposal had been approved. Therefore, a relevant proposal was not prepared. Possibilities for applying for an HSS proposal were reviewed but according to the respondent no specific decision on that has been made.

Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

According to the respondent, the proposal underwent significant changes, as the implementation of the Round 10 grant in Ukraine is split between three Principal Recipients. The main changes resulted from a crossover between Rounds 6 and 10. Financing of Phase 1 was reduced by 10%. Funding for a pilot project on viral hepatitis was removed altogether, and the projects dedicated to Community Systems Strengthening were reduced.

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and budget? What impact would that have?

Ukraine does not have Rounds 8 and 9 HIV grants.

Is it expected that the active grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

According to the respondent, this is irrelevant for Ukraine as of yet. TFM—Ukraine cannot apply for TFM funding because of the same “recent funding” criteria. But Ukraine can apply for an extension of the active grants.

GEORGIA

What was included in the country’s Round 11 proposal, and what amount of funding would have been requested if the Round took place? What opportunities were lost because of the cancellation of Round 11?

Georgia initially was not eligible to apply for Round 11 HIV grant because of the “recent funding” requirement. They tried to use the flexibilities of this requirement and to prepare a proposal which will cover either other geographical area or to be targeted on other issues rather than their Round 10 proposal but their draft concept of such proposal was rejected by the GF at the end of August 2011.
Round 10 grant: what services and types of activities have been/will be cut and what amount has been cut from the proposal’s final budget?

Round 10 grant was consolidated with previous Round 9 HIV grant within SSF and according the representative of the Georgian HR Network (SR of the GF grant) the second phase budget of this grant to be cut up to 25% but these cuts will not concern the HR part.

Phase 2 of Round 8/9 grants (or earlier grants): are there any concerns about possible cuts to services/activities and budget? What impact would that have?

According to the Georgian HR Network no cuts and reprogramming of activities planned within Round 9 grant (which was consolidated with Round 10 grant) are expected.

Is it expected that the active grants will be reprogrammed? What would that entail, and what consequences are expected? Is the country planning to submit proposals in the framework of the Transitional Funding Mechanism?

No information available yet.

May 2012

Written evidence submitted by Gender and HIV, UK Consortium on AIDS and International Development

The Working Group on Gender and HIV of the UK Consortium on AIDS and International Development welcomes the opportunity to respond to this enquiry. The Working Group is a forum for deepening debate and sharing expertise on the issues related to gender and HIV and AIDS in order to advance more effective policy and practice.

Globally women now represent over 50% of people living with HIV, and in sub Saharan Africa this proportion rises to 59%. HIV prevalence is three to eight times higher among women aged 15–24 than it is among men in the same age group. Violence against women fuels the HIV epidemic wherein up to 71% of all women experience physical or sexual violence in their lifetime. As HIV has emerged as the leading cause of mortality among women of reproductive age in this region as elsewhere, the urgency for increased financing to address the gender dimensions of the pandemic have become apparent.

The Prospects for DFID Achieving its Development Objectives if Current Funding Shortfalls at the Fund are Not Addressed

The Coalition Government has stated that investing in girls and women in every area of their work is one of the top priorities for DFID and has issued revised policy guidance to reflect this renewed commitment. Policy analysis of two of these health strategies published by the Global Coalition on Women and AIDS argued that “continued funding support to networks of women living with HIV and other women’s groups is essential to assist DFID to achieve its targets for the health and well-being of women and girls.”

Additionally DFID published “A new strategic vision for girls and women: stopping poverty before it starts” detailing interventions to improve access to; education, resources, family planning and strategies to combat violence against women. The UK Consortium on AIDS recently released a report responding to DFID’s expression of the need to demonstrate how action in these four areas could be synergized with HIV and AIDS interventions. The report pointed out that DFID relies on their grant to the Global Fund to reach two important indicators: the number of HIV positive women provided with treatment to prevent vertical transmission of HIV and the number of people receiving treatment for AIDS (a figure which is not gender disaggregated either by DFID or the Global Fund).

In November 2008, the Global Fund Board approved a Gender Equality Strategy, which set strategic directions to ensure the grant portfolio could address the gender related vulnerabilities to poor health. The strategy intended to provide countries with an opportunity to ensure that biomedical services would address inequalities in health service access as well as respond to structural drivers that increase vulnerability to the three diseases, HIV in particular.

An evaluation of the Gender Equality Strategy undertaken in 2011 revealed that it has not been fully operationalized within Global Fund Secretariat operations or at country level in Country Coordinating Mechanisms. A global survey of women’s organisations undertaken within the evaluation found that awareness of the strategy was low in many countries. Survey respondents called on the Global Fund to set a dedicated channel of funding in the next Round for grants which directly respond to the Gender Equality Strategy. In November 2011 the Global Fund Board endorsed a Five-Year Strategy (2012–16) which provides key opportunities to reassert the importance of integrating gender equality into grant management including through the promotion of human rights. Regrettably this opportunity is now restricted by the suspension of grants.
THE IMPACT ON PEOPLE IN DEVELOPING COUNTRIES FROM THE DELAY IN FUNDING OF NEW GRANTS

We are concerned that restricted granting from the Global Fund will severely limit the options for continued and expanded HIV services to meet the needs of women and girls and address the structural drivers of HIV. Quotations taken from “Surviving the Global Fund Crisis: What next for women?”

“In Tajikistan women do not have access to quality health care services because they do not have their own money. Support is aimed at injecting drug users, mainly men, and many women are denied. Women with HIV are in a difficult situation...if the Global Fund will not support people living with HIV, women in particular will suffer and the death rate from AIDS will be even higher. If there is no support for lobbying the interests of women and children and especially pregnant women, the rate of babies born with HIV will be higher year on year. We need ARVs, PMTCT, advocacy and lobbying for the rights of women with HIV. We could not do without the care and support of the Global Fund.”

“Through the Global Fund women are getting treatment and care. They can then work as role models in the community to prevent HIV in the new generation. If the Global Fund reduces its support then there is no other option for women to continue their treatment in Nepal. Most of the women living with HIV are single mothers with children with and affected by HIV and they have no source of income to buy medicine, improve nutrition and get medical tests. It will reverse the work that has been done to make life longer and prevent HIV in new people...it will revert to how it was in the early stages of HIV.”

“The Global Fund must continue to invest in women’s health because women still bear the brunt of the HIV epidemic. Women still do not have access to information and services—some are forced to walk long distances to go to a health centre...In Zimbabwe, poverty and other socio-economic factors prevent significant numbers of women and children living with HIV from accessing treatment. Problems with purchasing ARVs, drug stock-outs and user fees prevent more women from accessing treatment. 51.6% of adults and children are still in need of treatment and women account for half of those.”

The impact on community based women’s organisations engaged in HIV and AIDS service provision as recipients of Global Fund grants could take years to reverse. DFID has moved away from funding such organisations because they are considered “too small” and since the UK’s overseas development aid is increasingly delivered through budget and sectoral support. The need for community based solutions for effective HIV prevention strategies targeted to women and girls and to avert obstacles and abuses faced by women living with HIV and others in the public health system are key to controlling and reversing the pandemic. There is an on-going need for increased funding for organisations and networks of women living with HIV and other women’s organisations to provide quality services that respond to the needs and respect the rights of affected women.

THE UK’S ROLE IN INFLUENCING OTHER INTERNATIONAL DONORS

The Global Fund Gender Equality Strategy was significantly supported during its development and launch in 2008 by Germany and has been monitored by Canada and other governments. Through their engagement with the Global Fund’s reform process DFID should serve as a champion to action the strategy by ensuring that there is greater support for women’s organisations and networks of women living with HIV who are pushing for CCM commitment. DFID should provide technical support or leverage UNAIDS to help build capacity for community based women’s organisations to understand Global Fund processes, develop relationships within the CCM and determine how they can maximize the potential for funding from the Global Fund in the future and fill current funding gaps.

REFORMS UNDERTAKEN BY THE GLOBAL FUND TO ITS MANAGEMENT AND BUSINESS MODEL, AND IMPROVE RISK MANAGEMENT

The Consolidated Transitional Plan released by the Global Fund indicates that, “alignment of the Secretariat’s workforce to bolster grant management, including immediate strengthening of Country Team Approach (CTAs) will be prioritised.” This revised approach must prioritise building staff capacity to action the Gender Equality Strategy, importantly among Fund Portfolio Managers and Finance Officers. Unpublished research undertaken at the London School of Hygiene and Tropical Medicine revealed barriers to the implementation of the Gender Equality Strategy within the Secretariat including a lack of dedicated training for key staff and low buy for the approach among those involved in day to day grant management. DFID’s engagement with Global Fund reform processes should ensure that staff leadership for the Gender Equality Strategy is not diminished but that ownership is explicit and strengthened to ensure its full and effective implementation.

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ix UK Consortium on AIDS and International Development. Girls and Women: Mainstreaming planned pregnancies, safe births and healthy newborns. The UK’s Framework for Results for improving reproductive, maternal and newborn health in the developing world

x DFID (2010) Choices for women: planned pregnancies, safe births and healthy newborns. The UK’s Framework for Results for improving reproductive, maternal and newborn health in the developing world

xi As asserted by the Social Drivers working group of the AIDS 2031 research consortium the key dimensions of the social, political and economic context, referred to as structural factors, are essential in shaping HIV and health outcomes. AIDS 2031 Working Paper 24. http://www.aids2031.org/docs/aids2031%20social%20drivers%20paper%2024-auerbach%20et%20al.pdf


xiv This approach had been used in Round 9—a Most at Risk Populations channel which funded proposals that specifically targeted key populations including men who have sex with men, sex workers and injecting drug users.


March 2012

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**Written evidence submitted by Health Poverty Action**

**Health Poverty Action**

Health Poverty Action (www.healthpovertyaction.org) has a vision of a world in which the poorest and most marginalised enjoy their right to health. The organisation was first formed in 1984 by a group of doctors and now operates programmes in thirteen low and middle income countries, with an annual budget of approximately £9 million and 450 staff. Health Poverty Action works with communities in Africa, Asia and Latin America, often in very difficult environments, to enable them to achieve immediate and long-term health improvements, promoting this as their fundamental human right. We improve health care comprehensively, strengthening health systems while also addressing the social determinants of health.

Health Poverty Action has reached more than 1.5 million people with programmes funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) over the last five years, mainly targeting malaria and tuberculosis (TB). For example, in the China/Myanmar border region, where resistance to antimalarial drugs is high and treatment of falciparum malaria had been difficult, we have helped to reduce the prevalence of the malaria parasite from 13.63% to 2.78%.
Ev w14 International Development Committee: Evidence

INTRODUCTION

Health Poverty Action welcomes the International Development Committee’s (IDC) one-off evidence session on the Global Fund. Between 2002 and 2010 the Global Fund’s programmes are estimated to have saved at least 6.5 million lives by providing antiretroviral medicines to three million people, diagnosing and treating 7.7 million cases of tuberculosis and distributing 160 million insecticide-treated mosquito nets.20 The Department for International Development (DFID) has assessed the Global Fund as one of the strongest multilateral agencies in its Multilateral Aid Review (MAR) and as “critical in the delivery of health related MDGs”.21

In its first decade the Global Fund has operated on the basis of a demand-based model, disbursing grants to 150 countries that demonstrated the need to address the three diseases covered by its funding portfolio. Its minimal in-country presence enabled country ownership in setting priorities. The significant inclusion of middle income countries in the portfolio ensured that marginalised communities in those countries were also able to benefit from the Global Fund’s programmes. In recent years the Global Fund has also increasingly acknowledged the need to bolster the fight against the three killer diseases through health systems strengthening, community systems strengthening and civil society engagement.

Recent announcements of the transformation of the Global Fund’s modes of working and funding and in particular the cancellation of Round 11 give rise to concern, however. Health Poverty Action would thus like to comment on the following issues raised in the terms of reference for the evidence session.

THE CURRENT FUNDING SITUATION OF THE GLOBAL FUND AND DFID’S CONTRIBUTION TO THE FUND

As detailed above, Global Fund programmes delivered by Health Poverty Action have benefited well over a million people, especially those whose lives have been saved as a result of vital treatment against malaria or (multi-drug resistant) TB. Health Poverty Action has, for example, delivered TB-treatment to extremely marginalised San communities in Namibia, which is classed as an upper middle income country. Or it has distributed bed nets and brought malaria education to marginalised areas in China. It will have to be monitored closely what effect the exclusion of upper middle income countries belonging to the G20 or the newly instituted thresholds of counterpart funding will have on the poorest parts of a country’s population. DFID can play an important role in monitoring the health equity effects of the changes in the Global Fund’s grant renewal policy.

Health Poverty Action is also concerned that at least until 2014 no stand-alone, cross-cutting Health Systems Strengthening requests will be accepted. Strong health systems and a well-trained health workforce are vital in delivering the services provided via Global Fund funding. In particular in fragile and post-conflict contexts health systems are often weak and the benefits of Global Fund programmes could reach far more people if health infrastructure was strengthened.22 DFID’s MAR of the Global Fund states “The Fund uses the same business model in fragile and non fragile states which causes some problems because of weak local capacity in Country Coordinating Mechanisms and in choice of Principal Recipient.” This weak local capacity often extends to capacity for health service delivery; and the deprioritisation of health systems strengthening thus directly conflicts with DFID’s development priority of supporting transformation in fragile states. DFID can contribute by sharing its experience on operating in fragile contexts and advise the fund on making its funding policies more context-specific.

THE PROSPECTS FOR DFID ACHIEVING ITS DEVELOPMENT OBJECTIVES IF CURRENT FUNDING SHORTFALLS AT THE FUND ARE NOT ADDRESSED

See the above point about health systems strengthening and adapting funding policies to fragile contexts.

THE IMPACT ON PEOPLE IN DEVELOPING COUNTRIES FROM THE DELAY IN FUNDING OF NEW GRANTS

Over the last year the Global Fund has been affected by a number of cases of fraud and has reacted on a zero-tolerance basis with immediate suspension of funds. While Health Poverty Action welcomes strict sanctions on corruption these often directly affect patients in low and middle income countries.

Health Poverty Action’s programmes have been affected in two instances and not only had to fear for the livelihoods of its mostly local employees whose salaries were funded by the Global Fund. More importantly, TB-patients in Tsumkwe in the Otjozondjupa region of Namibia faced discontinuation of treatment, including 66 cases of multi-drug resistant TB. The financial cost of treating cases of MDR-TB after an interruption would far outweigh the modest costs of curbing the serious public health threat at the time. Similarly there was an immediate suspension of malaria funds in the China/Myanmar border area at the beginning of the rainy season, potentially affecting the treatment of hundreds of malaria patients. We commend DFID and other partners for their flexibility in cooperating with us to meet the temporary shortfalls and therefore patients’ needs. But we would suggest that in future the Global Fund must evaluate disciplinary measures for each sub-recipient on the

22 The Global Fund Results Report for 2011 states: “based on data from 2002 to mid-2010 there were some differences in grant performance—especially in fragile states that had suffered recent humanitarian crises.” See Footnote 1, p. 48.
basis of their internal audits. If these have shown to be satisfactory there is no reason to suspend funding of these sub-recipients.

RECOMMENDATIONS

— DFID can play an important role in monitoring the health equity effects of the changes in the Global Fund’s grant renewal policy.

— DFID can contribute to Global Funds policy implementation by ensuring continued prioritisation of health systems strengthening, sharing experience on operating in fragile contexts and advising the fund on making its funding policies more context-specific.

— DFID should work with the Global Fund to develop mechanisms to address fraud in a manner that is least disruptive to patients’ treatment courses.

May 2012

Written evidence submitted by International HIV/AIDS Alliance

INTRODUCTION

1. The International HIV/AIDS Alliance (the Alliance) welcomes the opportunity to provide a submission to the International Development Committee for the evidence session on the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). We will draw on the Alliance’s extensive experience of working on Global Fund governance and policy at a global level as well as nationally as an implementing partner. Currently Alliance Linking Organisations (LOs) receive 10 Global Fund grants as Principle Recipients and 17 grants as Sub-Recipients.

2. Established in 1993, the Alliance is a global partnership of nationally-based linking organisations working in over 40 countries, to support community action on HIV/AIDS in developing countries. The Alliance recently reviewed the effects of the underfunding of the Global Fund in five countries: Bangladesh, Bolivia, South Sudan, Zambia and Zimbabwe and published its findings in the report, Don’t Stop Now: How Underfunding the Global Fund to Fight AIDS, Tuberculosis and Malaria Impacts on the HIV Response. These countries were, until the funding crisis, making solid progress towards reducing HIV infections and AIDS related deaths.

3. In November 2011, due to a funding shortfall, the Global Fund announced that its scheduled funding round (Round 11) was cancelled and no new grants could be funded until 2014. Reducing funding for HIV at this critical moment is counterproductive. Sustained, predictable and well-targeted investment is essential for continued progress in reducing HIV infections and AIDS related deaths.

KEY RECOMMENDATIONS

4. We urge the UK government to make a solid long term financial commitment to the Global Fund and use this announcement as a leverage to secure funding commitments from other donors. The UK needs to provide an additional £384 million for the replenishment period 2011–13.

5. The UK should leverage its leadership position and support the effort to secure a replenishment opportunity for the Global Fund at the forthcoming G20 meeting in June. This will be essential to ensure the scale up required to reach the health related MDGs.

PROGRESS UNDER THREAT IN THE HIV RESPONSE

6. UNAIDS data released in 2011 showed considerable progress in curbing the global pandemic. New HIV infections are at their lowest levels since 1997, an additional 1.35 million people are receiving HIV treatment in just one year and the potential to eliminate new HIV infections in children is in reach.

7. The new Investment Framework presented by UNAIDS and the landmark research on the effectiveness of HIV treatment as prevention together demonstrate for the first time in the history of the epidemic it is conceivable to realistically plan for a world without AIDS. This is not the time to slow down our efforts.

8. The Global Fund has direct investments in 150 countries and plays a crucial role in strengthening and linking health and community systems to ensure that programmes can be sustainable, mutually supportive and effectively scaled up. Of the total international funding to fight AIDS, TB and malaria, the Global Fund channels two-thirds for TB and malaria services and a fifth of the financing against HIV.

25 HTPN 052—A Randomized Trial to Evaluate the Effectiveness of Antiretroviral Therapy Plus HIV Primary Care versus HIV Primary Care Alone to Prevent the Sexual Transmission of HIV-1 in Serodiscordant Couples
26 Global Fund website Jan 2012
9. The Global Fund has been a powerful force in advancing human rights of those infected and affected by HIV, particularly people vulnerable to human rights violations such as key populations (sex workers, men who have sex with men and injecting drug users). It has become the main donor who funds services for highly marginalised and stigmatised populations when national governments or other donors find this work too politically sensitive.

**How the Funding Shortfall Impacts on Countries**

10. The country impact studies in the Alliance’s *Don’t Stop Now* report documents the many ways in which the HIV responses are now endangered. For example:

- In **Bangladesh**, the 20% planned increase in coverage of HIV services for most-at-risk populations will no longer be possible; the national response to HIV will be effectively stalled.
- In **Bolivia**, there are no available means of scaling up HIV prevention services for key populations, including at-risk groups not currently being reached such as prisoners and indigenous people. Therefore an increase in HIV transmission amongst vulnerable populations is expected.
- In the **new Republic of South Sudan**, 80% of the national AIDS plan remains unfunded. South Sudan was counting on Round 11 to cover antiretroviral treatment costs and to fund a nascent HIV prevention strategy.
- In **Zimbabwe**, an earlier Global Fund grant funded care and support services in every district, including mobilising clients for HIV testing, treatment-adherence support, and the provision of incentives, equipment, and training for caregivers. The funding crisis puts these services in jeopardy.
- In **Zambia**, where 80% of TB patients are HIV positive, Round 11 funding was critical for strengthening integrated TB/HIV services. Priorities included strengthening intensified TB case finding and diagnostic capacity, as well as scaling up isoniazid preventive therapy. Failure to fund these services will threaten hard-won progress in reducing HIV/TB-related deaths.

**Global Fund Funding Crisis and Reforms**

11. The Global Fund Replenishment meeting (October 2010) for the period 2011–13 produced only $11.7 billion in pledges, well below the stated target of $20 billion and even below the low “maintenance” level of $13 billion.

12. In 2011, the Office of the Inspector General, the Global Fund’s own accountability mechanism, made public audit reports in which there was corruption and the misappropriation of funds in a small number of programmes. The negative media reports that ensued led to the suspension of funding from a number of donors. The Global Fund responded proactively to address cases of corruption and implemented improvements in risk management, fiduciary controls and governance.

13. In September 2011 after a review by the High Level Panel the Global Fund produced a Consolidated Transformation Plan that mapped how all the necessary changes would be made. This is currently being implemented. The Global Fund has appointed a new General Manager Gabriel Jaramillo, who has been overseeing the restructuring at the Secretariat focused on improving grant management and restoring donor confidence.

14. Following the reduction in donor contributions and the cancellation of Round 11 the Global Fund launched the Transitional Funding Mechanism (TFM) to fill the granting gap between January 2012 and 2014. The TFM is established to allow continued funding for “essential services” for any country experiencing a service disruption between January 2012 and 2014. The definition of “essential services” has wide-ranging implications. The TFM will allow for continuation of treatment, but not for new treatment places. In a country such as Zambia, where 131,971 people need treatment, no new treatment places will be provided. In short, it is a mechanism for the status quo and not a mechanism to scale up services to reach MDG 6.

**DFID’s Role:**

15. The Department for International Development (DFID) have maintained the previous Government’s £1 billion to 2015 commitment to the Global Fund. The UK should make an additional contribution of £384 million for 2011–13.

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27 Key populations are groups that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context but include vulnerable and marginalised groups such as people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, people who use drugs, orphans and other vulnerable children, migrants and displaced people, and prisoners.

28 This is essentially an extension of the already existing “Continuation of Services” mechanism

29 TFM information Note, Global Fund, P.3

16. DFID released a Multilateral Aid Review (MAR) in 2011. Through the MAR, the UK publicly acknowledged how critical the Global Fund is to the delivery of MDG6. The MAR rated the Global Fund highly in terms of good value for money and delivering results.

17. The UK Government has brought forward a number of payments from its future contributions to the Global Fund to help offset the cash flow problems caused by donors delaying payments. We welcome the UK Government’s flexibility and support, but urge that the UK announce its full pledge.

18. DFID currently holds the role of Chair of the Global Fund Board and is helping to oversee the reforms described earlier in this submission. This is a critical leadership role and the UK is uniquely positioned to ensure that the Global Fund is able to effectively deliver on its mandate. A fully funded Global Fund is both critical and necessary.

19. The UK has traditionally demonstrated historic leadership on HIV which has been reflected in DFID’s strategies (2004 Taking Action and 2011 Towards Zero Infections). DFID will be decreasing the levels of HIV funding through bilateral aid by almost a third over the next four years. As a result of the shift in resource allocation, the delivery of DFID’s HIV commitments will be dependent on multilateral organisations. A well functioning and fully funded Global Fund will be an essential mechanism through which DFID can reach its own HIV commitments.

20. The Alliance is calling on DFID to support the calls for a replenishment opportunity at the G20 Summit in Mexico in June. By supporting the call for a replenishment opportunity at the G20 the UK could play a central role in leveraging support from other donors.

21. It is essential that additional resources are mobilised urgently. This could lead to a new funding window which would in turn lead to HIV, TB and malaria programme scale up and new people reached with life-saving services. Waiting until 2014 will undermine the gains made so far in the HIV response and will lead to unnecessary illness and death.

May 2012

Written evidence submitted by International Planned Parenthood Federation (IPPF)

SUMMARY OF RECOMMENDATIONS

1. DFID, and other global health stakeholders, must recognise that funding shortfalls at the GFATM threaten progress on HIV and linked Millennium Development Goals relating to Sexual and Reproductive Health (SRH) and family planning, and so emphasise these links in fostering support for the GFATM.

2. DFID, and other global health stakeholders, should ensure civil society involvement is retained and promoted as the GFATM is reformed and restructured.

3. DFID, and other global health stakeholders, should publicly recognise the existing strengths of GFATM management and reporting systems, and ensure that any reporting and discussion of challenges within GFATM is proportionate and fair.

IPPF’S EXPERIENCE IN WORKING WITH THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The International Planned Parenthood Federation (IPPF) is a global service provider and advocate for Sexual and Reproductive Health and Rights (SRHR). We are active in 172 countries, working with 153 national level Member Associations, supported by six regional offices and our central office in London. Based on the common causes of HIV and sexual and reproductive ill-health and the mutual benefits to action, HIV is a core focus for our work. In 2010, the latest full year for which we have reported, we provided 88.2 million services worldwide, of which 12.1 million were HIV related.

The GFATM was founded to take action on HIV, Tuberculosis and Malaria. Since its inception there has been the increasing realisation that progress on these goals is only possible with action to support SRH and health systems strengthening. The GFATM has responded through clarifying that funds can be used to support these interconnected priorities.

IPPF has sought to work closely with the GFATM to achieve our goals of integrating action on SRH and HIV. Currently, 34 of our Member Associations are members of Country Coordinating Mechanisms (CCMs), 31 are sub-recipients and 11 are principal recipients.

Recommendations and Supporting Evidence

1. DFID, and other global health stakeholders, must recognise that funding shortfalls at the GFATM threaten progress on HIV and linked Millennium Development Goals relating to Sexual and Reproductive Health (SRH) and family planning, and so emphasise these links in fostering support for the GFATM.

The Millennium Development Goals (MDGs) for child health (4), maternal health (5) and HIV (6) are interconnected: progress on one goal requires, and supports, progress on others. These interconnections reflect the fundamental links between SRH and HIV, with the majority of HIV infections being sexually transmitted or linked with pregnancy, child birth or breastfeeding.

These links between HIV and SRH mean that the progress on HIV prevention, treatment and care supported by the GFATM brings additional SRH benefits; whilst SRH services and programmes funded by the GFATM also supports the specific goals of HIV prevention, treatment and care. The shortfalls in GFATM funding therefore pose a challenge to achieving the MDGs as they relate to SRH as well as to HIV.

This threat to progress on the combined goals of progress on SRH and HIV comes at a crucial time. Donor focus on HIV is fading. Attention on SRH generally, and family planning in particular, is rising; DFID in particular are leading globally on family planning through the upcoming “golden moment” event. Both represent challenges requiring sustained resources.

Donors, including DFID, should continue to emphasise the support needed for both HIV and SRH goals, reflecting the overlaps between the two areas, as part of efforts to ensure support is generated for the GFATM and its continued work.

2. DFID, and other global health stakeholders, should ensure civil society involvement is retained and promoted as the GFATM is reformed and restructured.

The GFATM has made great progress since its inception, achieved in part through its governance mechanisms incorporating civil society and the involvement of those living with HIV, TB and Malaria. This involvement is at Board level as well as in national level CCMs. This involvement has considerable benefits in ensuring the realities of living with HIV are included in the GFATM and this accountability ensures that services and programmes respond to need and human rights.

Ongoing organisational reforms should ensure this accountability to civil society and those living with HIV, TB and Malaria is retained. Recent decision making within the GFATM has led to concerns about a lack of transparency and accountability in key decisions. Retaining a central role for civil society is important in ensuring this.

3. DFID, and other global health stakeholders, should publicly recognise the existing strengths of GFATM management and reporting systems, and ensure that any reporting and discussion of challenges within GFATM is proportionate and fair.

Donors, like DFID, should do everything they can to ensure the proper use of funds, respecting their accountability to tax payers and citizens in other countries. In ensuring this, donors should ensure that their oversight and management is fair and proportionate.

Recent reporting in the media and statements by some political leaders on the GFATM has not recognised the central role the GFATM itself played in recognising and reporting any challenges within the organisation’s systems. The GFATM is in fact regarded as more transparent than many other funding organisations and has been ranked as one of the five best performing donors in measurements of aid transparency.

Important reforms are needed at the GFATM. However, it is important to ensure that these are debated seriously and fairly, drawing attention to past achievements and effective existing processes to ensure optimum future success.

References


The Current Funding Situation of the Global Fund and DFID’s Contribution to the Fund

2.1 Since its creation in 2002, the Fund has become the biggest multilateral funder of the health-related Millennium Development Goals (MDGs). By 2011, it had approved a total of US$ 22.6 billion to 150 countries. While significant, however, this still only represents a small proportion of the US $15 billion

Written evidence submitted by Medicines for Malaria Venture

1. Introduction

1.1 MMV is delighted to respond to the International Development Select Committee’s call for evidence on the Global Fund to Fight AIDS, Tuberculosis and Malaria (called the Global Fund throughout this submission).

1.2 MMV is a not-for-profit public-private partnership, established as a foundation in Switzerland in 1999. Our mission is to reduce the burden of malaria in disease-endemic countries by discovering, developing and facilitating the delivery of new, effective and affordable antimalarial drugs. Our vision is a world in which these innovative medicines will cure and protect the vulnerable and under-served populations at risk of malaria. Ultimately, we hope to eradicate this terrible disease.

1.3 Supported by UK DIFID, USAID, the Bill and Melinda Gates Foundation, the Wellcome Trust and other donors, MMV has helped develop and introduce four new medicines over the last several years, saving an estimated 270,000 lives. We currently have seven projects in clinical development to address areas of unmet medical need, such as simpler and more effective medicines, therapies tailored for children and pregnant women, and medicines to block malaria transmission and prevent relapse.

1.4 MMV strongly supports the important work of the Global Fund. Much of the progress made in the last decade in reducing the numbers of malaria-related deaths has been due to significant investment by the Global Fund, 29% of which has been towards procurement of malaria drugs, distribution of bed-nets and indoor residual spraying.

1.4.1 The effective switch from the commonly used but failing drugs, chloroquine (CQ) and sulphadoxine-pyrimethamine (SP), to artemisinin-combination therapies (ACTs) in the early 2000s, ACTs, which are recommended by the World Health Organisation (WHO), are more effective than single therapies because i) they have a longer duration of action in the body and ii) they impede the development of parasite resistance to the partner drugs (artemisinin and its derivatives are a group of drugs that possess the most rapid action against Plasmodium falciparum malaria). Between 2006 and 2010, ACT intake increased from under 60 million treatments per year to over 130 million per year. This was significantly aided by the Global Fund.

1.4.2 The expansion of bed net distribution programmes in malaria-endemic countries. Between 2003 and 2011, the Global Fund distributed over 230 million nets.

1.4.3 The Global Fund greatly extended programmes of indoor residual insecticide spraying to kill the mosquitoes that spread malaria.

1.5 Our response to this inquiry is limited to the following questions in the Committee’s call for evidence:

— The current funding situation of the Global Fund and DFID’s contribution to the Fund (Section 2).
— The impact on people in developing countries from the delay in funding new grants (Section 3).
per year that experts estimate is needed to prevent and treat HIV-AIDs, TB and malaria effectively on a
global scale.\footnote{Information from the Global Fund website: \url{http://www.theglobalfund.org/en/about/donors/}}

2.2 The Global Fund is heavily dependent on donations from governments to deliver its commitments. Pledges from the public sector represented 95% of all pledges to the Fund between 2001 and 2011. Pledges from the private sector and from innovative financing initiatives, such as the Debt2Health mechanism, constituted the remaining five\%.\footnote{Information from the Global Fund website: \url{http://www.theglobalfund.org/en/about/donors/public/}}

2.3 In February 2011, the Department for International Development in the UK published the outcome of its Multilateral Aid Review and an assessment of the Global Fund. In the report, the Department concluded that the Global Fund would remain “a significant vehicle for delivering DFID’s strategic priorities”\footnote{Multilateral Aid Review: Assessment of the Global Fund to fight AIDS, TB and Malaria, Department for International Development, 2011} (including its pledge to reduce malaria deaths by half in ten of the worst affected countries by 2015\footnote{WHO. World Malaria Report 2011}). MMV welcomed this announcement, and the positive approach taken by the UK Government to continued support for the Fund and the goal of eliminating malaria. MMV believes that defeating malaria will take global commitment on all fronts: from the development of innovative and affordable antimalarial interventions to supporting their distribution. The Global Fund should remain central to supporting this effort.

2.4 In November 2011, however, the Global Fund announced that substantial budget challenges in some donor countries, compounded by low interest rates, were having a significant impact on new grant funding.\footnote{Demand Forecast for Artemisinin-based Combination Therapies in 2012–2012, UNITAID Forecasting Service Q3 2011} It concluded that it would need to make savings in its existing grant portfolio in order to finance essential services for on-going programmes that would come to their conclusions before 2014. Moreover, it would need to limit the support given to middle-income countries over the next two years.

3. THE IMPACT ON PEOPLE IN DEVELOPING COUNTRIES FROM THE DELAY IN FUNDING OF NEW GRANTS

3.1 The recent delay in Global Fund projects could have damaging consequences for people in developing countries in the medium to long term:

3.1.1 Without support from the Global Fund, most malaria-endemic countries will be unable to procure ACTs, or will only be able to procure quantities far below the level required. The forecast demand for ACTs for 2012 is 295 million treatments.\footnote{Information from the Global Fund website: \url{http://www.theglobalfund.org/en/about/donors/}} Even if increased use of Rapid Diagnostic Tests (RDTs) and a successful re-deployment of needed replacement bed nets leads to diminished demand (which is uncertain, given the funding constraints), there will be between 300 and 450 million ACT treatments between 2012–14 that will require financing with Global Fund monies.\footnote{UK aid: Changing Lives, Delivering Results, Department for International Development, 2011}

3.1.2 The lack of Global Fund grant monies for malaria drug procurement in 2012–14 will also significantly slow the uptake of the life-saving injectable artemesunate, at the cost of many young lives. Injectable artesunate is easier to administer and is faster-working than alternative treatments for severe malaria. It has been seen to reduce mortality by 35\% in adults and 22\% in children (compared to parenteral quinine)\footnote{Demand Forecast for Artemisinin-based Combination Therapies in 2012–2012, UNITAID Forecasting Service Q3 2011} and is considered as important as the switch from chloroquine to ACTs was in the early 2000s.

3.1.3 The role played by the Global Fund in assuring the standard of malaria treatments in the developing world must also be considered. Through its Quality Assurance policy, it helps to ensure that only drugs approved by stringent regulatory authorities or WHO pre-qualification are used for the treatment of malaria. If quantities of Fund-approved products are reduced, it is likely that more unsafe and inadequate (if cheaper) medicines will come into circulation, reversing the many gains made in improving patient safety in the last decade.

4 CONCLUSION

4.1 Significant advances have been made in the fight against malaria in recent years. From 2002 to 2010, grant recipients distributed 160 million insecticide treated nets and enable the treatment of 170 million cases of malaria\footnote{Saving more lives with artesunate injection, Injectable Artesunate Stakeholders’ Meeting Report, Geneva, 11 November 2011 http://www.mmv.org/sites/default/files/uploads/docs/publications/Infectable20Artesunate20Stakeholders20Meeting20Report.pdf}.

4.2 These gains, though sizeable, do not tell the whole story. In many malaria-endemic settings, the availability of latest-generation RDTs and ACTs is poor, and specific medicines for children and pregnant
women are notably lacking. The spectre of widespread resistance to ACTs is also present. Were this resistance to establish a foot-hold, any recent gains we have made on malaria will be lost.

4.3 In 2010, RBM estimated that if the current scale-up trends of global malaria prevention were maintained until 2015, the lives of an additional 1.14 million African children could be saved between 2011 and 2015. If funding were to cease and funding efforts fall, an estimated 476,000 additional children would die during that same period.47

4.4 For the last decade, the Global Fund has been a positive force in reducing and managing the incidence of malaria throughout the developing world. It requires the continued support of developed countries to ensure the opportunity to defeat the disease is not lost.

May 2012

Written evidence submitted by Médecins Sans Frontières—Doctors without Borders

SUMMARY

1. To date DFID has not provided additional funding to the Global Fund beyond the initial £1 billion pledged for the Global Fund’s replenishment period 2008–15. However, reassurances of a significant increase and a renewed per annum addition for funds have been indicated in keeping with DFID’s good record of support.

2. Over the past two years, Médecins Sans Frontières has repeatedly raised concerns over the donor retreat from global commitments to scale up and support HIV and TB treatment programmes.48 The decision of the board of Directors of the Global Fund to Fight AIDS, Tuberculosis and Malaria to cancel its 2011 funding round (Round 11) is the most recent and possibly most extreme manifestation of the donor retreat. The Board’s decision means there will be a two-year gap before new grants proposals to pay for scale up of lifesaving HIV, tuberculosis (TB), including drug resistant TB (DR-TB) and malaria treatment scale up can be submitted.

3. Evidence shows that there is hope for reversing the spiral of new HIV infections and needless deaths, as well as evidence that scale-up for TB treatment can both prevent the rise in drug-resistant tuberculosis cases and improve treatment outcomes. Despite this, Médecins Sans Frontières sees that the potential to reverse these epidemic trends is now very much under threat.

INTRODUCTION

4. Médecins Sans Frontières (Doctors Without Borders, MSF) is an independent international humanitarian organisation that delivers emergency medical aid to people affected by armed conflict, epidemics, natural and man-made disasters or exclusion from health care in more than 60 countries.

5. MSF supports over 220,000 men, women and children living with HIV/AIDS with anti-retroviral treatment in 19 countries. MSF also delivers comprehensive treatment to 31,149 people with tuberculosis, including drug-resistant tuberculosis and treats up to 983,425 confirmed malaria cases per year (2010).

6. MSF teams witness first-hand the tremendous impact on people’s lives that programmes supported by the Global Fund are having. This impact has been possible because the Global Fund has been a results-oriented, demand-driven and patient-focused funding mechanism.

FACTUAL INFORMATION

The current funding situation of the Global Fund and DFID’s contribution to the Global Fund

7. The Global Fund is experiencing an overall funding shortfall for the period 2011–13 because of a disappointing replenishment effort that did not raise enough contributions; many of its donors have not fulfilled, or are not expected to fulfill, their pledges and projected contributions. Whilst DFID is not one of those donors, what is of equal concern is that other mechanisms that DFID supports—UNITAID and the World Bank—are phasing-out support and scale-up of HIV treatment, and the transition strategies of programmes financed by UNITAID were based in large part on an presumed ability to hand over to the Global Fund. Given the Fund’s current funding situation, these transition strategies are at risk.

8. With regards to tuberculosis, whilst it is acknowledged that DFID gives support through multilateral funding and a combined HIV/TB strategy, there is no stand-alone strategy for tuberculosis and no specific evidence of commitment to this disease. This is of particular concern at a time when the full extent of the MDR-TB epidemic is just starting to be realised.

9. Most high-burden countries—some of which DFID supports, such as Malawi and Zimbabwe—are highly dependent on external funding for HIV support. According to MSF’s dialogue with DFID at field and UK

47 Saving Lives with Malaria Control: Counting Down to the Millennium Development Goals. Roll Back Malaria Report, Sept 2010
level, the latter claim to be a leading and committed supporter of the Global Fund. The Global Fund also scored highly in DFID’s March 2011 Multilateral Aid Review being assessed as “offering very good value for money for UK aid”.49 The UK is a donor that has so far fulfilled its replenishment funding as pledged for the period 2008–15. However, there is to date no replenishment to this initial sum announced. This is despite reassurances that a renewed per annum increase of funds will be given.

10. MSF considers that the current financial status of the Global Fund without additional funding will mean that the original strategic objectives set out by the Global Fund to be achieved by 2016—and supported by the UK—are unlikely to be reached.

The prospects for DFID achieving its development objectives if current funding shortfalls at the Global Fund are not addressed and the impact on people in developing countries from the delay in funding of new grants

11. DFID’s own development objectives focus on the implementation of integrated services (treating those co-infected with HIV and TB in one place), the reduction of new HIV infections (including early infant diagnosis), and an improvement in the health and rights of women and girls with tuberculosis. MSF has the view that the current financial state of the Global Fund puts these objectives at risk.

12. To put the outlined situation into human terms, the following examples—chosen due to the ongoing support from the UK government and DFID to these countries—illustrate the impact a delay in funding new grants is having on both DFID’s development objectives and the populations concerned.

13. Uganda presents a pertinent example. In Uganda mother-to-child transmission (MTCT) was the source of 20% of new infections in 2010, yet the coverage of prevention of mother-to-child transmission (PMTCT) services is only at 50%. The Ugandan government has adopted the state-of-the-art protocol for PMTCT (Option B+), which provides all HIV-positive pregnant women with life-long treatment. However, it has only been implemented in pilot sites supported by non-governmental organisations. Uganda had hoped to phase in PMTCT Option B+ using funding from Round 11.

14. To take another case, Lesotho (DFID bilateral funding phased out in 2011), has the seventh highest TB incidence in the world and a TB-HIV co-infection rate of 76.5%. There is low antiretroviral treatment (ART) coverage (below 30%) among co-infected patients and little integration of TB and HIV services. Nearly 1,000 people each year contract strains of drug-resistant TB. Lesotho was planning to include a TB component in Round 11 to address some of these challenges. The example presented calls into question DFID’s reduction in the number of countries they cover, as well as the amount of money given to their bilateral support programme.

15. Zimbabwe’s coverage of ART is 67% (MoH, October 2011). Even with a proposed increase of the portion of a national AIDS levy, Zimbabwe cannot shoulder the costs of its ART program on its own. It faces immediate funding gaps due to an ending of the ARV funding from bilateral donors such as DFID and the European Union (through the Expanded Support Programme). Round 11 would have at least partly covered the overall shortfall, which leaves more than 60,000 people in 2012 and potentially 120,000 by 2014 without ART. MSF has discussed with DFID officials their concerns with regard to continued treatment for patients already on treatment in Zimbabwe. There has been an openness to discuss detail of how to respond to this problem both at country and UK level but to date there has been no concrete response in terms of allocated funding.

16. In Malawi, there is difficulty getting funding to help pay for tenofovir-based treatment in first line, despite WHO guidelines clearly stating that this drug regimen has better patient outcomes. With Round 11 being cancelled and in the absence of alternative donor support, the country will continue rationing this important drug for specific groups only, thus leaving patients in dire need of effective treatment.

The UK’s role in influencing other international donors

17. So far the UK claims to be working hard to persuade other international donors to support the Global Fund and acknowledges a recent increase of confidence, as seen through donations by the Bill and Melinda Gates foundation, the United States and Japan. MSF considers that the UK’s own announcement for replenishment would be an effective way to renew international donor confidence and commitments.

Reforms undertaken by the Global Fund to its management and business model

18. It is clear that the UK has a central interest in the Global Fund reform process, not least because renewed future funding from DFID is dependent on how the Global Fund takes forward reforms as part of the consolidated transformation plan and implementation of its new five-year strategy. As a stakeholder to the Global Fund—and with its stated commitment to a public health approach that respects human rights and addresses concentrated epidemics (2011 strategic plan)—DFID should consider that while several reforms are likely to improve the Fund’s effectiveness overall, it is crucial that said reforms abide by the Global Fund’s founding principles and that the reform process will not be allowed to hamper ongoing programme implementation.

RECOMMENDATION FOR ACTION

19. MSF acknowledges the need for affected countries to increase national funding from domestic resources for HIV, TB, and other health programmes. MSF also stresses the need to increase the pace of scale-up for HIV and TB treatment, and to include optimal HIV treatment (earlier treatment with better drugs) in line with international standards. DFID’s bilateral support and support through multilateral funding should reflect this principle.

20. DFID must show in concrete terms how it is able to influence other donor governments to work towards sufficient funds to meet HIV, TB and malaria treatment commitments. This will be done by supporting a fully functioning and funded Global Fund, which would include providing affected countries with a new early funding window in 2012 to support the expansion of life-saving treatment programmes. MSF believes that it is necessary to convene an emergency donor conference at this year’s G20 summit to pay for the new early funding window of the Global Fund. The UK as a key donor can both influence this event happening and build the confidence in the Global Fund through pledging to double the contribution it has made for the 2011–13 period by providing an additional £384 million for the rest of the current replenishment period.

May 2012


RE—GLOBAL FUND FOR AIDS, TUBERCULOSIS, AND MALARIA—MEETING TUESDAY 17 APRIL 2012, COMMITTEE ROOM 5, PALACE OF WESTMINSTER

We are unable to attend this Oral Session, but having worked in Malawi for 30 years, we have a close interest in your deliberations.

We have seen huge sums of money spent by the Global Fund on Antiretroviral Drugs. In 2005 the total cost of ARV drugs for only 30,000 of the million HIV victims was more than the total government budget to fund all the Government Central and District Hospitals in Malawi.

Meanwhile two million Malawians risking grave disease problems due to chronic bilharzia were neglected. At Chinteche a Clinical Officer found 62 children at local school tested positive for bilharzia, but the cheap drug PRAZIQUANTEL had been out of stock for a year—at all government hospitals.

Vast Global Funds spent on ineffective anti-AIDS propaganda meant that medical and nursing staff were taken away from treating patients in overcrowded hospitals to attend AIDS-workshops where they were paid per diems far exceeding their normal salaries for useful clinical work.

The expatriate officials supported by the Global Fund were obvious in their huge 4x4 landrovers, driving from their luxury offices and homes.

District Hospitals and Health Centres were underfunded and understaffed, with persistent shortages of cheap, lifesaving drugs—this was a list of drugs out of stock at district hospitals in 2006—sutures, halothane, ketamine, lignocaine for dentistry, rubber gloves, antiseptic fluid, Plaster of Paris, Chloramphenicol (effective cheap antibiotic), cistapen and other penicillins for diarrhoea, Indocid, flagyl, Praziquantel (not seen for a year), thermometers, only 10 syringes left, feeding tubes, and some X-Ray Films.

A Malawian obstetrician asked us “How can I save maternal lives without Pitocin or oxytocin?”

It is poetic justice to note that when President Mutharika had a heart attack on 5 April 2012, he was taken to the large Lilongwe Central Hospital—where ADRENALIN (cheap drug but can be life saving in Heart Attacks or Anaphylactic Shock) was NOT AVAILABLE!

He had grossly misused state funds in useless schemes and a private jet. We hope that President Joyce Banda (whom we have met) will have better judgement.

So our recommendation is that more British money should be spent on British-managed Projects—and not diverted via another Aid Agency like the Global Fund or the European Union. Let the Malawians decide what should be done with more British help and British monitoring of modest donor projects.

May 2012
Written evidence submitted by ONE

The UK should double its current financial contribution level to the Global Fund—from approximately GBP 128 (US $203) million per year to GBP 256 (US $407) million per year. This would:

— Better position the Global Fund to drive progress toward critical global health milestones, including the virtual end of mother-to-child transmission of HIV, the beginning of the end of AIDS, and the end of malaria deaths.
— Reaffirm the findings of the Multilateral Aid Review (MAR) and more effectively match the UK’s funding priorities to its MAR outcomes.
— Send a strong signal to other donors about the importance of investing new resources in the Global Fund in this critical year.
— Send a strong message about the Global Fund’s value and the UK’s confidence in the Global Fund as a mechanism.

RESULTS OF THE GLOBAL FUND

The Global Fund is the single most powerful tool in the fight against HIV/AIDS, tuberculosis and malaria—three deadly diseases that collectively claim the lives of nearly four million people each year. Since its inception in 2002, the Global Fund has supported programs that have saved an estimated 7.7 million lives. Global Fund support includes financing for:

— Antiretroviral treatment for 3.3 million people living with HIV/AIDS.
— 230 million insecticide-treated bednets for families at risk of malaria.
— Treatment for 8.6 million cases of tuberculosis.
— Disease-specific and cross-cutting health systems strengthening (HSS) efforts.

In the UK’s 2011 MAR, the Global Fund was one of nine multilateral mechanisms out of 43 surveyed which were found to give “very good value to the UK taxpayer”. The MAR found that the Global Fund played a critical role in delivering health-related Millennium Development Goals and was likely to remain a key financier of existing and new approaches to tackling AIDS, tuberculosis and malaria. Secretary of State Andrew Mitchell went on the record in support of the Global Fund following the review, noting “We will increase funding because they have an excellent track record for delivering results”.

Particularly as the UK government continues to emphasise the importance of fighting malaria and of halving malaria deaths in ten of the worst affected countries, the Global Fund will remain a critical vehicle for achieving these objectives. In addition to support for bed nets, the Global Fund has helped communities rapidly expand access to ACT treatment, indoor residual spraying, and other innovative efforts to fight the disease.

REFORMS UNDERWAY FOR INCREASED EFFECTIVENESS

The Global Fund has disbursed well over US $14 billion to more than a thousand grants in 150 countries during the 10 years it has been in existence. The vast majority of grants have delivered important results, helping to save more than 100,000 lives every month. The Global Fund has a long-standing zero tolerance approach to fraud and corruption; it takes decisive action to suspend or terminate grants when serious fraud and abuse is detected, and also takes immediate action to recover lost funds.

The Office of the Inspector General (OIG) is one of several mechanisms created to preserve the integrity of donor resources and to safeguard the Global Fund’s investments through rigorous grant audits and investigations. The OIG regularly conducts audits and investigations as part of a policy of active vigilance of grant money. The audits are part of the Global Fund’s regular and routine efforts to ensure that grant money is used as efficiently as possible.

The Global Fund is also changing substantially, from an organisation providing an emergency response to one that will manage sustainable support to tackle the three diseases. This change is based on the recommendations of a high-level independent panel, which reviewed the Fund’s grant management and pointed to the need to strengthen risk management. A detailed transformation plan was put to the Global Fund Board in November of 2011, and many changes are now underway.

Two of six pillars of the Consolidated Transformation Plan (CTP)—which is being implemented under the management of General Manager Gabriel Jaramillo—are “Transforming Risk Management” and “Transforming Grant Management”. Among other changes, the CTP will:

— Refocus staff and resources on grant management in high-risk countries;
— Develop a new operational risk management framework to guide the analysis and mitigation of risks for each Principal Recipient, disease program and country portfolio;
— Define a process by which the Global Fund portfolio will go through risk-based segmentation;
— Taking into account applicable risks, disease burden and volume of financing per country;
— Reform the way the Global Fund approves grants by moving toward a more interactive process with applicants and partners; and
— By July 2012, introduce measures to identify and mitigate risks prior to grant-signing to ensure reduced risk exposure in future grants.

As an additional outcome of the CTP, a new Chief Risk Officer (Cees Klumper, who most recently served as the GAVI Alliance’s Director of Internal Audit) will also be in place at the Global Fund effective 16 April 2012. He will be in charge of a new risk register which will identify emerging risks, provide periodic guidance on risk tolerance, and monitor and manage changes in corporate risk.

THE UK’S HISTORIC ROLE AND THE CASE FOR RENEWED INVESTMENT

The UK is the third-largest contributor historically, having contributed nearly US $1.67 billion to the Global Fund since 2002. For every US $1 the UK government has contributed historically to the Global Fund, more than US $11 has been leveraged from other governments, generating a significant return on investment for UK taxpayers.

In 2011, the UK made the fourth-largest government contribution to the Global Fund, committing nearly US $238 million as part of a GBP 384 million (US $610 million) pledge for 2011–13 subject to the UK Multilateral Aid Review. The UK also demonstrates significant leadership through Simon Bland’s chairmanship of the Global Fund Board, helping to usher in a series of critical new reform efforts that will make the Global Fund even more efficient and effective.

Continued and strengthened British leadership is critical to the Global Fund’s ability to draw on financial contributions worldwide and scale up its life-saving interventions. With adequate resources, the Global Fund’s new strategy for 2012–16 puts it on an important trajectory: through targeted health interventions, save 10 million lives and prevent 140–180 million new infections of all three diseases.

The UK should now double its current financial contribution level to the Global Fund—from roughly GBP 128 (US $203) million per year to GBP 256 (US $407) million per year. This would allow life-saving programmes to progress and send a strong signal to other donors about the importance of investing new resources this year.

May 2012

Written evidence submitted by Oxfam

Thank you for the opportunity to make this submission on Oxfam views on the Global Fund to fight HIV/AIDS, TB and Malaria (GF), including the UK’s role in relation to the Fund.

In our submission to the Multilateral Review last year, we stated “the Global Fund is the greatest multilateral achievement in the last decade”. Oxfam still believes that the GF is the best mechanism to deliver aid to fight three of the deadly diseases facing developing countries. Oxfam supports the GF because:

1. It achieves results in terms of both saving lives (seven million to date) and improving the quality of people’s lives.
2. It is a model for donor coordination which translates multiple donors’ contributions into one system of grant making.
3. It enhances country ownership of the development process.
4. It is a leading agency in promoting transparency and in fighting corruption.
5. It sets a new model for civil society participation in decision making at global and national levels.

The GF is the main funder for treatment of the three diseases. Treatment scale up in all countries is an essential measure in the road to stopping HIV and TB and to eliminating malaria. New scientific evidence has shown clearly that:

1. HIV treatment acts as a means of prevention of new infections—reducing the risk of transmission to partners by 96%.
2. Early HIV treatment yields better results in terms of survival and quality of life.
3. Expanded programmes of Prevention of Mother to Child Transmission makes it possible for all children to be born free of HIV, and prevent their mothers dying.
4. Treatment of TB and current anti-drug resistant TB avoids the emergence and global spread of new TB strains that can be resistant to all known medicines.
5. Scale up of prevention, diagnosis and treatment of malaria is essential to halt the emergence of drug- and pesticide-resistant malaria.

Therefore a well-funded and better-performing GF is a global priority. The UK has played a key role in enabling the GF to reach the achievements it has realised so far. The UK needs to continue to play this leadership role especially at this time when the GF is facing several serious challenges.
1. **Funding Crisis**

At the last replenishment conference in New York, the GF called for $20 billion to enable scaling up of countries’ responses to the three diseases and bending the upward curve of infection and death. Donors’ total pledges amounted to only $11.7 billion, which would be just enough to maintain the gains achieved so far but not to allow the massive programme scale up that is needed to combat the three diseases. Yet to date, even that figure was not achieved—delays or lack of donor payments have meant that these agreed pledges have not been delivered and therefore there is even less financing being available for GF programmes. Thus last November, the GF board decided to cancel Round 11. This was a blow to many countries that have been waiting for the Round to fund continuation of programmes whose grants were ending, and/or to start new programmes.

Through GF, Malawi for example, managed to put about 50% of HIV positive people on treatment. As the country’s grant from Round 7 ends, it has submitted a funding proposal for Round 11. It is still unclear how the country can secure funds for treatment for new patients and for maintenance of the current prevention programmes. Malawi is not unique in this situation. Other countries such as Mozambique, DRC, Zimbabwe, Lesotho, are also struggling and need the help of the GF.

With the disastrous news that Official Development Assistance is falling for the first time in over a decade, and a number of leading donors (Netherlands, Canada) deciding to decrease their overseas aid funding, leadership among donors is urgently needed. The UK must play this leadership role to persuade all donors to continue their funding for the GF. Oxfam specifically calls on the UK to:

- Enable the GF to hold a pledging event at the G20 meeting in Mexico.
- Lead by example by announcing a doubling of the UK contribution to the GF.
- Persuade traditional and new donors to make multi-year commitments to the GF.

2. **Improving Performance: Governance and Grants Reforms**

The Consolidated Transformation Plan of the GF has been the basis for the current governance reforms. It is crucial that the new governance structure of the GF leads to better performance in terms of effectiveness and efficiency of the GF operations and grants.

Oxfam believes that a better performing GF must be ensured by:

(i) Securing the fundamental principles of the GF, particularly country ownership, the demand driven fund, and civil society participation. The new governance structure and operational procedures must enable better implementation for these principles.

(ii) Monitoring and addressing the gaps in the current secretarial reforms. Oxfam is alarmed at the recent decision to dismantle the well-functioning medicine unit at the GF secretariat. Such a unit is needed to ensure smooth operations linking global policies (eg treatment guidelines, quality assurance, price reporting) to grant negotiation, monitoring of implementation and feeding the learning from the programmes to the policies.

(iii) Working closely with partners in countries to use GF grants to unblock systemic bottlenecks especially by investing in the capacity of the drug procurement and supply chain.

(iv) Contributing to countries’ efforts to build functioning fiduciary systems within their health care systems as a fundamental element in building accountability and fighting corruption in a sustainable way.

(v) Achieving an appropriate balance between speedy grants disbursement and ensuring accountability and prevention of inefficient use of resources and corruption.

Therefore Oxfam calls on the UK to work with the board, committees and senior management to address the above points. We specifically urge the UK to urgently address the gaps in the secretariat reforms plan especially on the medicine unit.

**Conclusion**

The GF has been and continues to be an invaluable vehicle for delivering aid to fight three deadly diseases and contribute to building effective and well functioning health systems in developing countries. Yet the GF is facing serious challenges in terms of securing sufficient funds to scale up programmes that will eventually curb the three diseases; and in ensuring that the current reforms lead to a more effective and efficient GF.

The UK has been playing a commendable leadership role in enabling the GF to realise its great achievements in terms of saving lives. As a chair of the board, the UK has the opportunity to ensure that the GF can overcome these challenges and achieve its ultimate goals of cutting infections and saving lives.

**References**

1. Oxfam Submission to the UK Multilateral aid review August 2010
May 2012

**Written evidence submitted by Dr Patricia Nkansah-Asamoah**

SUMMARY OF THE INTERNATIONAL DEVELOPMENT SELECT COMMITTEE ONE-OFF EVIDENCE SESSION ON THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA

My experiences with the Global Fund started with the implementation of policies and services in the Prevention of Mother to Child Transmission of HIV in 2002 in a 200 bed hospital in Tema General Hospital (TGH) in Ghana. The planning and execution of an HIV service for pregnant women at that time has resulted in a structured and well tested programme. All pregnant mothers attending antenatal care in this hospital are offered HIV counselling and testing as part of routine care and more than 95% of them accept this service. Those identified to be positive are treated with medication to reduce the transmission of HIV to infants and enrolled into care.

This paved the way for the hospital to be accredited for comprehensive HIV services in 2006, comprising of educational and preventive as well as curative services. I managed the TGH out-patient HIV clinic with more than 3,000 clients, a workforce of about twenty including doctors, medical assistants, nurses, counsellors, pharmacists, and laboratory and data managers.

Tuberculosis was found to be the leading cause of death among people living with HIV in developing countries. Almost 25% of deaths among people with HIV are due to TB. In 2010 there were an estimated 1.1 million new cases of HIV-positive new TB cases, 82% of whom were living in Africa (WHO 2012). Ways to actively screen HIV positive persons for TB resulted in a screening tool designed with input from my HIV clinic and adopted by the National TB Programme of Ghana. Initiation, implementation and scale up of TB/HIV collaborative activities were funded by the Global Fund—resulting in TB patients being tested for HIV and HIV patients being screened for TB. Early diagnosis and free treatment for TB has resulted in improved health outcomes among TB/HIV patients.

However, at the end of 2011 the Global Fund announced that it would not be able to fund new projects until 2014 because of funding gaps.

THE UK’S AID OBJECTIVES AND THE GLOBAL FUND

Some of DFID’s developmental objectives from the Bilateral and Multilateral Aid Review were outlined by the Secretary of State for International Development in a statement he read a year ago.

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- We will dramatically increase our focus on tackling ill health and killer diseases in poor countries, with a particular effort on immunization, malaria, maternal and newborn health, extending choice to women and girls over when and whether they have children; and polio eradication.
- We will do more to tackle malnutrition which stunts children’s development and destroys their life chances; and do more to get children—particularly girls—into school.
- We will put wealth-creation at the heart of our efforts, with far more emphasis on giving poor people property rights and encouraging investment and trade in the poorest countries.

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THE GLOBAL FUND’S FINANCING GAP

The prospect of DFID achieving these objectives would not be possible with current funding gaps at the Global Fund. Interwoven with the objective of dramatically increasing maternal and newborn health, tackling malnutrition in children and wealth creation for the poor, are interventions to prevent HIV transmission from mother to child (PMTCT) and treatment of Persons Living with HIV (PLHIV) with medication. Children born with HIV are more prone to diseases, are more likely to present with malnutrition, failure to thrive, stunting and even death. PLHIV and AIDS who are not on treatment are among the poorest in the world. They get sick more often, spend huge sums of money on treatment and usually at the time of diagnosis are unable to work to look after their families and themselves. The gains made in the fight against HIV would be reversed.

Tuberculosis is interlinked with HIV. Reduced immunity makes people prone to all forms of diseases. Tuberculosis is the main cause death among persons with HIV/AIDS in developing countries. Free diagnosis and treatment of tuberculosis reduces death in PLHIV. In malaria endemic areas, HIV transmission from mother to child is enhanced when mothers are infected with malaria which affects the placenta and facilitates transmission.

High levels of community HIV counselling, and testing which promotes behaviour change for persons either HIV positive and negative, cannot be promoted. Few people want to know their HIV status if nothing can be done in terms of treatment. Few people would access treatment early; patients would come in bedridden, very sick and dying. This is demotivating for health care workers and its effects spill-over to other areas of care.
International Development Committee: Evidence

The same doctors attending to HIV cases see other medical conditions as well. When one is constantly confronted with a helpless situation, there could be depression.

Further delays in funding and approval of new grants means newly diagnosed patients cannot be treated. The anxiety of waiting, the constant fear of death and the increase in opportunistic infection would make these patients even poorer than they already are—defeating the objective of putting wealth-creation at the heart of DFID’s efforts. There is an increase in hospitalizations and frequent hospital visits, increased work load for Health Care Workers (HCW), decreased quality of care and increased workplace stress for HCW. Workplace stress is influenced by nature of work, work environment, volume of work and staffing levels. In such circumstances the volume of work increases (frequent hospital visits), the nature of work is depressing (constant death and a feeling of helplessness), and the work environment diminishes (crowded because of repeated hospital visits and hospitalization). Very few HCWs want to work in such depressing situations for a long time. High staff turnover for all HIV related programmes would be expected. Experienced staff finding more challenging jobs would leave. Hospitals seeing PLHIV will turn into hospices.

In treatment acceleration for Persons Living with HIV, developing countries have demonstrated commitment and resourcefulness in the administration of HIV drugs. The complications which were feared with the introduction of these drugs are not even considered now. What was hitherto considered impossible is now common place and it is as if it was never an issue.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has strengthened health systems in developing countries. Laboratory equipment for AIDS/TB/Malaria is used for the diagnosis and monitoring of other infectious and chronic diseases. Training of health care workers provides other non-tangible benefits like team building, leadership skills, and communication skills.

What the UK can do?

The Secretary of State for International Development stated organisations that have been assessed as providing very good value for the British taxpayer in the aid reviews will have increase funding, because they have a proven track record of delivering excellent results for poor people. If UK now steps up and delivers new financing for the Global Fund it could influence other donors to undertake similar funding commitments.

May 2012

Written evidence submitted by Sightsavers

Background

The Global Fund to Fight AIDS, TB and Malaria was set up 10 years ago. Since then it has been the largest funder of efforts to meet the health-related Millennium Development Goals, in particular MDG6, and has delivered anti-retroviral drugs to 3.3 million people living with HIV, treated 8.6 million cases of tuberculosis and distributed 230 million insecticide-treated bednets—all great achievements in the field of global health which have made an enormous impact on the lives of poor people. It was rated highly in the DFID Multilateral Aid Review, including a positive rating for financial management and results focus; however, this has yet to lead to an increase in the funding allocated by DFID to the Global Fund’s activities.

Recent Challenges

Towards the end of 2010, the Global Fund announced that some instances of funds meant for health projects going astray had been uncovered by its independent auditor. The resulting media coverage has led to a number of donors withholding funding; on top of the already problematic fundraising situation the Fund was in, this has led to the cancellation of all new programme funding until 2014—a very worrying development. DFID is to be commended for bringing forward some of its future scheduled payments to the Fund to help it deal with its current difficulties.

It is due to its commitment to transparency that these instances have come to light. The Fund has responded quickly, suspending all training programmes (where much of the problems were found) and appointing a new manager to oversee changes. The management has also brought in tighter expenses procedures, and is checking expenditures in high-risk countries. It is possible that these further investigations will bring to light other examples of misuse of funds.

While the scenario all aid should aim for is that of zero misuse of funds, the fact remains that distributing large sums of money in countries with weak financial infrastructure has risks. Transparency has been a popular concept in aid for some time, and as it is implemented further we should expect to see cases such as these come to light. The Global Fund was able to discover this information itself, and should be commended for doing so; for making the information public; and for the swift response it is implementing. All of this represents good practice, and the Fund should be supported while it carries out necessary reforms, and to share its lessons learned within the sector.
It is important that the Fund is not penalised for responding openly to issues in its financial management; not only will many poor people suffer from the diseases it tackles when they need not, but it would also disincentivise other organisations from being as open and confident in rooting out and tackling corruption in future—meaning that the world’s poorest would lose out twice over.

Suggested questions:

— How will the Global Fund ensure its lessons in operational transparency and dealing with corruption are communicated in a manner for other organisations to learn from?
— How will DFID support the Global Fund in carrying out its current reforms?
— What steps is DFID taking to a) increase funding for the Global Fund as per the results of the Multilateral Aid Review and b) encourage other donors to increase their support, so that new programming can resume?

**INTEGRATING WITH NEGLECTED TROPICAL DISEASES**

The Global Fund has so far made huge gains in targeting malaria, HIV and tuberculosis. However, as has recently been pointed out by Professor Jeffrey Sachs and others in an article in the New England Journal of Medicine, greater value for money and greater benefit in terms of global health could be achieved if efforts to fight these three diseases were linked with work to tackle the so-called “neglected tropical diseases”, which affect approximately one billion people worldwide.

Many of the strategies used to tackle the diseases are similar; from the training and deployment of community health workers, to mass drug distribution, and emphasis on the importance of clean water supplies to reduce breeding grounds for disease-spreading flies. There is a large amount of geographic overlap between the areas affected by the NTDs and the illnesses that the Global Fund targets, and in some cases sufferers from one disease may be more likely to acquire another—for example, female sufferers of schistosomiasis may be more likely to become HIV positive, and those infected with helminths more likely to acquire tuberculosis (Sachs et al, 2011).

There are various practical methods in which treatment programmes can be integrated. For example, community health workers can distribute bednets for malaria along with ivermectin for onchocerciasis, and pregnant women can be given drugs to treat intestinal helminth infections alongside ARVs to prevent mother to child HIV transmission.

DFID has recently announced increased funding for NTDs; it has also rated the Global Fund highly as one of the multilateral agencies it will continue to support. It would be beneficial, then, to investigate potential integration of NTD treatment into other major health initiatives can be integrated. For example, community health workers can distribute bednets for malaria along with ivermectin for onchocerciasis, and pregnant women can be given drugs to treat intestinal helminth infections alongside ARVs to prevent mother to child HIV transmission.

**AID EFFECTIVENESS**

Of late, the Global Fund has made greater efforts to ensure that its work aligns with national health strategies, through use of the “National Strategy Application approach”. The benefits of this approach are well-recognised, and form part of the Global Fund’s commitment to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. It streamlines the application process for government bodies applying to the Global Fund, as they need only supply that additional information which is not included in the jointly-assessed national strategy documentation, thus reducing transaction costs; and it aligns the work of the Global Fund with national processes and timelines, whilst allowing the Fund to maintain its core commitment to performance-based funding.

The Global Fund is currently on what it refers to as the “second wave” of implementing this way of working. This is encouraging, but there is more to be done to better align the Global Fund’s approach to national strategy applications with other efforts being led by the International Health Partnership (IHP+), of which the Global Fund is a signatory, to conduct joint assessments of national health sector strategies. In addition, DFID could encourage the Global Fund to engage more proactively with national Ministries of Health and other relevant
national ministries such as education and welfare, to better align and harmonise strategies, plans and budgets of national HIV/AIDS commissions with national health sector strategies.

Suggested questions

— What are the Global Fund’s assessments of how it has progressed with the National Strategy Applications approach thus far, and how does it intend to align this approach with the IHP+’s approach to joint assessment of national health sector strategies?

— How is DFID supporting the Global Fund to strengthen its engagement with national ministries and commissions, and align its work more closely with the aid effectiveness principle of country ownership outlined at Paris and Accra?

Sightsavers is an international charity which works with partners to eliminate avoidable blindness and promote equality of opportunity for disabled people in the developing world. Our vision is a world where nobody is blind from avoidable causes, and where people who are visually impaired participate equally in society.

Sightsavers has never received any funding from the Global Fund in any of its work.

May 2012

Written evidence submitted by Stop AIDS Campaign

KEY POINTS

— A fully funded Global Fund is essential to global health, the achievement of the health MDGs, and DFID’s development agenda.

— The funding crisis at the Fund must be addressed alongside reforms to ensure the lives currently at risk as a consequence are not lost.

— The UK must use its stated intention to increase its support for the Global Fund to leverage more from other donors by announcing a doubling in its contribution and committing serious political will to achieving a successful pledging moment with other new and traditional at the G20 in Mexico in June.

— New evidence gives us the chance to begin the end of AIDS. We cannot allow that chance to slip away—the Global Fund must begin implementation of its new strategy through a new funding window this year to allow scale up to recommence.

THE CURRENT FUNDING SITUATION OF THE GLOBAL FUND AND DFID’S CONTRIBUTION TO THE FUND

1. The current funding crisis at the Fund has its origins in the 2010 replenishment process which sought to generate the financing to scale up the response to the three diseases in 2011–13 building up to the achievement of the health MDGs. $20 billion was needed to expand at the pace required to achieve those ambitions. The minimum required to meet its existing commitments and deliver some modest expansion was $13 billion. The total raised was $11.7 billion.

2. Part of this total also included projections of anticipated contributions made by the Fund based on historic behaviour of donors. In the months following the replenishment conference and through 2011, donors paid much less than anticipated. This reduced the total raised to approximately $9.7 billion—wiping out any financing available to scale up programming.

3. This came to a head at the November Board meeting when—the Global Fund Board took the decision to cancel all funding of new programming until 2014 at the earliest, in anticipation that its resources will by then have been increased by the 2013 replenishment (to cover 2014–16).

4. DFID have stuck to the commitment to the Fund made under the previous government to deliver £1 billion to the Fund over 2008–15. They reconfirmed this at the 2010 replenishment conference, committing to give £384 million over 2011–13.

5. DFID resisted demands to make an increased pledge at this replenishment conference, stating that they would make a decision on any increase once the Multilateral Aid Review (MAR) was completed.

6. The MAR found the Global Fund to offer “very good value for money”, performing strongly in its results focus, impact, reporting, accountability mechanisms, financial management, and capacity for positive change; highlighting the Fund’s role as a “major driver for a range of innovations in transparency”.

7. The UK committed to a significant increase in its contribution to the Fund following the results of the MAR, but over a year later, we are still awaiting that increase. In the interim the UK has played a constructive role, bringing forward some contributions from the next replenishment cycle to help resolve cash-flow issues at the Fund, and responding in a measured way to press reporting of instances of corruption uncovered by the Global Fund’s internal audits of grants.
8. However, the much needed increase from the UK should have been made in 2010 and we believe the government must move swiftly to deliver this increase. We call on the UK to pay its fair share vi of need for this replenishment period—at least a doubling of its current £384 million contribution. vii Furthermore we urge the UK to deliver this increase in a way that does most to leverage more form other donors and maximises our chance to resolve funding crisis at the Fund to allow scale up across the three diseases to recommence as soon as possible.

9. It is imperative that the 2013 replenishment process does not deliver a total for the 2011–14 replenishment period so far removed from global need as happened in 2010. We urge the government to commit to supporting an ambitious replenishment target based on country-led demand, and to working hard to ensure it is achieved.

10. The government should consider how innovative financing, including a financial transaction tax, could help deliver the sustainable and predictable financing needed to fund global health—particularly its role in helping other donors, who are currently not committed to achieving the 0.7% ODA target, to increase their investment in international development.

The Prospects for DFID Achieving Its Development Objectives if Current Funding Shortfalls at the Fund Are Not Addressed

11. The Global Fund has ruled out funding for new programming until 2014 at the earliest—in reality this would mean no-one newly placed on HIV treatment through the Global Fund until 2015 when the funding would be translated into on the ground activities. In the interim the Fund is providing limited resources to ensure continuity of essential services though a Transitional Funding Mechanism. But the lack of scale up will have a serious impact on DFID’s development goals.

12. DFID’s commitment to the goals of universal access by 2015 is outlined in its 2011 position paper “Towards Zero Infections—The UK’s Position Paper on HIV in the Developing World.” iv DFID has said that “support to the Global Fund will put 37,000 HIV-positive women with treatment to prevent transmission to their babies and 268,000 people with treatment.”

13. The UK was active in getting agreement of ambitious global targets at the UN High Level Meeting on AIDS in June 2010, v in particular the commitment to get 15 million people on treatment by 2015. This would be a 127% increase from the current coverage of 6.6 million people. The Fund currently provides half of all ARV treatment for HIV in the developing world.

14. DFID is also committed to global targets to bring a virtual end to children being born with HIV by 2015; vi a 50% reduction in HIV transmission amongst people who inject drugs by 2015; vii and a 50% reduction in deaths from TB amongst people living with HIV.viii

15. Delivering on all of these requires a rapidly expanding Global Fund, as DFID is—in contrast to its overall budget, and its budget for global health—cutting its bilateral spend on HIV by 30% over the next three years.ix

16. Furthermore the opportunity presented by the UNAIDS Strategic Investment Framework x and the results of the HPTN 052 clinical trial which prove that HIV treatment reduces the risk of transmitting the virus to your partner by 96% xi to begin the end of AIDS and dramatically reduce medium and long term deaths and costs relies on dramatically scaling up effective response between now and 2015. The cancellation until 2014 of all new programming squanders the opportunity experts believe we have to end the epidemic.xi

The Impact on People in Developing Countries from the Delay in Funding of New Grants

17. As successful applications to Round 11 would only have translated into programmes on the ground later this year the full impact of this delay is yet to be fully understood. However research by the International AIDS Alliance xii and MSF xiii have detailed incredibly worrying examples of countries and people likely to be effected.

(a) The Democratic Republic of Congo has 1m people living with HIV, and only 14% of those in need of treatment are being reached. The DRC was eligible to apply for Round 11 grants and would have used it to scale up its treatment coverage. Now uncertainty about new funding is stopping doctors from enrolling new patients on treatment and treatment targets are being revised down.

(b) Zimbabwe has achieved 67% coverage with its treatment programme but is reliant on external funding despite innovative efforts to increase domestic resources including the national AIDS levy which supports 26% of patients. Round 11’s cancellation not only puts an end to any ambitions of scale up but also puts at risk current treatment coverage.

(c) Less than half of people who need HIV treatment in Uganda are getting it. Uganda had hoped to double the pace of new enrolments, but has now been forced to abandon these plans.

(d) South Sudan has a very credible National AIDS Strategic Plan but it is largely unfunded. Round 11 was hoped to deliver much of the resources needed to begin tackle HIV across the new republic.
18. These are a snapshot of the problems which are repeated across Africa, Asia, Eastern Europe and Latin America. This funding crisis, if unchecked, will lead to millions of tragic crises in families across the developing world.

THE UK’S ROLE IN INFLUENCING OTHER INTERNATIONAL DONORS

19. The UK is key to resolving this crisis. It is currently Chair of the Global Fund Board and is one of the few donors on the record as intending to increase its contribution. Others will look to the UK. The leadership DFID show in the coming months will define our ability to minimise the number of lives lost and damage done to global health by this funding crisis.

20. DFID’s intention to increase its contribution can be used to lead others to step up to help resolve the crisis. Given in isolation the increase will be welcome, but it will not be transformative. By using the promised increase to leverage more from others, the UK could help deliver the increased funds needed to recommence scale up across the three diseases and fund the implementation of the new strategy.

21. A pledging moment championed by the UK would help to build pressure on others to act, particularly those traditional donors who have fallen behind in their payments such as Spain and the USA; others who could scale up their investment similar to the UK such as Australia or Germany; and emerging economies who could become donors such as Turkey and Mexico.

22. UK leadership was incredibly effective in delivering a significant increase in resources for GAVI. By doubling their contribution despite the economic condition the UK could again be an example to the world.

23. By holding such a pledging moment at an event at the G20 in Mexico a wide range of the relevant donors and potential would be present; the location in an emerging Latin American economy allows for better engagement of these important growing global players; and has the profile necessary to raise pressure on attendees to deliver. Furthermore it lays a solid foundation for the replenishment conference set to happen in 2013 to raise funds for the next replenishment period—2014–16.

24. We call on the UK government to maximise the impact of its increased contribution by supporting the growing calls for a pledging opportunity at the G20 in Mexico in June, and to ensure the success of the G20 event by committing serious political capital to drawing in other donors to join them in resolving the crisis.

AND REFORMS UNDERTAKEN BY THE GLOBAL FUND TO ITS MANAGEMENT AND BUSINESS MODEL, AND IMPROVE RISK MANAGEMENT

25. There is significant support for the new Global Fund Strategy and we believe all reforms should help to strengthen the Fund’s ability to deliver on it. We believe the reforms suggested by the High Level Panel on risk, must not undermine the core principles of the Fund: a demand-driven, country led and truly global fund.

26. It is essential the reforms place improvement of disbursement and country level coordination as a priority and we welcome the implementation of the new country team approach.

27. Moves to refocus multi-lateral spend on low income countries must not ignore the fact that the majority of people living with HIV are now in Middle Income Countries (MICs), often in marginalised key populations such as people who inject drugs, sex workers and transgender populations. The Fund must not arbitrarily cut funding from vital interventions in MICs, abandoning these already underserved groups.

28. Changes which have been made to the Fund Secretariat structure have caused concern, including the dramatic reduction in civil society support, reducing it to a function of the resource mobilization team, which fails to reflect the critical role civil society plays throughout the organisation—from implementation of grants to accountability and scrutiny of the governance.

29. The decision to effectively dissolve the staff team responsible for access to medicines at the Secretariat runs counter to the new Global Fund strategy and board and UK priorities on value for money. Ensuring the Fund has expertise to maintain awareness of the availability and affordability of health commodities, and design interventions to steer market actors is critical. New proposed roles will not deliver the same seniority of staff or level of capacity needed to deliver an area of the Fund’s work which must expand rather than contract in an era of reduced investment in global health, and increased threats to affordable generic medicines.

Suggested Questions:

— How does the Secretary of State envisage using the proposed UK increase to leverage more from others to maximise the impact of UK investment in the Global Fund?
— With DFID bi-lateral spend on HIV being cut by 30% over the coming years and the Global Fund being forced to focus limited resources on Low Income Countries, how will DFID ensure growing HIV epidemics across middle income countries will be tackled?
— How can we achieve the MDGs on health without a short term investment of additional resources in the Global Fund?
— Does the Secretary of State agree that any UK increase should?
REFERENCES

i http://www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf

ii Calculated by wealth or GNI—a methodology used by the Fund and others to indicate suggested contribution. The wealthier a donor the more they should contribute. http://www.theglobalfund.org/documents/replenishment/2010/Replenishment_2010HagueIllustrativeContribution_Note_en/

iii This figure may vary across submissions due to exchange rate fluctuations. Fair share calculations were made in dollars, with the UK’s being $1.245 billion. In 2010 that equated to approximately £840 million. Today it is closer to £780 million. The fact remains that the UK must more than double its contribution for this replenishment period (2011–13) to reach its fair share—at least an additional £384 million.


vi http://www.dfid.gov.uk/get-involved/your-campaigns/24—Response to Stop AIDS Campaign


viii ibid


xii http://www.sciencemag.org/content/333/6038/13.summary

xiii http://www.aidsalliance.org/includes/Publication/Alliance%20global%20fund%20report_V6.pdf

xiv http://www.msf.org.uk/UploadedFiles/Losing_Ground_201203295146.pdf

May 2012

Joint written evidence submission from the Stop AIDS Campaign, Malaria No More UK, RESULTS UK and the White Ribbon Alliance for Safe Motherhood

KEY POINTS

— The Global Fund remains the leading source of funding for the international effort to end the unnecessary deaths caused by AIDS, TB and Malaria.

— The UK is uniquely placed to champion the Fund’s efforts to scale-up its work on the three diseases and to put in place the reforms necessary to further improve its effectiveness.

— Additional funding this year is essential. The UK must provide an additional £384 million to meet its fair share.

— The UK must use its position of leadership and the opportunity of the up-coming G20, to leverage more from other donors to ensure sufficient finance is raised to open a new funding window this year allowing countries to resume scale up and the Fund to begin implementation of its new strategy.

THE CURRENT FUNDING SITUATION OF THE GLOBAL FUND AND DFID’S CONTRIBUTION TO THE FUND

Funding context

1. Whilst the Global Fund has grown over the last 10 years, the last three funding rounds have been getting steadily smaller (Round 8—$3.06 billion, Round 9—$2.2 billion and Round 10—$1.7 billion). At the 2010 replenishment the Fund aimed to raise $20 billion, with $13 billion needed at minimum to cover 2011–13. In fact, it raised $11.7 billion.

2. This low total was, in part, reliant on projections of expected contributions based on donors’ track records of payments to the Fund. Donors performed considerably worse than they had in the past and so the Fund is not on track to receive even the anticipated $11.7 billion.

3. Donor contributions were, in some cases, further delayed following media reports in January 2011 of the OIG findings of the previous year. In October 2010 the Fund’s independent internal auditor—the Office of the Inspector General (OIG)—published reviews of grants which identified instances of misspending and fraud in a small percentage of the portfolio. These were brought to the attention of the board and action was taken to arrest those guilty of fraud and recover the money lost.

4. We condemn corruption in the strongest possible terms; believe the issues identified by the OIG to be of critical importance; and welcome many of the on-going reforms of the Fund to further strengthen systems to
ensure money that should be saving lives is not lost. We commend the renewed commitments made to the Fund by many this year, including the Gates Foundation, Saudi Arabia and Japan.

5. However, the failure of donors to fully fund the response to the three diseases has led to the cancellation, for the first time, of a funding round for new programming. This decision suspends until 2014 any prospect of scale up across the three diseases putting the health MDGs, and the lives of millions in countries reliant on the Global Fund at serious risk.

**UK funding**

6. DFID has maintained the previous government’s £1 billion, 2008 to 2015 commitments to the Global Fund, paying annual contributions in line with this pledge—£384 million for 2011–13. However, a “fair share”,\(^5\) of funding (based on donors wealth or GNI, a benchmark used by the Global Fund) would require just over a doubling of the current UK contribution.\(^6\)

7. The UK did not make an increased pledge along with other donors at the 2010 replenishment, delaying its announcement of an increase in funds for the Global Fund until after the outcome of the Multilateral Aid Review (MAR).\(^7\) The MAR found the Fund to offer “very good value for money”, praising its results focus, impact, reporting, accountability mechanisms, financial management, and capacity for positive change, highlighting the Fund’s role as a “major driver for a range of innovations in transparency”.\(^8\)

8. The Secretary of State for International Development has confirmed that the UK will “significantly increase” its contribution to the Fund but we are still awaiting the UK’s increased pledge 12 months after the publication of the MAR.\(^9\)

9. DFID’s increased pledge, when it comes, must reflect the reality that it should have been made in 2010, and therefore must cover the entire replenishment window, including retrospective payments for 2011 and 2012, as well as 2013. Legitimate reasons for delaying the announcement, should not be used as excuses for giving less than we should.

10. DFID is currently chairing the Fund and helping to oversee the reforms. This is a critical role and an important contribution to the Fund. It is imperative that this role is used to lead the Fund to a position where it can fully deliver on its mandate—the end of the three epidemics. Full financing for the Fund is a central part of this effort.

11. The UK should be praised for bringing forward a number of payments from its future contributions to the Fund to help with cash flow problems caused by other donors delaying their payments.\(^10\)

12. In addition to encouraging UK support of a pledging opportunity this year, we strongly urge the UK to re-align itself with other donors in pledging for the next replenishment period. Ensuring it will pledge for the next period (2014–16) alongside other donors at the replenishment conference that will be organised by the Fund in 2013.

**The Prospects for DFID Achieving its Development Objectives if Current Funding Shortfalls at the Fund are Not Addressed**

13. DFID has made significant commitments on health which rely on an expanding Fund:

   (a) DFID’s commitment to the goals of universal access by 2015 is outlined in its 2011 position paper “Towards Zero Infections—The UK’s Position Paper on HIV in the Developing World.”\(^11\) DFID has said that “support to the Global Fund will put 37,000 HIV-positive women with treatment to prevent transmission to their babies and 268,000 people with treatment.”

   (b) The paper clearly states that in order to achieve its goal “we must address the challenges in varying HIV and TB epidemics”. It describes the Global Fund as the “principal mechanism the UK uses to finance our contribution to HIV and TB treatment”. The success of DFID’s strategy to tackle HIV and TB is unequivocally linked to the success of the Global Fund.

   (c) Achieving success on DFID’s commitment to help halve the number of Malaria deaths in ten high burden countries by 2015, as outlined in its Framework for Results Document,\(^12\) relies heavily on continued Global Fund financing of key interventions for malaria prevention, diagnosis, treatment and surveillance in these regions.

   (d) By the end of 2010 36% of the Fund’s investments were supporting health systems strengthening.\(^13\) The impact this has on maternal and child health is significant, with the Global Fund estimating between 44 and 55% of all its investments benefit women and girls.\(^14\) As financial shortfalls lead to the restriction of funding to essential continuity of services, these broader DFID priority areas will suffer most.

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\(^5\) UK “fair share” financial ask is calculated based on donors wealth or GNI (a benchmark used by the Global Fund and in other replenishment processes) and the percentage share this equates to out of the total $20 billion needed by the Fund to scale up towards the health MDGs in 2011–13. Essentially the richer you are the more should give. Fair share calculations were made in dollars, with the UK’s being $1.245 billion. So this figure may vary due to exchange rate fluctuations. In 2010—the date of the replenishment conference for 2011-13—that equated to approximately £840 million. Today it is closer to £780 million. The fact remains that the UK must more than double its contribution for this replenishment period (2011–13) to reach its fair share—at least an additional £384 million.
14. Individual organisation submissions will respond to this question and the question on the impact of delays in new funding on developing countries in more detail, but it is clear that the Fund is essential to the government’s ambitions in improving global health.

THE UK’S ROLE IN INFLUENCING OTHER INTERNATIONAL DONORS

15. There is growing evidence\textsuperscript{11,12} that the delay until 2014 of all new Global Fund programming poses a significant threat to millions of lives—and that a short-term replenishment is needed now.

16. A pledging opportunity could help secure the full contributions of governments that have fallen behind in their payments; as well as secure additional resources from both traditional and new donors. This could in turn make it possible for the Fund to open a new funding window this year to address current gaps.

17. The UK is one of a small number of countries who have given a firm indication that they are interested in giving an increased contribution—therefore others are looking to them for leadership. The UK’s position as Chair of the Fund, is a further reason the rest of the world will look to the UK to determine the path to resolving the funding crisis, and increases the UK’s ability to shape international partners’ behaviour.

18. By supporting the growing calls for a pledging opportunity at the G20 in Mexico the UK could help to leverage additional resources from other governments including Australia, Spain, Germany and emerging economies.

19. The G20 would provide a perfect pledging opportunity as it brings together a broad range of nations critical to the Fund’s future, and is located in one of the emerging economies that, with time, should transition from being a beneficiary to a contributor to the Fund.

20. A specific pledging opportunity would help generate the pressure and scrutiny needed to secure additional resources from other governments—ensuring UK development aid has a multiplier effect.

21. This pledging opportunity will also be a vital step in restoring confidence in the Fund in the lead up to the next replenishment cycle in 2013, which will fundraise for 2014–16.

22. We encourage the UK government to commit significant political capital to securing this pledging opportunity, working closely with the Fund Secretariat and Mexico to ensure its success. We call on the government to maximise the impact of the UK increase by working hard to use it to leverage more from other donors through letters, phone call and other diplomatic efforts by senior civil servants, DFID ministers and the Prime Minister.

AND REFORMS UNDERTAKEN BY THE GLOBAL FUND TO ITS MANAGEMENT AND BUSINESS MODEL, AND IMPROVE RISK MANAGEMENT

23. The reforms at the Fund are important, and should happen, but they are not an excuse for the international community to allow the Fund to fail to deliver on its core mandate to scale up the response to the three diseases. Reform, and scale up must go hand in hand.

24. Many of the reforms contained in the Consolidated Transformation Plan are welcome, but it is essential the Fund does not lose sight of its founding principles to be a truly global institution, to be country-led, and demand driven. The implementation of the new strategy which focuses on implementation of the best practice interventions which can turn the corner of the epidemics must be a priority.

25. Changes to the structure of the country level support functions are important and welcome, and should ensure improved grant performance and overcome problems—better delivery at the country level should be at the heart of reforms. Some changes instigated by the new General Manager are not contained within the Consolidated Transformation Plan. It is imperative that proper oversight and scrutiny of his leadership is maintained.

26. We have serious concerns about changes in the staffing structure at the Fund, in particular staff with expertise on access to medicines and the Civil Society Support structure. While civil society plays an important role in engaging with donors, disbanding the existing Civil Society team and creating two posts within the Resource Mobilisation Team will undermine the role civil society delegations are primarily designed to serve: providing oversight and informed scrutiny at every level, representing communities affected by the diseases, and implementing grants. DFID’s MAR highlighted the Fund’s strength in including beneficiary voice throughout the organisation. Civil Society should be supported by a team with a much wider remit. As a leading member of the Fund board, current chair and champion of the involvement of affected communities, DFID can and should press for the correct representation and engagement of Civil Society.

27. At the November 2011 meeting the Global Fund board chose to enforce a ruling stating that 55% of its investments must be made in Low Income Countries. The Global Fund is now imposing 25% cuts on Middle Income Countries’ “Phase II” renewals, to achieve this balance making it exceptionally difficult for implementers to achieve their original targets. The imposition of the 55% rule was unnecessary—a number of smart tools had been introduced in 2010 to control MIC investment including new eligibility criteria, a decision to focus on most-at-risk populations, and compulsory co-financing were already working. Recent allocation decisions, including making China ineligible, seem based on political expediency rather than the needs...
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identified in countries. This does not represent the most strategic way to tackle the three diseases, nor does it help to deliver a better balanced grant portfolio and donor group. We hope DFID will press the Fund to review its position.

REFERENCES


ii This figure may vary across submissions due to exchange rate fluctuations. Fair share calculations were made in dollars, with the UK’s being $1.245 billion. In 2010 that equated to approximately £840 million. Today it is closer to £780 million. The fact remains that the UK must more than double its contribution for this replenishment period (2011–13) to reach its fair share—at least an additional £384 million.

iii It should however, be noted that the UK did pre-empt the MAR to make its World Bank IDA contribution


v http://www.theyworkforyou.com/debate/?id=2012–03–14b.244.2


ix http://theglobalfund.org/documents/publications/progress_reports/Publication_2011Results_Report_en/

x ibid

xi http://www.aidsalliance.org/includes/Publication/Alliance global fund report_V6.pdf

xii http://www.msf.org.uk/UploadedFiles/Losing_Ground_201203295146.pdf

May 2012

Written evidence submitted by World Vision UK

1.1 World Vision is a child focused Christian relief, development and advocacy organisation dedicated to working with children, their families and communities to overcome poverty and injustice. We are the world’s biggest local charity, working in 100 countries and to improve the lives of 100 million people worldwide.

1.2 World Vision welcomes this opportunity to provide evidence to the International Development Committee inquiry. As one of the largest iNGO recipients of GFATM grants globally, World Vision currently delivers more than US$200 million in 28 countries including as a principle recipient of four grants.

2. The Funding Shortfall

2.1 The underlying causes for the financial crisis at the Global Fund are primarily due to donors not honouring their pledges. The Global Fund urgently needs to raise US$2 billion in order to issue the “Round 11” call for proposals but the shortfall from donors means this much needed, and previously promised money, is not being delivered. The UK has consistently provided welcome international leadership for global health and for the Global Fund specifically which we hope will continue.

2.2 The current shortcoming in funding commitment and fulfilment to the Global Fund means no new funding for scaling up or intensifying national programmes to fight the three diseases for at least two years, and a critical loss of momentum towards the goal to eliminate vertical transmission of HIV to newborns, to achieve universal access, to eradicate malaria and multi-drug resistant TB. The new initiative to integrate more maternal and child health interventions in grant proposals, which World Vision strongly supports, will be delayed. Some Round 10 grants will be delayed, further reduced, or possibly not signed. Without continued funding for the Global Fund, development gains are likely to be undermined by the three diseases.

2.3 World Vision supports the contribution which DFID has made to the fund and recommends that they use their position of leadership to urge other donors to meet their commitments.

3. Alignment with DFID’s Objectives

3.1 Part of the Government’s international development commitment is to prioritise aid spending which will “restrict the spread of major diseases like HIV/AIDS, TB and malaria”. The Global Fund is central to the UK for achieving this objective.

3.2 The Global Fund’s life-saving interventions represent 50% of the total people on anti-retroviral treatment, half of “prevention of mother to child transmission” services and about two thirds of those treated for TB and malaria. The Fund have significantly contributed to a decline in the global number of AIDS-related deaths, the
incidence rate, as well as mortality from TB and the number of malaria deaths. At the same time, child mortality in sub-Saharan Africa dropped by approximately 20%.51

3.3 DFID is committed to health system strengthening, and recognise this is essential to reach the MDGs. Despite the three disease focus of the Global Fund, it seeks to strengthen health systems, encourages applications to include HSS, and has created a Health Systems Funding Platform with the GAVI Alliance, the World Bank and WHO.

3.4 Amongst the innovations of the Global Fund, are its country-driven approach and its inclusion of civil society as decision-makers and implementers. In many countries it is this approach which means that Governments are taking action. Without the funds, our experience is that much of this work would not happen and many governments would not prioritise these three diseases.

3.5 Without continued funding of the Global Fund these successes are unlikely to be sustained and further progress on controlling these critical diseases is likely to be very limited, potentially undermining development gains.

3.6 World Vision recommends that on delivering their commitments, donors should identify ways to increase their funding of the Global Fund as an effective way of tackling AIDS, Malaria and TB.

4. Global Fund Reforms

4.1 World Vision’s experience of the Global Fund is that it is one of the stronger and more effective funding mechanisms. Some reform is needed but it is already more accountable and transparent than most and offers value for money to the taxpayer.

4.2 Health systems strengthening—Although the Global Fund supports health systems strengthening, this could be improved, especially in fragile states. In many countries the Ministry of Health does not have capacity or resources to compare with the value of the Fund’s investments. This can lead to the local prioritisation of these diseases over other equally prevalent causes of morbidity and mortality. A stronger emphasis needs to be placed on aligning programmes with long term government led objectives, and ensuring that the Fund’s contribution strengthens the whole system without drawing attention away from other pressing priorities such as other aspects of maternal, newborn and child health programming. The Global Fund should broaden its maternal, newborn and child health work beyond the AIDS, TB and malaria.

4.3 World Vision recommends that DFID work with the Global Fund to increase their role in strengthening the weak health systems of fragile states.

4.4 World Vision recommends that the Global Fund includes maternal, newborn and child health in line with DFID’s commitment to programmes which reduce maternal and infant mortality and expands this work beyond AIDS, TB and malaria.

4.4 The Fund has expanded programmes rapidly and activity needs to be sustained. In comparison with other donors, the Fund rarely closes a programme out and programmes are regenerated through extensions and continuing Rounds in order to guarantee countries sustainable funding for their disease-fighting programmes. World Vision has noted that the scalability of the Global Fund is addressed through collaboration with National Governments and NGOs to strengthen health systems and support the eventual phase out of Global Fund financing, in order to promote sustainable lasting health service delivery.

4.5 Community systems strengthening—The Global Fund seeks to support community systems strengthening, however there are challenges with its engagement with CSOs. The Global Fund is a relatively lean organisation without country missions, relying on Country Coordinating Mechanisms to identify, present the country needs and oversee implementation through Principle Recipients (PRs). Local Fund Agents (LFAs) review and verify information presented to them by PRs. The role of LFAs has changed since the reports of corruption and mismanagement last year. They have become more like “auditors” of PRs and that is adversely affecting the already poorly functioning relationship between the PRs and LFAs. There is an increase in micro-management and implementation bottlenecks created by the Fund in its efforts to manage risk as a response to the Inspector General’s reports of mismanagement. The survey report called on the Fund to balance its risk-mitigation efforts and implementation bottlenecks created by the Fund in its efforts to manage risk as a response to the Inspector General’s reports of mismanagement. The survey report called on the Fund to balance its risk-mitigation efforts with a realistic perspective of the challenges of implementing grants in difficult contexts and the need for flexibility and innovation for quality programmes. The Fund may be causing an undue burden for some implementers by way of instituting measures to the point that they take resource away from implementation. World Vision recommends that the Global Fund review and simplify the demands placed on CSOs, especially in more challenging contexts, whilst maintaining high standards.

4.6 Corruption and Mismanagement—Some of the donors who defaulted on their funding commitments to the Global Fund announced reduction or delay in their contributions due to concerns about the Fund’s fiduciary controls and reports of large scale corruption and mismanagement of grants in some countries, as reported by the Global Fund’s own Inspector General.

4.7 World Vision argues that the Global Fund has a rigorous and transparent process to identify and publicise corruption and mismanagement. While the Global Fund has acknowledged management and oversight weaknesses it is aggressively seeking to remedy this with success.

4.8 *World Vision calls on donors to work with the Global Fund on these reforms and not withdraw funding which punishes those who are most affected by AIDS, TB and malaria.*

4.9 The Global Fund is also aggressively addressing its internal management weaknesses. It has been implementing a Comprehensive Reform Plan originally proposed to the Board in December 2010 and simultaneously commissioned a review of management, investment and risk-mitigation procedures by an “Independent High Level Panel” of eminent persons. The Fund responded to the High Level Panel’s report by combining its recommendations with the previous reform plan into a “Consolidated Transformation Plan” that was approved by the Global Fund Board in November 2011. *World Vision recommends that the Global Fund should be granted time to implement the changes and that DFID continues to monitor and evaluate the performance of the Global Fund with a results focus, as was done through the Multilateral Aid Review process.*

5. **SUMMARY OF RECOMMENDATIONS**

5.1 DFID use their position of leadership to urge other donors to meet their commitments.

5.2 Donors should identify ways to increase their funding of the Global Fund as an effective way of tackling Aids, Malaria and TB.

5.3 DFID work with the Global Fund to increase their role in strengthening the weak health systems of fragile states.

5.4 The Global Fund includes maternal, newborn and child health in line with DFID’s commitment to programmes which reduce maternal and infant mortality and expands this work beyond AIDS, TB and malaria.

5.5 The sustainability of the Global Fund is addressed through collaboration with National Governments and NGOs to strengthen health systems and support the eventual phase out of Global Fund financing, in order to promote sustainable lasting health service delivery.

5.6 The Global Fund review and simplify the demands placed on CSOs, especially in more challenging contexts, whilst maintaining high standards.

5.7 Donors to work with the Global Fund on these reforms and not withdraw funding which punishes those who are most affected by AIDS, TB and malaria.

5.8 The Global Fund should be granted time to implement the changes and that DFID continues to monitor and evaluate the performance of the Global Fund with a results focus, as was done through the Multilateral Aid Review process.

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