

Evolving the Global Fund for Greater Impact in a Changing Global Landscape

Report of the Development Continuum Working Group

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Foreword

The Development Continuum Working Group¹ was convened by the Global Fund Secretariat in the fall of 2014 as a time-limited group to assist in understanding the evolving health and development landscape, highlighting the resulting implications for the Global Fund, and providing suggestions to the Global Fund on how to improve the strategic impact and effectiveness of the Global Fund's engagement with countries across the development continuum.

While the short timeframe of the Working Group made it impossible for us to consult as widely as we would have liked, we have endeavored to be as inclusive as possible and welcomed a wide range of inputs into our work. We believe this report describes a number of important issues that will require the Global Fund to evolve to maintain its impact in a changing landscape.

We make a small number of unanimous, high-level suggestions, and provide numerous options for consideration. We hope and trust this input will be helpful to this critical institution as the Global Fund embarks on developing its next Strategy.

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Executive Summary

The Global Fund has been an important part of amazing progress in global health, with substantial achievements against three of the world's most deadly epidemics and derivative benefits to broad health capacity in many countries. At the same time, access to lifesaving services is still out of reach for too many, with significant inequities between and within countries. As the world prepares to adopt the Sustainable Development Goals, which will emphasize country ownership of development, increased ambition for impact, and the continued need for effective partnerships, it is important the Global Fund continually consider its important role in this changing landscape. We believe that addressing gaps, solidifying the gains already achieved, and increasing impact requires ongoing engagement with countries that reflects where they are in various stages of a development continuum.

We believe that to continue to be an effective and leading global health institution, the Global Fund must increasingly tailor its engagement with countries according to their unique characteristics. This requires flexibility, diligence, coordination, and ongoing dialogue with the countries it seeks to assist. Based on how the global landscape for health and development has and will continue to evolve, knowledge of the Global Fund today, and a more multifaceted understanding of the development continuum, the Working Group has detailed numerous options for consideration and further exploration by the Board and the Secretariat during the development of the next Global Fund Strategy. These options are elaborated in detail in the attached, comprehensive development continuum report.

The Working Group found that the changing landscape will require further evolution of the Global Fund to continue its important and impactful role. We make the following unanimous suggestions which provide the organizing structure for this report. Under each suggestion, we provide detailed options for further consideration:

- 1) The Global Fund is now engaged in an increasingly diverse and complex global environment. To continue to maximize impact, we believe the Global Fund must evolve **towards increased differentiation and tailored partnerships with countries in different places along the development continuum**. Progress along this continuum is not in one direction only, as countries both advance and experience setbacks, and is multi-dimensional, including political, policy, institutional, social, economic, and public health dimensions. Options for consideration include:
 - Develop a differentiated investment policy
 - Evolve the Global Fund's business model along the development continuum
 - Consider a differentiated approach to investing in HSS
 - Advocate for increased domestic financing for health
 - Consider complementary funding arrangements
 - Address concentrated epidemics
- 2) The Global Fund should support country efforts to include **sustainability planning** from grant inception, **consider more appropriate metrics for eligibility and transition** (through the EAI and additional efforts), and establish a responsible transition policy that seeks to ensure sustained impact against the three diseases, particularly for key populations. Options for consideration include:
 - Develop an operational definition of sustainability

- Require a “country compact” or a sustainability plan
- Utilize more appropriate transition criteria and benchmarks
- Conduct a transition readiness assessment
- Engage with the Ministries of Finance early
- Ensure alignment with country systems
- Promote access to pharmaceuticals
- Provide support for new technology assessments
- Explore flexible and alternative grant agreements
- Allocate specific funds towards transition planning and related activities

3) The Global Fund should become ***more responsive to health needs in challenging operating environments***. It could do so by improving its flexibility and agility to support effective responses, by targeting investments in health and community systems to ensure impact, and by broadening engagement and partnerships with development and humanitarian actors. Options for consideration include:

- Determine countries requiring flexibility on a case-by case basis
- Develop standard operating procedures for COEs:
- Allow more flexibility in re-design of grants during implementation
- Consider regional grants as modality to support countries facing challenging circumstances
- Consider revising the eligibility criteria for MICs in crisis
- Make targeted investments in health and community systems to ensure impact
- Take a rights-based and resilience-based approach
- Pay special attention to human rights concerns
- Improve engagement with in country-level UN coordination clusters (health and early recovery clusters)
- Ensure greater preparedness for crises

4) The Global Fund should enhance its engagement to contribute to evidence based health policies and ***pro-health human rights*** frameworks through working effectively with partners, especially civil society. Options for consideration include:

- Promote pro-health policy change
- Emphasize gender based programming
- Engage civil society and key populations
- Promote inclusive dialogue
- Utilize regional cooperation to address challenges

1) The Changing Health and Development Landscape: Opportunities and Challenges

The Global Fund has been and continues to be an important part of the amazing progress in achievement of global health goals, with substantial successes in the fight against three of the world's most deadly epidemics and derivative benefits to broad health capacity in a large number of countries. At the same time, access to lifesaving services is still out of reach for many, with significant inequities between and within countries. Addressing these gaps, and solidifying gains already achieved, requires ongoing engagement with countries in a way that reflects where they are along a development continuum.

Civil society and communities most affected by the three diseases continue to make significant and unique contribution in the fight against the three epidemics. As an important actor within the global health community, their role in ensuring equitable access to appropriate life-saving services will remain critical as the broader health and development landscape evolves.

Building on this success and effectively navigating future challenges is more important now than ever for the Global Fund, as the global context and development landscape is evolving quickly. New scientific evidence also shows that the world has an unprecedented opportunity to accelerate high impact prevention and treatment interventions and bring about the end of these epidemics.

The evolution of the new global agenda for health post 2015 – transitioning from MDGs to SDGs – is not only a matter of adjusting the goals to reflect changing health needs, but also represents a shift to a much more diverse global development agenda relevant and important to all countries across the world. Funding will come from a range of public and private sources and there exists a strong global commitment to leaving no one behind.

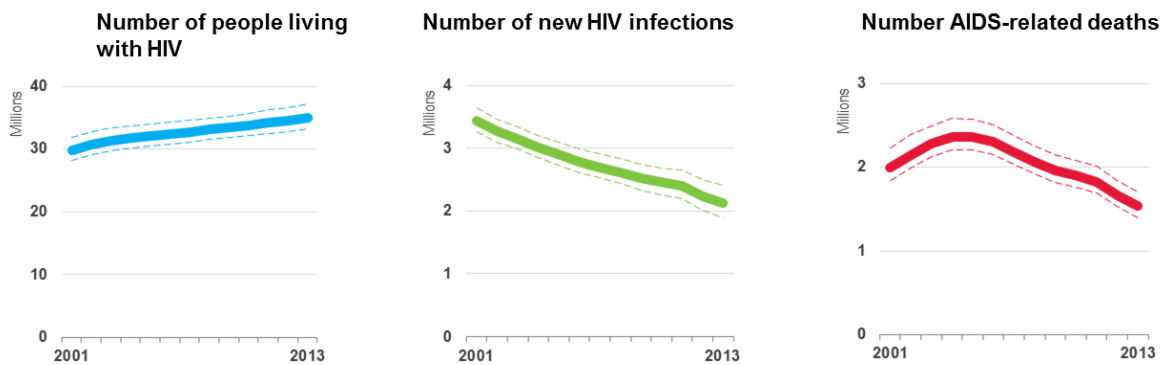
Moving from the present MDG set up with three goals specifically targeting health (reduced child and maternal mortality and halting the spread of major deadly diseases) to a broader single goal aimed at improving health and well-being across each lifespan, will provide opportunities for greater integration and impact, as well as challenges for continued progress, attention and focus.

1.1 Evolving health needs

Since the creation of the Global Fund in 2002, the world has witnessed unprecedented improvements in global health at a speed never experienced before. Child and maternal mortality have been halved since 1990 and life expectancy in most countries has increased dramatically. While these achievements are laudable, the progress has been uneven between and within countries. The gap between those who benefit and live a longer, healthier life and those who don't is increasing. The recent outbreak of Ebola has demonstrated how vulnerable this progress truly is.

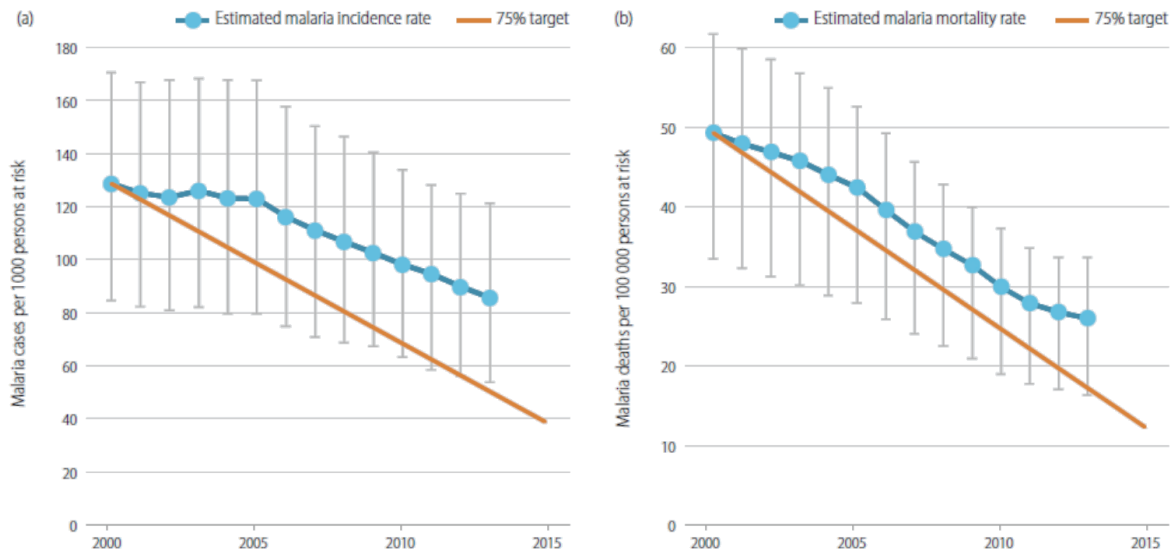
One of the most striking achievements of the past 20 years is that individuals diagnosed with **HIV** are now able to survive and live normal lives. The scale up of ARV treatment that enabled this is extraordinary. In 2002, around 100,000 people had access to ARVs, while today over 14 million people are on treatment. Yet, we have not met the HIV targets under MDG6. The majority of people living with HIV still do not have access to treatment, and too many people are still infected every day. Adolescents and youth are particularly affected. In addition, people living with HIV and key populations, including injecting drug users, sex workers and men having sex with men, too often face stigma, discrimination, prohibitive laws and policies.

Figure 1: Decrease in HIV incidence and related mortality²



Successes against **malaria** have been just as dramatic. The malaria related mortality rate declined by 47% between 2000 and 2013 globally, and by an astounding 54% in Africa. This has greatly contributed to the decrease in child and maternal mortality in many countries. The malaria target under MDG 6 has been met, and 55 countries are on track to reduce their malaria burden by 75%. These changes were possible thanks to the expansion of cost effective interventions such as artemisinin-based combination therapy, long-lasting insecticide treated nets and reintroduction of indoor residual spraying; which were largely funded by the Global Fund, PMI and country partners. Despite these impressive gains, this work is not finished. The risk of resurgence of malaria is a real possibility in many places if funding and effective prevention and control measures are not sustained. Furthermore, climate change has a strong impact on malaria.

Figure 2: Decrease in malaria³



The fight against **tuberculosis** has also achieved substantive results. The MDG target to halt and reverse the TB epidemic by 2015 has already been achieved, with TB incidence declining at a rate of 1.5 percent per year between 2000 and 2013. Worldwide, mortality from TB has fallen by 45 percent since 1990 and it is estimated that 37 million lives were saved between 2000 and 2013 through effective diagnosis and treatment. The decline in TB rates is slow, however, and an estimated 3 million TB cases are missed every year by

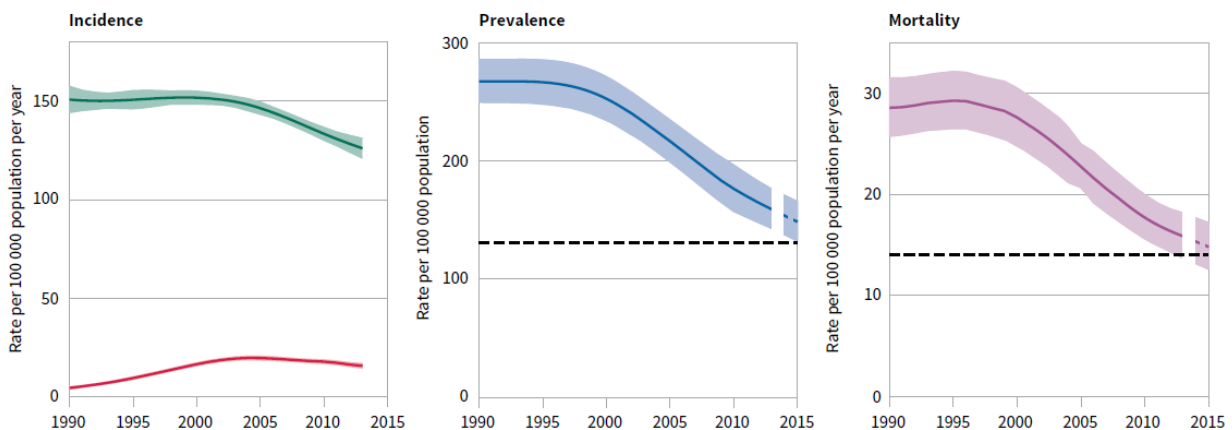
² UNAIDS Global Report 2014

³ WHO World Malaria Report 2014

national programs. Challenges remain in detecting and treating all TB patients, and in combatting TB/HIV co-infection and the increase in MDR-TB cases, very real global health threats that require sustained financial and technical support.

One of the critical challenges for the world is the control of multi-drug resistant tuberculosis. Every case of MDR-TB costs 100-fold the costs of non-resistant tuberculosis. If TB is going to be controlled, then controlling the spread of MDR-TB is imperative. Most MDR-TB is concentrated in middle income countries with particular challenges in Eastern Europe and Asia. This is due, in part, to weak TB control and public health systems. To address these challenges requires engagement in broader issues of health systems including introduction of social health insurance and universal health coverage, as well as new approaches to reaching patients currently treated in the private sector.

Figure 3: Decrease in tuberculosis⁴



Clearly countries and the global health community have made great strides in the fight against the three diseases, but substantial work remains to be done. Progress has been uneven between and within countries and regions. The lives and rights of an estimated 3.3 million⁵ people who inject drugs (PWID) in Eastern Europe and Central Asia (EECA) are in jeopardy as the policy environment for human rights and civil society participation in policy dialogue is worsening and financial support for harm reduction services and advocacy in most countries is becoming less available to the region's middle income countries. Progress has been particularly slow in fragile states affected by conflict and natural disasters, and too many people have been left behind global improvements in health. The recent outbreak of Ebola dramatically demonstrated our vulnerability to the spread of diseases to new geographic areas.

Health systems strengthening (HSS), and community systems strengthening (CSS) are widely recognized as a necessary element to maximize the impact of HIV, TB and malaria programs. Several factors indicate that HSS will be prioritized during the post-2015 MDG period including: sustained focus on scaling-up universal health coverage; emphasis on sustainability and value for money; increased evidence on the effectiveness and cost-efficiency of integrated service delivery platforms; and newly emerging recognition of health system challenges as highlighted by Ebola.

In addition, there has been notable progress in improving women and children's health during the past decade. The number of women dying due to complications during pregnancy

⁴ WHO Global tuberculosis report 2014

⁵ The estimate of 3.3 million PWID is based data reported by UNODC: 410 000 for Central Asia and Transcaucasia and 2 900 000 Eastern and Southeastern Europe. Estimates for Central Europe are not included.

⁶ Harm Reduction International's Global State of Harm Reduction 2014 states that there are 3.1 million people who inject drugs in the region (all 29 countries) based on information provided by civil society.

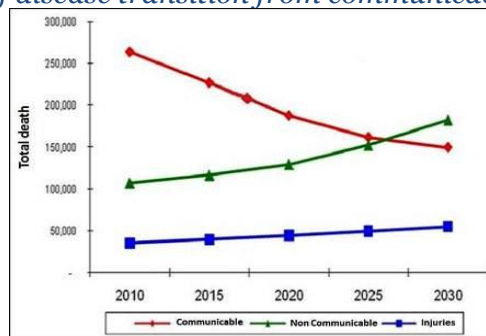
and childbirth has decreased by 45%, from an estimated 523,000 in 1990 to 289,000 in 2013. Similarly, under-five mortality declined by 49%, falling from an estimated rate of 90 deaths per 1000 live births to 46 deaths per 1000 live births. Neonatal mortality rates per 1000 live births declined from 33 to 20 over the same period – a reduction of 39%, although this decline is slower than that for overall child mortality. Despite the evidence of progress, the gains remain insufficient to reach the relevant targets on reduction of maternal and child deaths, set as part of the Millennium Development Goals (MDG 4 and MDG 5A).

In order to reduce **newborn, child, and maternal deaths**, it is crucial to ensure access to and receipt of effective interventions and good-quality health care. Progress in accessing such care has been unequal and insufficient globally, as seen in progress in the MDG target 5B of achieving universal access to reproductive health. Adolescent girls' needs are increasingly of concern. About 16 million adolescent girls between 15 and 19 give birth each year. Babies born to adolescent mothers account for roughly 11% of all births worldwide, 95% occurring in developing countries. HIV remains the leading cause of death of women of reproductive age⁷. Other sexual and reproductive health problems including sexually transmitted infections (STI), effects of unsafe abortion, early marriage, female genital mutilation, and violence against women and girls continue to persist.

In addition to the persisting issues of maternal and sexual and reproductive health, other emerging health matters that increasingly influence women's health include women's cancers (cervical cancer, breast cancer); other non-communicable diseases and related risk factors such as obesity, hypertension; and mental health problems. In the area of newborn and child health, more needs to be done to address the main causes of mortality and morbidity such as prematurity, infections, birth asphyxia, diarrhoea, and malaria, as well as the broader determinants such as under-nutrition. Under-nutrition is in fact associated with nearly half of all under-five deaths and low-birth weight associated with 80% of all newborn mortality.

Looking ahead, an epidemiological transition is occurring in which the global burden of disease is **shifting from infectious to non-communicable diseases** and total deaths from non-communicable diseases are projected to overtake those from communicable diseases just after 2025 (see Fig.4). This trend is associated with economic growth and demographic projections, and is already happening not only in high and middle income countries but also in low income countries. However, the relative share of communicable diseases is still higher in Sub-Saharan Africa. There are clearly substantive outstanding needs to fight against the three diseases and to support broader public health improvements. This transition and the continuing needs for the three diseases call for increasingly integrated approaches to funding and service delivery.

Figure 4: Global burden of disease transition from communicable to non-communicable⁸



⁷ GAP Report 2014 p.232

⁸ http://blogs.worldbank.org/african/files/african/communicable_dis.jpg

1.2 Political changes, power relationships and policy shifts

Power and political relationships are shifting as the G-20, BRICS and the MIKTA countries increase in relative economic power. Regional political structures are gaining more influence, the African Union and the ASEAN being two important and positive examples. These structures are assuming the responsibility of conveners in discussions of health priorities as well as facilitators of political engagement, and are making positive and substantive contributions in this space, one example being the Common African Position on the Post-2015 Development Agenda.

As leadership is changing over time, so do political priorities and related policies. The degree to which governments are giving a priority to health varies not only over time but also between countries and within distinct federal systems in countries. The trend in financing and prioritization for health has been generally positive and some important political commitments to increase financial resources for health exist. However there are also examples of governments that have put regressive financial policies in place which have a negative impact on access to quality health services in their country.

1.3 LIC and MIC domestic economies are growing, while poverty and disease burden are increasingly located in MICs

Under the old development paradigm, ODA was the single most important source of financing for health in low and lower-middle income countries. Most of the world's poor lived in low-income countries, and the global burden of communicable diseases overlapped quite clearly with country income levels. The Global Fund and other international partners could fund LICs and LMICs to target many of the key populations⁹ most in need.

In the last decade, however, important economic and public health shifts have occurred.

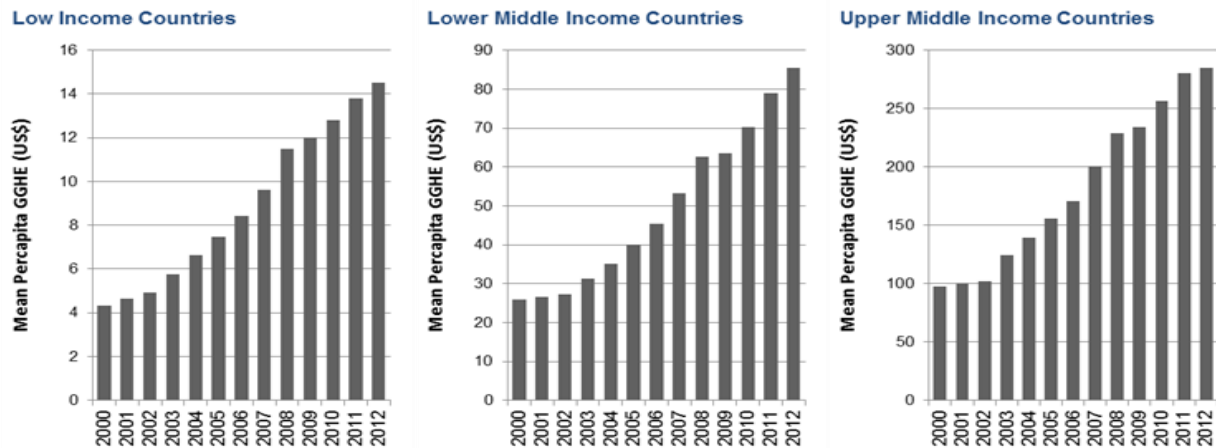
First, many countries are moving from LIC to MIC status resulting in more than 50 countries which are forecasted by the IMF to grow at a per capita income rate of above 3.5% in the current decade. Seven of the 10 fastest growing economies are in Africa. However, some countries still also occasionally move in the opposite direction from MIC to LIC status. It should also be noted that measures of GNI per capita are a limited tool in assessing health and development.

Second, and as a positive corollary, government expenditure for health is increasing in most countries. A recent review of 117 key disease programs found that governments have committed an additional US\$3.5 billion for 2015-17, compared with their spending in 2012-14 - a 56 percent increase in domestic financing. The degree to which sound, evidence based, health policies exist varies between countries. However, there is in general a positive trend in terms of more countries using investment frameworks to maximize the impact of their resources. Unfortunately this does not always translate into services that are targeted appropriately for key populations: This continues to be a major impediment to achieving impact on the three diseases and ensuring basic human rights.

Furthermore, in countries with low public spending, there is often a commensurate increase in private spending that tends to place a burden on the poor and acts as a barrier to access to essential health services. These out of pocket health expenditures are an important result and cause of poverty amongst many of world's poor.

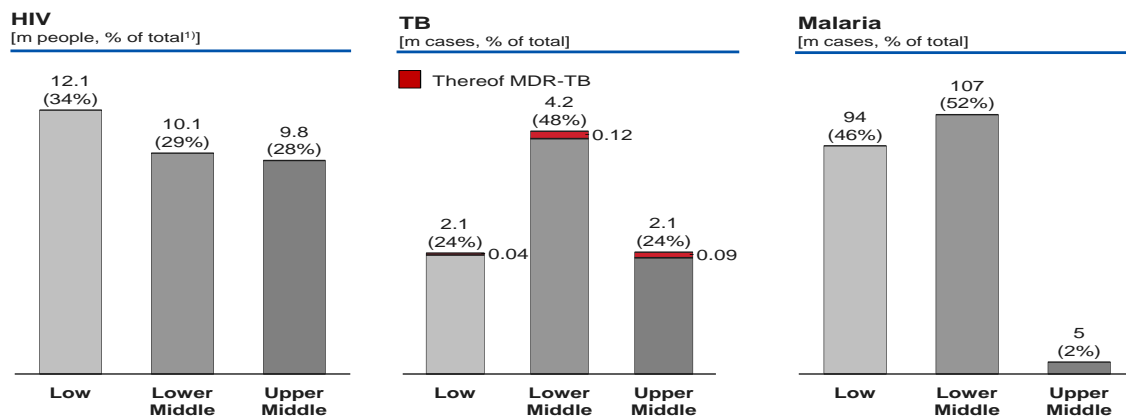
⁹ The Global Fund defines key populations as those who face (1) high risk of or vulnerability to one or more of the three diseases, (2) poorer access to services than in the general population, and (3) frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization. The Global Fund CCM Guidelines note that key populations differ from place to place but may women and girls, men who have sex with men, people who inject drugs, transgender people, sex workers, prisoners, refugees and migrants, people living with HIV, adolescents and young people, orphans and vulnerable children, and populations of humanitarian concern. The Global Fund's "Key Populations Action Plan 2014-2017" recognizes that the notion of key populations is better developed for HIV and TB than for malaria.

Figure 5: Trends in mean per capita general government health expenditure (2000-12)¹⁰



Third, the world's poor are no longer concentrated in LIC but now live primarily in middle income countries (with many having just crossed the boundary from LIC to MIC) and low income fragile states. The burden of the three diseases is also concentrated in MICs, with approximately 57% of AIDS, 72% of TB, and 54% of malaria in MICs, although large MICs, including India, China, Nigeria and Indonesia, contribute heavily to these statistics.

Figure 6: Disease burden in low-, lower-middle- and upper-middle income countries



1) Total global HIV estimate: 35.3 m
Notes: UNAIDS data, WHO 2012 data, Global Fund analysis – Results are indicative only and should not be used outside Global Fund bodies without prior consent.

Finally, while international assistance can be critical and catalytic, it now comprises a shrinking percentage of resource flows to low and middle income countries, and has been far eclipsed by both private capital flows and remittances.

These changes in the global health landscape have led to transitions in a growing number of countries where programs to fight the three diseases are increasingly domestically funded. In an ideal transition from international to domestic funding, investments in health, poverty reduction and development would lead to economic growth so that government resources, over time, would replace international support. Historically, however, there is potentially a

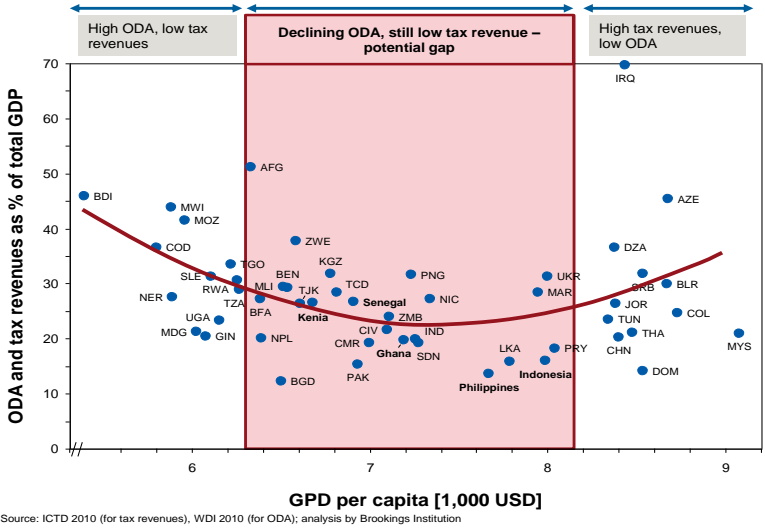
¹⁰ Source: Global Health Expenditure Database, WHO (<http://apps.who.int/nha/database>)

delay – a ditch (see figure 7 below) – in that transition from ODA to domestic resources. In many cases, ODA has declined, but due to a combination of difficulties building tax revenue, fiscal space, and policy choices, budgetary pressures rise and can become significant. International partners can play an important role during these transitions by providing tailored and differentiated support and by setting the right incentives for sustainable health progress.

It is clear that the transition towards increased domestic financing must be planned, staged, and managed well in order to avoid service disruptions and potential loss of public health impact. In many MICs, health and specifically programs to fight the three diseases, are often low on the list of budget priorities. Within a constrained funding environment there may be an even lower willingness of governments to fund services for key populations due to political or cultural factors. In these countries, it is not necessarily realistic to expect that national resources will be allocated for services targeting key populations if Global Fund support decreases without first ensuring that a planned, responsible transition to domestic health funding takes place.

Another period of transition often occurs post-conflict where international assistance is declining but domestic revenues have not been raised to expand health services. To overcome this gap, governments need assistance on capturing greater revenue through public sector. There may be also scope for diversifying revenue sources including taxes of alcohol and tobacco, innovative financing mechanisms, introduction of mandatory insurance, etc. Across both of these scenarios, ODA can play a critical role in managing the transition to domestic self-sufficiency if properly tailored.

Figure 7: Potential sustainability gap

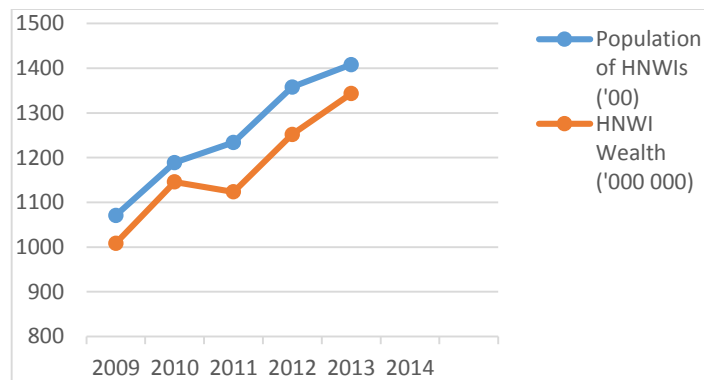


Occurring concurrently is an interesting rise of African philanthropy¹¹. Africa’s prosperity has given rise to an emerging middle class¹² and an increasing number of High Net Worth Individuals (HNWIs), who in some cases, have an interest in funding these types of services.

¹¹ S. Dare (2015) The rise and rise of African Philanthropy: Harnessing Africa's Wealth for African Development. Concept Note for 'I Will Give' CHESTRAD International. January 2015

¹² Middle class is defined here as households earning between US\$8,500 and US\$42,000 a year

Figure 8: Growth in the population of High Net worth Individuals (HNWIs) in Africa



The number of HNWIs and their wealth has grown at an average rate of 7.1% and 7.6% respectively¹³, with the middle class in major economies forecasted to grow from today's 16M to over 40M by 2030¹⁴. These factors will play important parts in deepening Africa's platforms for organized philanthropy including private donations and voluntary giving.

Finally, under the evolving development landscape, as implementing countries are tasked with taking on greater levels of responsibility for financing programs, they are increasingly looking to the private sector as a partner in innovation, resource mobilization and service delivery.

Box 1: Growth of Private Giving and Grant Making in Africa

'Based on an estimated 37 million adults in Africa making charitable donations combined with a 2% average of disposable income directed to charity and other forms of private giving, the African Grantmakers Network (AGN) estimates the annual pool of charitable donations through mobilized philanthropy to be US\$2.61 Billion.

The African Grantmakers network (AGN) notes that with a population growth rate of 2.3% across Africa, together with an annual average rate of urban migration at about 3%, the annual pool of givers would increase by more than 5% annually'.

www.southernafricatrust.org/changemakers/february2014/page5.html¹

1.4 Institutional, technical and human resource capacity varies

It is widely recognized that measuring development and sustainability only in economic terms is insufficient. Organizational and systemic capacity is equally important to achieving health outcomes. An additional critical dimension is how effectively a country can convert resources into health outcomes. For most countries increases in domestic financing for the health sector have mirrored a similar trend in increased capacity to implement programs. This has resulted in greater human resource, technical, and institutional capacity.

¹³ Cap Gemini & RBC Management (2014). World Wealth Report 2014.

¹⁴ Standard Bank (2014). <http://www.blog.standardbank.com/node/61428>

Historically the role of international partners was to “fill the gap” i.e. provide financing and capacity where it otherwise doesn’t exist. This is becoming less relevant as countries’ health resources are increasing and capacity is built internally. The level of institutional and programmatic capacity does, however, vary greatly within and between countries. For example, many countries still struggle to provide incentives and strengthen the technical competencies and capacity of their workforce and institutions; while others only require inputs in terms of policy advice and access to best practices and the latest evidence and research.

The gap between countries with weaker human and institutional capacity and those who have made strides in this area has grown wider during the past decade. Countries in conflict or post-conflict situations, as well as countries suffering from protracted emergencies, are especially vulnerable. This is clearly demonstrated by the slow progress towards the MDGs in low-income and conflict-affected states. These gaps in capacity often also put a country at high risk for low performance within the health sector and for mismanagement of resources.

At the other end of the continuum sit countries that will soon be fully funding their health sector including all programs in their entirety. This requires that programs previously funded through development partners are integrated fully into domestic financing and service delivery systems. In these countries, challenges exist related to: full integration of health services into health insurance as part of universal health coverage; contracting with non-governmental organizations through the public financial management system; ensuring integrated delivery platforms like supply chains; and integration of disease programs into primary care. There is also a clear need for robust domestic advocacy platforms linked to regional and international networks to hold governments accountable and to sustain the response.

1.5 Challenging operating environments

While many countries are making great gains in the fight against the three diseases, a large and increasing number of countries across the world are experiencing challenges and special circumstances that are thwarting the effectiveness of their responses, unravelling past achievements, and undermining the sustainability of their investments in the health sector.

These countries can potentially be divided into two groups: (i) countries facing challenging circumstances more broadly, including chronic weaknesses in capacity and governance, and (ii) crisis countries in war or dealing with the aftermath of natural disasters.

These countries and contexts can be found all along the development continuum and are often experiencing decades of chronic weaknesses in institutional capacities and national systems due to historical legacies and failed investments in development. Many are caught up in the political instability spreading across North Africa and the Sahel, through the Middle East and into Central Asia. Some are hit by natural disasters which are on the rise due to the impact of climate change, or epidemics (e.g. Ebola) that can destroy the already fragile health sectors in the affected countries, or falling oil prices that are putting a major dent in countries fiscal resources and undercutting investments in the health sector.

More specifically, these “challenging operating environments” (COEs) include a very wide variety of often overlapping country contexts and circumstances, including:

- Chronically weak institutional capacities, poor and inequitable access to health services, and weak health systems;
- Impaired/weakened institutions and loss/diversion of national budgetary resources as a result of political instability, conflict, insecurity, disasters, health emergencies, economic downturns, falling commodity prices, or other internal or external shocks;

- Political upheavals, instability, and longer-term chronic complex political situations;
- International partner sanctions and limitations on transfer of funds to Governments;
- Poor governance, lack of accountability, corruption and weaknesses in financial management capacity;
- Policies and laws that fail to protect and promote the human rights of people affected by the three diseases, disregard international commitments and undermine the effectiveness of health programs;
- Institutional bottlenecks and legal obstacles that obstruct effective implementation of health programs, especially lack of legal frameworks for the operation of civil society organizations;
- Complex emergencies due to conflict or natural disasters;
- Acute or chronic humanitarian crises affecting the whole or parts of countries, including cross border crises.

According to the TERG report cited by Aidspan¹⁵, there is a clear correlation between a state's fragility and poor health services coverage, with fragile states performing more poorly, for example, in terms of access to ARVs and to tuberculosis diagnostic and detection services. Likewise, global malaria burden is increasingly concentrated in fragile states.

Moreover, a study conducted by the French NGO Solthis¹⁶ shows that the risk management policy applied by the Global Fund in fragile states (and especially its additional safeguard measures) is not well adapted to these contexts and causes significant malfunctions that jeopardize both the impact and the sustainability of these programs.

Given the increasing prevalence of volatility and chronic fragility in the development context there is a need for more effective linkages and coordination between development and humanitarian actors and their responses while recognising their different roles and mandates.

1.6 Accountability and the key role of civil society

Since the launch of the Global Fund in 2002, the economic and partnership landscape, as well as the corresponding expectations of respective roles and responsibilities, has shifted. Relationships at country level with partners other than government increasingly play a central role in the fight against the three diseases.

Civil society plays a prominent role in mobilizing communities to access health services, delivering services, advocating for appropriate and adequate health services. It also increasingly supports accountability in the health sector.

The involvement of civil society is particularly critical to the provision of quality services in many settings where there are criminalized or marginalized populations that are not effectively or voluntarily reached by government services. As such the involvement of civil society continues to be critical:

¹⁵ Thematic Review of the Global Fund in Fragile States, June 2014, p. 27 ; p.33-35 and Lauren Gelfand, AIDSPAN, « New TERG review offers window into challenges inhibiting impact in world's most fragile states », http://www.aidspan.org/gfo_article/new-terg-review-offers-window-challenges-inhibiting-impact-worlds-most-fragile-states

¹⁶ Solthis, Therapeutic Solidarity and Initiatives Against HIV/AIDS, "Managing Risk in Fragile States: Putting Health First! Optimizing the Efficiency of the Global Fund's Grants", 2014, www.solthis.org

- to provide quality services in many settings, particularly where there are criminalized or marginalized populations that are not effectively reached by government services;
- to advocate for policy and program change (including the protection of human rights);
- to monitor and gather evidence regarding budget expenditure on health service provision and quality, and documentation of human rights abuses;
- to hold governments accountable for their commitments;
- to mobilize more resources for civil society and for the national responses to the three diseases; and to influence the political will of governments to invest in health.

Global Fund investments in Community Systems Strengthening (CSS) have elevated and helped sustain civil society's role in delivering health services, as well as independent community based monitoring aiming for quality and accountability of government services. However, studies on financing community responses (such as the World Bank study on the role of communities in the HIV response) clearly show that funding for civil society is still far short of what is needed. As civil society organizations rely disproportionately on external funding, it is essential that discussions on transitions from donor support consider how this mandate will be fulfilled in the context of domestic financing.

2) The Global Fund

The Global Fund has been a critical partner to countries across the world and part of unprecedented progress in global health, with substantial achievements against three of the world's most deadly epidemics and derivative benefits to broad health capacity of low and middle income countries.

Established as a partnership, the Global Fund works closely with a wide diversity of partners: implementing governments, development partners, civil society, international development organizations, the private sector and communities living with and affected by the three diseases. This partnership model supports country-owned approaches that develop and implement effective, evidence-based programs. Partners are actively involved with the Global Fund at all levels: as members of the Board and its committees, supporters of resource mobilization activities, members of country coordination mechanisms (CCMs), providers of technical assistance and, implementers of programs in communities. These effective partnerships are key to the success of the Global Fund. This is in line with a broader global trend of moving towards more cohesive partnership models in international development.

The Global Fund's Partnership Strategy ensures the voices of civil society are brought forward as equal partners in all aspects of its work and governance framework. It also supports the inclusion of innovative private sector initiatives and the work of technical partners to ensure that programs are technically sound. Implementers are central to and drive the Global Fund's partnership approach. They deliver services, produce results, and stimulate innovation.

Partners also hold the Global Fund accountable to one of its most important core principles, supporting the implementation of country owned national strategies and priorities through country-led processes and mechanisms. This is achieved through the CCMs, which serve as country-level multi-stakeholder partnerships responsible for the development of Global Fund grant proposals based on priority needs at the national level; and oversight of grant implementation. CCMs consist of representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people most affected by the diseases.

In addition, the Global Fund has a unique commitment to the human rights principles of accountability and transparency. Human rights is one of the five strategic objectives in the current five year GF Strategy- Protect and promote human rights- which serves to ensure that the Global Fund does not support programs that infringe upon human rights, that human rights considerations are integrated throughout the grant cycle, and that the Global Fund increases investment in programs that address human rights barriers to accessing health services.

2.1 The impact of the Global Fund to date

The Global Fund has and continues to make strong contributions to the fight against the three diseases and to improving global health. The Global Fund has helped to fund a rapid scale-up in the prevention, treatment and care of HIV/AIDS, tuberculosis and malaria across more than 150 countries, contributing to tens of millions of lives saved. More specifically, in the past year:

- An additional 1.3 million people began treatment for HIV in programs supported by the Global Fund, a 20 percent increase, bringing the total to 7.3 million people;
- Approximately 1.1 million new smear-positive TB cases were detected and treated, bringing the total to 12.3 million;
- People treated for MDR-TB rose 39 percent in the past year to hit 150,000;
- The number of mosquito nets distributed for prevention against malaria rose by 90 million to hit a total of 450 million over the past year;
- In the same period, the cases of malaria treated rose 20 percent to hit 470 million

These investments have been delivered in a country-driven way, and through an innovative partnership between governments, civil society, technical partners and the private sector.

Figure 9: ART results by region (end 2014)

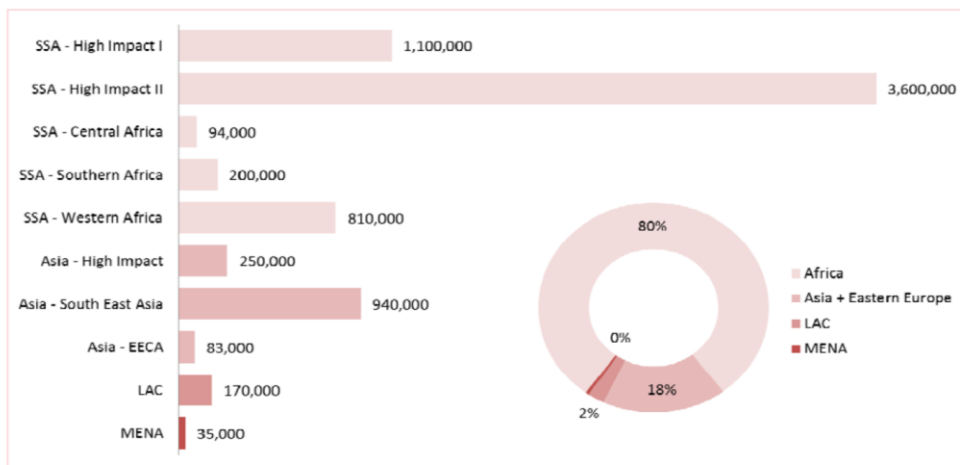


Figure 10: New smear positive results by region (end 2014)

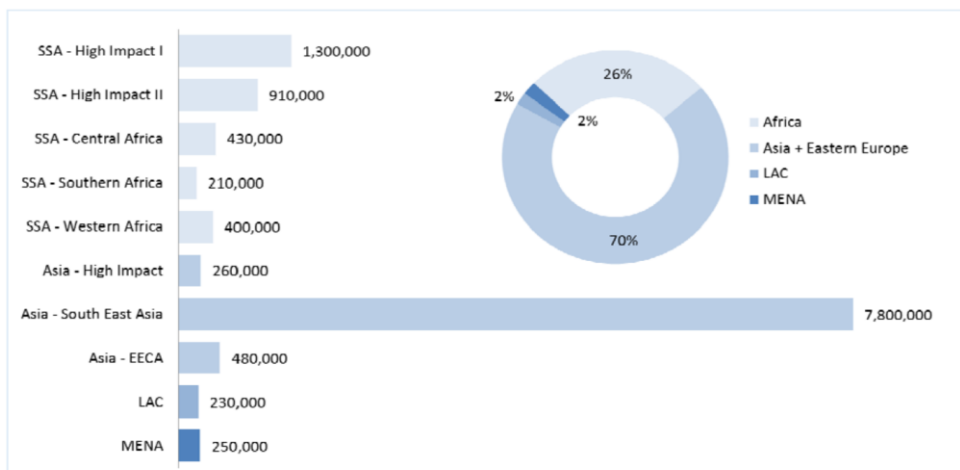
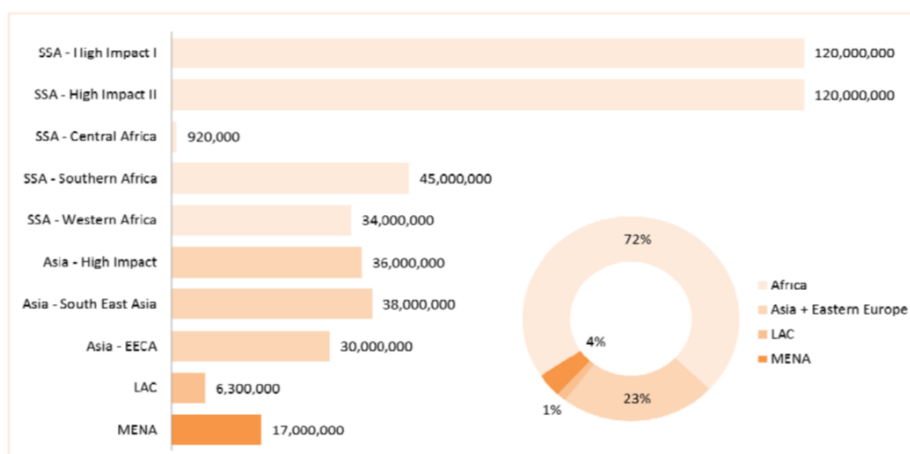


Figure 11: Malaria net distribution by region (end 2014)



HSS Case Study: Afghanistan

While Afghanistan continues to face significant capacity and human rights challenges, the country has taken an exemplary approach to aligning external investments to national strategic priorities. The Ministry of Public Health and its partners have developed a series of long- and medium-term national policies and strategies for strengthening the health sector. The country's vigorous approach to strategic planning led to a high-quality HSS concept note, which was the first stand-alone HSS application since the launch of the funding model. Also contributing to the success was a well-structured institutional setup of the Ministry of Public Health, allowing effective cross-program and cross-donor coordination. The Ministry of Public Health manages both Global Fund and Gavi, the Vaccine Alliance HSS grants, as well as many BPHS (primary health care) implementers under the SEHAT project.

A well-organized inclusive country dialogue process for concept note development also contributed, as it was informed by robust analytical assessment of health system priorities. The concept note was focused on three pillars: health and community workforce development (through building capacity of female community health nurses), service delivery (via revision of the laboratory network) and health information systems and M&E (via improvement of the HMIS). The health and community workforce will be deployed to scale up provision of basic package of health services, including HIV, TB, malaria and maternal and child health services. The program also aims to strengthen the laboratory component of the basic package of health services delivery platform by providing necessary equipment for regional and provincial laboratories, procurement of supplies and lab reagents, lab infrastructure development and training of lab personnel.

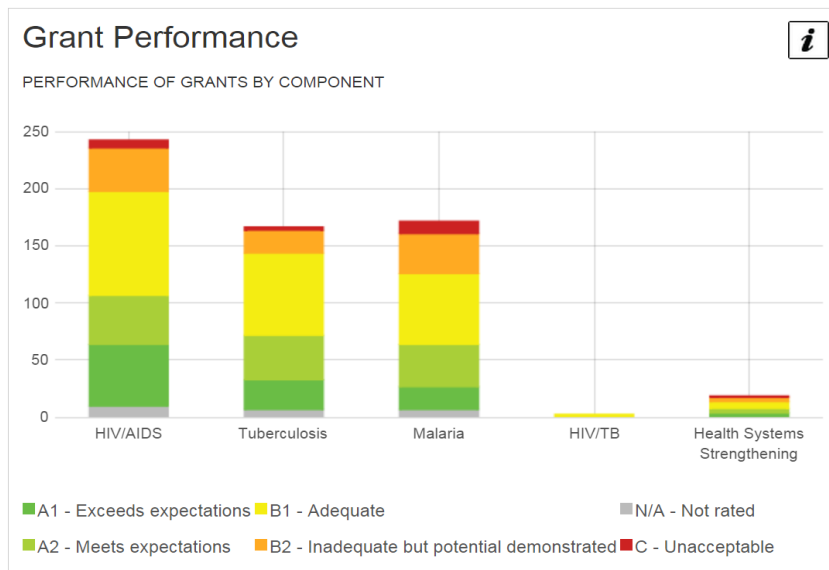
These investments in service delivery and human resources are complemented with strengthening the health information system, with the expected target to have over 90 percent of service facilities submitting high quality-monthly activity reports within one month of completion of the reporting quarter. The Global Fund's HSS investments in Afghanistan bring potential to increase vulnerable population's access to services, improve quality of care and optimize data availability. These investments are targeting HIV, TB and malaria programs.

Given the importance of the three pillars for the Afghanistan health system and the investments made especially in health workforce (more than 800 trained community health nurses to be deployed in their own communities) and service delivery (more than 100 new laboratories with wide range of diagnostic services initiated on different levels of the laboratory network), the investments also have spill-over effects on broader range of health outcomes, helping contribute to higher efficiency and value for money.

2.2 Managing performance

To manage performance and achieve results, the Global Fund uses performance-based funding, a method that was developed to ensure that Global Fund grants are spent on delivering services efficiently and effectively to those who need them most. Performance based funding provides a platform for countries to demonstrate that they can convert financing into results. Achievement of set targets is required to access additional disbursements. Depending on a particular country's results, the grant is given a rating that ranges from A1, A2, B1 or B2 and that rating directly impacts how much additional funding a country can access.

Figure 12: Global Fund grant performance



To verify these results, the Global Fund contracts a Local Fund Agent (LFA). The LFA provides independent assessment and verification services through risk-based approaches and methods at various stages of the grant lifecycle:

- Before grant signing, the LFA may be required to assess the proposed grant implementation arrangements, the implementers' capacity and track record and the effectiveness of internal controls and systems. This assessment may include a review of the implementer's detailed budget, work plans, and other grant related documents.
- During grant implementation, the LFA reviews the implementers' progress in achieving the performance targets and reviews appropriate use of funds in accordance with the grant agreement.
- When a grant reaches the end of its life cycle or is terminated, the LFA may be required to review the activities relating to the closing of the grant and advise the Global Fund on issues and risks related to grant closure.

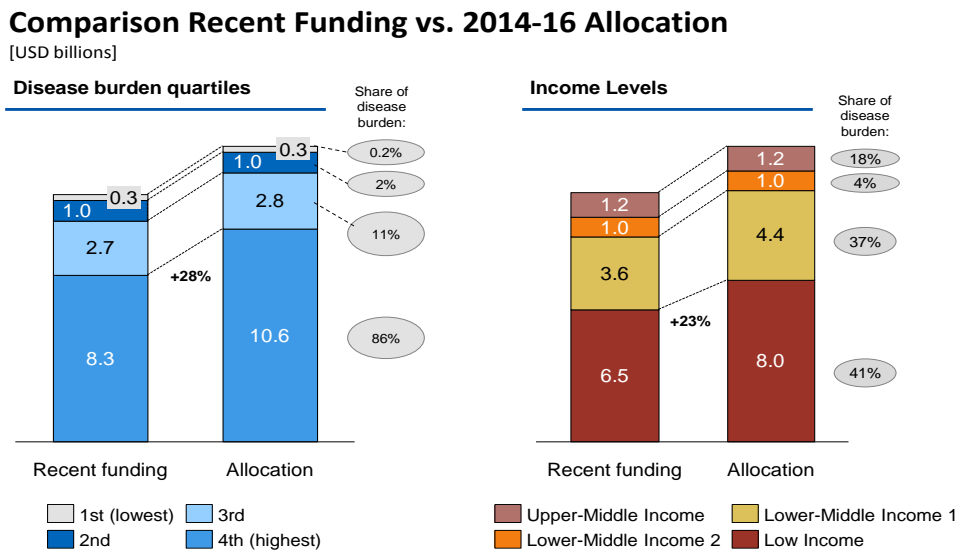
The LFA model is central to the Global Fund's management of risk. LFAs become more involved in countries where there is substantial risk of misuse of funding, for example in some challenging operating environments where aspects of good governance and accountability are not in place.

2.3 Evolving the “one size fits all” business model for impact

In 2012, the Global Fund adopted a new funding model, premised on the goal of “investing more strategically.” It was hoped that by using this model the Global Fund would achieve greater impact by targeting investments to the highest burden countries with the least ability to pay, and provide a more flexible and predictable approach to funding. While this model supports some country-driven differentiation, more nuanced targeting of investments according to specific country needs across the development continuum is possible in the future.

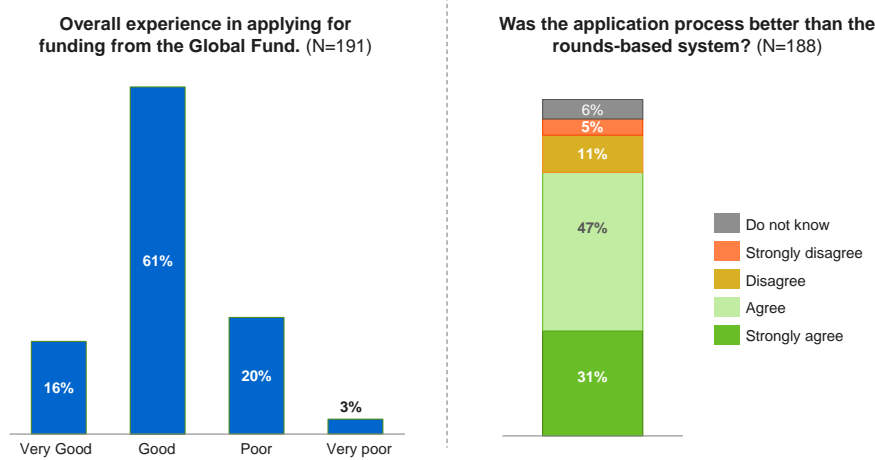
The model has transformed financing for the three diseases. An analysis comparing recent funding with the 2014-16 allocation shows a clear shift of Global Fund resources to countries with high disease burdens and limited domestic resources (see figure below), successfully focusing Global Fund support in areas where its investments have the potential for greatest impact.

Figure 13: Shift of Global Fund resources to countries with high disease burdens and limited domestic resources



The New Funding Model has largely been embraced by countries as an improvement, while recognizing the need for further enhancements. In a recent survey of Global Fund applicants, 78 percent of respondents felt that the new funding model application process was better than the rounds-based system, and 77 percent of participants said that their experience in applying for funding under the funding model was good or very good.

Figure 14: Survey results on new funding model perceptions and experiences from Global Fund applicants



Most countries utilized more inclusive country dialogues and better engaged key populations. In a recent survey of applicants, 90 percent of respondents said their concept notes were based on national strategic plans, a sign of greater alignment with country priorities within concept notes.

Implementation of the New Funding Model has highlighted challenges and opportunities for further improvement. There are tensions between funding specific interventions critical to the fight against the three diseases and investing in broader health systems (which also contributes to ending the three diseases.) While progress is being made in addressing human rights, gender and key affected populations in country concept notes, concrete interventions were often vague, insufficient in scope or deprioritized. There are concerns that the allocation model places too little funding in middle-income countries with concentrated epidemics, and concerns about continued gaps in essential services in high-burden and low-income countries. Establishing the right balance between saving the most lives and investing to end epidemics, particularly for malaria, will be a key question for the Global Fund.

The Global Fund is grappling with other questions as well, such as how to increase impact, value for money and aid effectiveness; better manage risk; and reduce bureaucracy and delay, while retaining its core principles. Resource mobilization has also become more challenging following the world's economic downturn. Despite all, there is a real opportunity now to significantly alter the trajectory of the epidemics.

Quality data is essential in these efforts. Going forward the Global Fund is seeking to improve the quality and availability of data, to enable strategic decisions from site, to district, to national, to global level. In this, it is emphasizing the need to support national targets and data reporting systems as well as the strengthening of Monitoring & Evaluation systems with strong feedback loops to ensure delivery of quality services.

In order to ensure access to better data, as part of the Global Health Leaders group, WHO led an effort to reduce the number and improve the quality of health indicators, focusing on 100 indicators. As part of that initiative, there is now important work underway to develop a common data verification platform, to yield a common approach for data and service quality reviews and health facility assessments.

The Global Fund also worked with technical partners to revise indicators to focus on impact, including coverage rates for key affected populations. As part of the transition to the new funding model, those indicators are “going live”. There has been extensive collaborative work with countries to ensure they are embedded within strong monitoring systems and that this will be aligned with the global effort.

Finally, since 2012 the Global Fund has worked with partners to support 20 high impact countries to do epidemiological and impact analyses. The findings from these exercises have been paramount in informing the revision of national strategic plans and subsequently the development of the concept notes.

2.4 The Global Fund in challenging operating environments

While countries implementing Global Fund grants have achieved impressive results, there are a number of challenges and risks which the Global Fund is encountering in challenging operating environments. These include:

- Poor grant performance and results when grants are implemented by national entities without adequate support from partners;
- Weak capacities, financial management, and fiduciary controls of national entities or weak non-governmental agencies that are selected as Principal Recipients and Sub-Recipients;
- Inadequate access to services, lack of equity, and violation of human rights of key affected populations;
- Inadequate governance, compliance and oversight;
- Disruptions in procurement and supply of lifesaving health products leading to stock-outs, interruptions of treatments, and loss of patients;
- Situations of refugees and internally displaced people, sudden humanitarian crises, deteriorating security, natural disasters, and other shocks;
- Difficulties encountered by the Global Fund Secretariat and the Local Fund Agents to oversee the grants due to safety and security concerns; and
- Inadequate M&E and lack of quality data in fragile and crisis countries.

The Global Fund has developed a range of policies and approaches to deal with these often volatile situations over the years. The Global Fund can invoke the “Additional Safeguard Policy” to exercise more control over the management of the grant, from the choice of the PR to the put in place of Fiduciary Agents, or the introduce zero cash policies to reduce fiduciary risks.

However, these policies are meant as temporary solutions and ultimately the Global Fund must develop an inherently more flexible country tailored approach to daily grant management that prevents interruption of program service delivery. Other instruments, like the recently created Emergency Fund, can allow the Global Fund to respond more quickly and effectively in emergency situations.

3) The Development Continuum

Currently there is no concrete science which is used to categorize countries according to the level of development that they have achieved. The normal way of using GDP per capita or GNI per capita has drawbacks and does not account for the full range of complex health and inequality issues.

Continued engagement with the broad range of the Global Fund's partners engaged in similar work and processes e.g. Gavi, the Vaccine Alliance, the World Bank, and UNDP, offers important lessons learned and coordination opportunities to assess support and engage with countries in a dialogue around the dynamics of the development continuum.

Different environments exist where multi-faceted dimensions of the development continuum become very real. In some settings there is strong leadership in place, good systems and a low risk for corruption but there are major shortages in terms of financial and human resources. In other situations there might be a higher ability to pay but the leadership to implement effective health policies might be lacking. Yet again in other contexts the systems for managing resources might be weak and the risks for corruption high. In some contexts the needs for investments in the three diseases are of major national importance but in others there are more isolated needs.

There is a need for a more multi-dimensional framework in order to be able to operate effectively in different country contexts and settings. The evolving landscape and environment in which the Global Fund operates requires the Fund to become more flexible, nimble and tailor-made in its ways of investing resources and working.

A possible way to codify the different aspects of development, which are of special importance to the Global Fund, could be the following framework. It should be noted that they are not ranked in order of importance but are interlinked elements of the Development Continuum:

- **Health status** (disease burden, disease trajectory/trends) at national and sub-national levels and among most affected populations is improving.
- **Relevant policies** (health, financial, systems and human rights) exist and are implemented.
- **Governance, leadership and management** is strong and adequate and policies are turned into action.
- **Financial resources** are adequate and available and financing is fair.
- **Institutional capacity, national systems and human resources** exist and are providing the necessary prerequisites for effective program management.
- **Systems for accountability and managing risks** are in place and effectively functioning.



Consideration of these six elements is necessary to take into account the many aspects of development, rather than the economic dimension only. Understanding the development continuum requires recognizing that where a country sits in relation to each of these elements is dynamic and changes over time. Ultimately a country should reach a point where the components of each of these elements are at the right stage for it to independently take on the fight against the three diseases and for health in general in an effective, accountable, and equitable way.

This will require an iterative process during which relationships with the Global Fund and other development partners will transition from full support to self-reliance on domestic resources within new forms of development cooperation where roles have changed from reliance to mutual benefit and cooperation; and a new global health architecture that supports the aspirations of the SDG.

This could mean and include (a) sustaining the achievements against the 3 diseases, reducing and preventing new infections (where technology and inputs permit control and/or eradication might be considered); (b) reduction in international resources for health and development; (c) increase in GDP and growing wealth LMIC transition to MIC; (d) potential transition from aid to trade and loans; (e) expansion and innovation in domestic financing; (f) transition from Technical Assistance to Technical Cooperation (From help to mutual benefit); (g) stronger political and democratic systems and (h) greater accountability

Understanding these context specific factors, the Global Fund could evolve its model in the following ways;

- a) The Global Fund could work in a more focused and strategic way with partners on policy challenges to public health progress, make resources available for policy analysis and policy development, and potentially support specific advocacy actors to push for policy change where needed.
- b) The Global Fund could tailor funding to support financial and programmatic sustainability by creating compacts that build towards responsible transitions and promote increased domestic funding for health where appropriate, while revising eligibility and co-financing policies to support sustainable investments.

- c) In situations where national structures for accountability are strong and the risk for corruption is low, and significant progress is being made on Human Rights, Gender equality and support for Key Populations and Civil Society, national systems could be used to higher degree and Global Fund resources channeled mainly through Treasuries. In other situations, results-based financing could be used to strengthen monitoring and evaluation while incentivizing increased impact.
- d) In fragile states, countries with especially weak national capacities, and crisis and conflict-situations, the Global Fund should be flexible and work closely with partners to better reach people with the three diseases who live in these challenging operating environments, and build resilience and recover the capacity of health and community systems.
- e) In large, complex and federal states, the Global Fund could target efforts at the sub-national level and invest greater staff resources in managing partnerships with these states.

In essence, the Development Continuum should be seen as a way of working, an analytical framework for Portfolio Managers and partners to use in a dynamic and responsible way to ensure that the Global Fund is making the best possible investments based on each specific country context.

4) Options to be considered

Based on the summary of how the global landscape for health and development has and will continue to change, the description of the Global Fund today and a more multifaceted understanding of the development continuum, the working group has explored different options and directions which could be further developed by the Board and the Secretariat.

*Those **options** have been grouped under **four overarching suggestions**;*

- ***Diversify engagement and investments along the development continuum***
- ***Increase the focus on sustainability and responsible transition***
- ***Become more responsive to health needs in challenging operating environments***
- ***Enhance engagement to contribute to evidence based health policies and pro-health human rights frameworks***

4.1 Diversify the engagement and investments along the development continuum

The Global Fund is now engaged in an increasingly diverse and complex global environment. To continue to maximize impact, we believe the Global Fund must evolve towards increased differentiation and tailored partnerships with countries in different places along the development continuum. Progress along this continuum is not in one direction only as countries advance and sometimes decline, and is not along one dimension only but includes politics, policies, institutions, economics, and public health.

Discussion and Options

Determining how best to invest and engage along the development continuum is particularly important for the Global Fund as it currently uses disease burden and income classification as metrics to determine which countries are eligible for grants and at what level. Countries which have historically been able to access Global Fund resources may not be able to access similar amounts of funding as economies grow and disease burden declines.

For countries that are at the “beginning” of the continuum, the Global Fund is likely funding a large percentage of disease program budgets, as well as potentially key system components such as a public financial management system that has implications beyond the health sector. Often, at this end of the development continuum, a country is going through the complex transition from a post-conflict fragile state to establishing forms of government administration and financial management. As such, there are often major systemic and capacity gaps in the health sector that greatly affect ability to implement programs.

Diversifying the way the Global Fund invests and engages in different country settings is not merely about the financial investments but also how the Global Fund as a financial institution also can positive influence political will, capacity development and long term programmatic and financial sustainability.

Then there are countries where governments are under-prioritizing health, despite the fact that they should (and might) be scaling up prevention and treatment interventions, thus increasing their reliance on international support. In many of these countries, health spending is less than 7% of government spending and actually decreasing.

Next, there are countries that are focused on the scale up of interventions. With scale up, questions of value for money and improving the efficiency of investments become particularly pertinent. Some countries have health systems that function at lower productivity levels which is a systemic constraint for scaling up.

Options for consideration

1) Develop a differentiated investment policy

The Global Fund could develop a more differentiated investment policy. This would require the Fund to develop guidance detailing what it could potentially finance at different stages of the development continuum taking into account local capacity, domestic spending on health, and possible impact. For example, funding for core commodities or HR, is a recurrent cost which is not a sustainable approach in the longer term, unless timely and gradually transferred to a host government budget. While this type of support may be necessary in countries at the beginning of the development continuum, in the longer term, these systems must be created and function independent of international support.

There could, however, be particular cases where the Global Fund should pay for commodities. This should be to save lives and to accelerate implementation of new and innovative prevention, diagnosis, and treatment technologies. In this case, funding should be seen as short to medium term and a transition to domestic financing should be included in the grant.

Finally, at the “end” of the continuum, the Global Fund possibly should not pay for core commodities like first line ARV, TB drugs, and anti-malarias. In addition, at this point, all human resource costs should be on budget and no longer dependent on Global Fund support for staff salaries. Instead, the Global Fund could be supporting key activities that will allow an effective transition to self-sustainability to take place. This would include activities such as those which ensure the government’s ability to contract with NGOs, integration of novel mechanisms such as RBF, and integrating all health costs into the government budget.

2) Evolve the Global Fund’s business model along the development continuum

The Global Fund could become an even more effective actor with more of a differentiated business model for its investments and engagement along the development continuum.

Based on the different dimensions of the development continuum conceptual model the Global Fund could tailor its ways of working;

- 1) How the Global Fund together with partners is engaging in the policy dialogue contributing to more pro-health policies or the use of even more evidence based investments frameworks. The need for this will vary from country to country and the capacity, partnering and competence of the Global Fund need to be adjusted accordingly
- 2) The potential for health impact depending on capacity, management and risks. In countries with strong national managerial systems and low risk national systems can be used for channeling funds, in other circumstances special safeguards might be needed.

- 3) The relative financial role of the Global Fund and international partners' active in the country. The CCM might be replaced by the national health sector steering committee.

3) Consider a differentiated approach to investing in HSS and CSS

Effective and well-functioning health and community systems are crucial to the success of the Global Fund. The Global Fund's strategy for investing in and contributing to inclusive and decentralized health systems is an in-direct one (or diagonal) rather than a direct one (or horizontal). The Global Fund needs to be sensitive to different country settings and approaches to develop national systems. Along the development continuum there will be a need for localized approaches based on proper analysis.

Along the development continuum there exist also many fundamental health and governance challenges which are beyond the Global Fund's mandate and organizational capacity but where it none-the-less could still contribute.

Currently, most Global Fund investments for public health are actually for personal health services like treatment which are both excludable and rivalrous. Investing in public goods and health and community systems inherently requires a focus on impact and activities that would be supported serve to measure the impact of investments rather than outputs.

The Global Fund could consider in addition to support for disease and/or HSS programs earmarking some percentage of its grant portfolio or a percentage in each individual grant for investment in public goods as part of strengthening health and community systems and national capacities. Examples of public goods in health are the absence of drug resistance, or herd immunity. Investment in such areas for the Global Fund could entail increasing funding going towards activities such as:

- 1) Disease surveillance: incidence/prevalence, fitting basic epidemiological models, resistance monitoring
- 2) financial management systems for public and community health, national health accounts, disease accounts, household survey on out of pocket spending, IMS dataset on pharmaceutical spending
- 3) Information systems, vital registration, household surveys like DHS, LSMS, MICs, HMIS like DHIS2

This is closely connected to the broader issue of health and community system strengthening and using a more targeted approach. One of the critical areas of investment is for better data collection and health information systems.

4) Advocate for increased domestic financing for health

The Global Fund could use its influence to exert pressure on countries that have low levels of health expenditure as a share of government expenditure to increase domestic financing for health. Even in countries where domestic spending on health is at or above the Abuja targets, the Global Fund should continue to support the government to find innovative ways to increase spending on the health sector and provide technical support to governments to measure health expenditure on a routine basis.

In addition, the Global Fund could support domestic advocacy groups to advocate for greater health budget accountability. Often budgets are not fully executed which makes it difficult to advocate for an increase in funding. Civil society can play a key role in monitoring budget spending levels and improving accountability. As such a key component of any transition strategy should be to develop civil society advocacy groups which can hold governments to account once donors have left. Some innovative approaches to budget transparency have already been utilized in South Africa and Brazil, and could be expanded to other countries.

Finally, there is a special group of countries that require more sustainable, political leverage. These are the countries where health spending is already low and falling. While in these situations there is a role for greater resource mobilization, these countries also present an opportunity for the donor community to raise this issue and exert political pressure. In many of these countries only 7% of government revenues are spent on health. Most of these countries are experiencing decentralization, and they need support to manage a complex fiscal process providing a key area for technical assistance.

5) Consider complementary funding arrangements

The Global Fund could use, or partner with other organizations to develop, a transition instrument such as a loan/credit agreement (for 5 or 10 years) to continue to provide support in countries that have transitioned from grant eligibility for key health systems issues. Funding from the instrument would not necessarily come from the Global Fund but could be facilitated through the Fund's partnership and ensure sustained health systems support over the longer term. Countries would decide independently whether to use such transition instrument.

There may also be scope for some type of hybrid instrument where international funding is used to buy down a loan to more concessionary rates. The Global Fund could reach out to regional development banks which are likely to play a greater role in development going forward, including newly created regional banks. There is scope for greater collaboration with the World Bank on integrating critical sustainability issues like procurement and supply chain into their health sector lending program. There may even be a possibility for the Global Fund to use its balance sheet to provide guarantees. A process should be set up to explore all of these options more comprehensively.

The Global Fund could also encourage CCMs to look at novel means for supporting HIV, TB, and Malaria programs prior to transition. This would include identifying local philanthropy which could potentially fund programs targeting key populations where the government may not be willing to do so, or social enterprise mechanisms focused on investing for impact. Social enterprise initiatives are well developed in a number of countries where the Global Fund currently provides financing and could be included in discussions around HIV, TB, and malaria programs at CCM level to ensure their continued engagement following transition.

6) Address concentrated epidemics

A large number of lower middle income countries will become classified as middle income countries in the next several years. Many of these countries, such as India and Nigeria, have very large underserved populations with high disease burden. A policy on health and community services strengthening for vulnerable, marginalized and most-at-risk populations in countries with concentrated epidemics could be developed in collaboration with partner organizations.

4.2 Increase the focus on sustainability and responsible transition

The Global Fund should support country efforts to include sustainability planning from grant inception, consider more appropriate metrics for eligibility and transition (through the Equitable Access Initiative and additional efforts), and establish a responsible transitions policy that seeks to ensure sustained impact against the three diseases, particularly for key populations.

Discussion and Options

A number of countries that currently receive Global Fund support are facing complex transition issues. In many of these countries, public health services for HIV, TB, and malaria are often not well incorporated into the mainstream health financing system represented by separation of functions with defined agencies having explicit responsibility for pooling and purchasing (as with, but not limited to, compulsory health insurance arrangements). Often, instead, these services are publicly funded and delivered vertically through public providers, they are not incorporated holistically into the country's health financing system.

Following transition, countries continue to face health system challenges particularly around controlling rising health care costs. Key drivers of rising costs include an ageing population and the necessity for technological change, along with the broader epidemiological transition from communicable diseases to non-communicable diseases.

In fact, all countries across the length of the development continuum face the challenge of rising incidence of non-communicable disease. This contributes to the burden on the health system.

Discussions of sustainability inevitably include both a *financial aspect* and a *programmatic aspect*. Financial sustainability may be defined as the fiscal capacity of a government to sustain or increase current spending, tax and other policies to ensure continuity of activities and services in the long run.

Programmatic sustainability is sometimes defined as the continuation of a program while maintaining the goals and values under which it was initiated, once external support, be it financial and/or technical, is removed. It should be noted that sustainability in this sense should not mean stagnation: A successfully sustainable program should target the same key populations under which the program was initiated, and with the same focus on the mix of prevention and/or treatment strategies. Therefore it is imperative that the Global Fund ensures that it fully engages countries through grant implementation, and adequately prepares with a partner country for the transition period.

All global development actors who are engaging in low and middle income countries have a responsibility to ensure that their development interventions have positive impact and this impact is sustained and sufficient and that their interventions result in stronger capacity and systems to maintain and build on the gains that have been achieved. It is only the combination of these two factors that make sustainability feasible and any withdrawal/transition of support responsible.

In the context of Global Fund support, transition away from different types of financial and non-financial support would happen at different points along a country's development continuum until such a point that the country was deemed able to take sufficient responsibility (programmatically, financially, politically, institutionally, legally) for maintaining and expanding upon their responses to the three diseases.

Options for consideration

1) Develop an operational definition of sustainability

For the Global Fund to effectively engage with countries, it must first decide upon an operational definition of sustainability to translate the concept of sustainability into terminology that is measurable for the institution. This would enable the Secretariat to measure its progress on implementing recommendations included in the Global Fund's 2017-2021 Strategy on sustainability and operationalize recommendations effectively.

2) Require a "country compact" or a sustainability plan

Country dialogues provide an appropriate foundation for a consultative process through which to develop a "country compact" and plan for transition involving all stakeholders. The Global Fund should ensure involvement of stakeholders especially those implementing the program to identify the sustainability requirements, appropriate sustainability strategies and ensure sustainability of their interventions.

The plan should detail longer-term vision for supporting the program, potential pitfalls that may impact its sustainability, and ways to mitigate those pitfalls. The plan should be staged to ensure that during implementation, the program is always co-funded by both the Global Fund and country and that there are progressive increased funding responsibilities for the government with associated timelines and milestones.

If country dialogues are fully representative and inclusive consultative processes then the transition plan, as an integral part of the concept note, will have buy in from all key stakeholders. The Global Fund should develop and issue specific guidelines on the content and process for developing transition and sustainability plans to guide countries. In addition to providing the guidelines, the Global Fund should work with technical partners and play an advisory and capacity building role in the development and implementation of the sustainability plans. Urgent attention is required for transition planning and special assistance for countries where programs particularly affecting key populations are facing funding cuts, including a transition plan for prevention programs and access to medicines.

The sustainability plan should be flexible and should be adjusted in real time to accommodate changes to country context as the grant is implemented. The Global Fund could consider the possibility of continuing to fund aspects of this compact even following transition for technical assistance purposes. The Global Fund can build on the experience of MCC and PEPFAR on compacts. In addition, one lesson from Gavi is to work more directly and reach agreements with Ministry of Finance on funding targets.

3) Develop and implement a responsible transition policy

For countries receiving Global Fund financing, transition away from different types of financial and non-financial support would happen at different points along a country's development continuum until such a point that the country was deemed able to take sufficient responsibility (programmatically, financially, politically, institutionally, legally) for maintaining and expanding its response to the three diseases. Principles, process and interventions for a responsible transition could be identified and agreed through the development of a Responsible Transition Policy. The Global Fund is very well positioned to lead on an evidence based, responsible transition based on pooling partners' and various sectors' strengths: governments, donors, civil society and communities, public health actors (among others).

The principles of a responsible transition from Global Fund support should include the following elements:

- 1) Countries are given advance notice and sufficient time to plan and implement the transition process with the full involvement of all key country stakeholders and key development and technical partners at all stages;
- 2) Countries have access to financial and technical assistance to prepare their systems (i.e. health, community systems and policy and fiscal spaces) for sustaining the programs, particularly, enforcement of legislation and budget allocations required services (including those provided through NGOs).
- 3) Countries are provided with technical support to meet necessary coverage and quality to control the epidemics. The services correspond to international standards as defined by the technical partners at the UN.

4) Utilize more appropriate transition criteria and benchmarks

Rather than using only income classification and burden of disease, more nuanced transition benchmarks should be developed.

We recognize the efforts of the Equitable Access Initiative, convened by Gavi, the Vaccine Alliance; The Global Fund to Fight AIDS, TB, and Malaria; UNAIDS; UNICEF; UNDP; UNFPA; UNITAID; WHO and the World Bank, to develop new frameworks to better identify health needs and constraints to equitable access to health, and to better inform decision making processes on health and development. The Global Fund could benefit from this ongoing work and other sources to develop and incorporate new criteria and metrics into its new strategy and allocation model.

The current method of using GDP per capita and GNI per capita as graduation criteria for development assistance is not without problems, as countries can change categories rapidly based on a depression or rebasing of their GNP. Furthermore, GNI per capita is not a good measure of public resources devoted to health. GNI per capita is linked to overall spending on health which includes both public spending as well as private spending i.e. direct out of pocket spending. Public spending is linked both to overall resource mobilization of the government as well as the priority governments put on health.

In addition, using a combination of GNI per capita and disease burden does not take into account the complexity of factors that need to be in place before a country can finance and implement the totality of its health programs effectively. This includes factors related to political will, institutional capacity, engagement and contracting of civil society actors, and effective technical partnerships.

The Global Fund could potentially create a framework of criteria that could include the following:

“Triggers” – conditions that put a country in a better position to take up greater responsibility for their HIV/AIDS, TB and malaria programs such as *population growth rate and GDP growth rate; per-capita income; disease burden; proportion of external financing as a percentage of total funding to HIV/AIDS, TB and Malaria programs; type of services being supported by Global Fund; proportion of Global Fund funding as proportion of external funding.*

“Enablers” – actions the country should undertake to sustainably transition from Global Fund support. In other words, a country can have enablers in place, but if it lacks the trigger conditions, it is not advisable for such a country to transition. Enablers of transitions include available *health financing; health [and community] systems; political will; institutional framework for coordination, management and implementation of these programmes; collaboration with [and between] other [country stakeholders and] development partners; involvement of the Global Fund in guiding countries during planning, implementation and monitoring of the transition.*

5) Conduct a transition readiness assessment

At an appropriate point in its financing relationship with a particular country, the Global Fund could conduct a comprehensive assessment with partners to identify potential bottlenecks to sustainability in the long and short term in order to mitigate them during grant implementation and eventual transition. This assessment should be used to inform development of the sustainability plan (see above). Findings from this assessment should feed into risk analyses for the grant and for the Global Fund's larger grant portfolio.

6) Engage with the Ministries of Finance early

Even before signing a grant, the Global Fund could engage with Ministries of Finance (and Ministries of Planning where appropriate) to understand potential financial implications on the long term sustainability of proposed programs and to ensure harmonization of donor support for the health sector and the country overall. The Ministry of Finance should remain engaged during grant implementation and could play an integral role during transition.

The Global Fund could play a catalytic role by investing in joint platforms with WHO and others to reach out to Ministries of Finance through such vehicles as the Collaborative African Budget Reform Initiative and OECD Senior Budget Officials network, and the Harvard training program for ministries of finance.

7) Ensure alignment with country systems

The transition process requires that countries manage their response to the 3 diseases using their own resources and country systems. In some countries where there are parallel systems supported by the Global Fund, they must be integrated into domestic systems as part of the transition process. This first requires integration into the national budgeting processes using the country's financial management system. Global Fund resources should be on-budget and also go through the budget. Ideally speaking, the transition from Global Fund supported parallel systems into country systems would take place over the longer term. Evidence from Gavi suggests that there are often unexpected challenges when aligning parallel systems into public financial management, procurement and supply chain, as well as health information systems.

8) Promote access to pharmaceuticals

One of the key transition issues is access to quality medicines and diagnostics. The experience of Gavi demonstrates that countries exiting from Gavi support ended up paying much higher prices for vaccines, which threaten the sustainability of scale up for new vaccines.

UNITAID works through market interventions to improve access to medicines, diagnostics, and preventive items used in HIV/AIDS, tuberculosis, and malaria. The benefit of adopting market-based approaches is that all countries, not only those receiving direct UNITAID support, benefit from UNITAID's market impact.

The Global Fund could assist countries so that they can both access good prices and also have robust procurement systems in place following transition. In the short run, this might also mean access to Global Fund prices while implementing a Global Fund grant, and even after a country has graduation from Global Fund support. In the longer term this could require sustained technical support to ensure good contracting practice and procurement.

9) Provide support for new technology assessments

The Global Fund could work to further support for new technology assessments. These initiatives would also include important system building activities to support the regulatory environment and to institutionalize rational decision-making processes around new technologies. This collaboration could include UNITAID and Gavi. In the case of a technology grant, the Global Fund would have a strict co-financing requirement for the commodity, so its implementation is sustainable in the longer term.

10) Explore flexible and alternative grant agreements

The Global Fund should look at potentially increasing or introducing a measure of flexibility into grant agreements. The three-year timeline is short for predictability and sustainability planning and thus may make it difficult for programs to transition effectively.

Furthermore, many Global Fund grants are implemented with an NGO PR or through dual track financing arrangements with one NGO PR and one government PR. Transition planning requires that the CCM or government determine how grant activities will continue following the end of Global Fund support. In many countries, this will require that the government take over activities that are best delivered through government systems, whereas other services e.g. programs for key populations, are most effective when delivered through NGOs and thus must be sub-contracted by the government to be implemented by the NGOs. This is an issue that could be discussed with both the government and CCM early in the funding relationship and certainly prior to a country's last grant before transition takes place.

11) Allocate specific funds towards transition planning and related activities

The experience of the Avahan project in India suggests that for effective transition, some percentage of the grant should be set aside from its inception to work towards transition readiness. In the case of Avahan, this was 28% of funding. The Global Fund could require that countries cost their transition and sustainability plans. This could be included in country requests for funding.

The Global Fund could also consider the creation of a “transition” grant that would be funding available, up to a certain level, for HSS considerations in countries that will transition in the near term from Global Fund support. Gavi currently does this through the development of catalytic grants which are negotiated with countries based on a transition assessment and are meant to provide targeted support in areas that are deemed “not ready” for transition.

Inclusion of novel financing arrangement such as Results Based Financing may make it easier for governments to transition. The Global Fund could encourage countries to explore how to incorporate RBF schemes, when appropriate, early in the grant cycle.

The Global Fund may choose to support partners to provide technical support in key grant areas to ensure adequate capacity is in place for transition. This technical support could potentially continue after transition has taken place and following the end of Global Fund support. Technical support should target both the government and civil society and could be provided by a range of capable technical support providers including donors, multilaterals & INGOs.

4.3 Become more responsive to health needs in challenging operating environments

The Global Fund should become more responsive to health needs in challenging operating environments. It could do so by improving its flexibility and agility to support effective responses, by targeting investments in health and community systems to ensure impact, and by broadening engagement and partnerships with development and humanitarian actors.

Options for consideration

1) Determine countries requiring flexibility on a case-by case basis

The Global Fund could make case-by-case determinations on countries facing challenging operational environments based on a range of objective criteria and not attempt an academic exercise to formally group, categorize or rank these countries. Criteria should include existing Global Fund risk register, capacity assessments by the Global Fund and other partners, UN crisis levels and other partners' assessments of crisis, and most importantly the in-depth knowledge of the Country Teams at the Global Fund about the countries in question. The level of the crisis or extent of the operating challenges will then define what special action is required and how the grants are overseen by the Global Fund.

2) Develop standard operating procedures for COEs

The Global Fund could become more agile, flexible and fast-moving in countries facing difficult development challenges. It is suggested that the Global Fund develops clear standard operating procedures (SOPs) for countries that have been determined by management as crisis countries or countries facing special circumstances on a case-by-case basis. These SOPs should include fast-track arrangements, short-cuts in approval processes, and clear guidance on flexibilities available to the Country Teams.

3) Allow more flexibility in re-design of grants during implementation

The Global Fund could become more flexible in allowing the re-designing and re-budgeting of grants during their implementation in crisis countries, including 'costed' grant extensions, with the possibility of additional funds to pay for rising costs of logistics, security, supply chain, support from partners. In some cases, alternative implementation arrangements will need to be put in place. As is sometimes already done, partners can be asked to step in to support specific aspects of the management of the grants and in some conditions a partner may need to be requested to take over the role of Principal Recipient until circumstances improve. It is important that transition strategies and capacity development plans are agreed upfront to ensure a return to regular implementation arrangements when circumstances permit and national capacities have been strengthened.

4) Consider regional grants as modality to support countries facing challenging circumstances

The Global Fund could consider using fast-tracked regional grants as vehicles to support programmes in countries facing challenging operating environments, including in the case of protracted crises with cross-border dimensions, which require longer-term interventions, such as the Syria and Iraq crises. The ineligibility of the UN and multilateral organizations to apply for regional grants could be lifted, as it has hampered Global Fund's ability to respond in a number of regions.

5) Consider revising the eligibility criteria for MICs in crisis

A challenging operating environments policy could include flexibilities on eligibility criteria for MICs in complex emergencies, such as Iraq, Lebanon, Jordan and Libya. For example, Iraq will likely no longer be eligible for Global Fund in the near future and likely does not have the 'ability to pay' for health service. Ongoing instability and weak government financing of health have focused 70-80% of the health budget on salaries and recurrent costs. Meanwhile, the spread of TB is accelerating among millions of IDPs, Syrian refugees, and host communities across the country but with little data available.

6) Make targeted investments in health and community systems to ensure impact

In countries with challenging operating environments, including those recovering from crises, the Global Fund could invest more smartly in developing national capacity and targeted strengthening of health and community systems to ensure the resilience and sustainability of the national disease programmes supported by the Global Fund. It is also critical to continue investment in addressing human rights and gender barriers that impede access to services for all three diseases.

7) Take a rights-based and resilience-based approach

In crisis countries, the Global Fund could maintain its role as a development partner even in the most challenging operating environments. It should take a rights and resilience-based development approach to its grant portfolio, with a longer-term perspective from the outset, focusing on strengthening the capacity of the health sector and communities to *cope* with the crisis during its occurrence to ensure continuation of life-saving services, *respond* to meet immediate needs of the population, *recover* from the impact of the crisis by regaining its ability to bring back the services at its previous level of quality and reach; *sustain* this recovery through a period of longer term strengthening of capacities and national systems, and *prepare* for a next shock from whatever source it may come.

8) Pay special attention to human rights concerns

In countries facing difficult circumstances and weak governance, special attention is required to address human rights violations, including gender based violence, that impede access to services in repressive contexts and human rights violations, include in the risks assessment in Global Fund grants, develop policies on how to engage with uniform personnel, prisoners, address gender equality and issues concerning women and girls, as well as in the case of rape as weapon of war.

9) Improve engagement with in country-level UN coordination clusters (health and early recovery clusters)

Given that it does not have country-presence, the Global Fund could reach agreements with in-country partners that participate in these clusters to share information to the Global Fund and inform the cluster what the Global Fund could do as a donor. Access to timely and reliable information from the country-level must be improved. The Global Fund needs to be properly plugged into the OCHA information systems, receive their SitReps, and reach agreements with partners on the ground to share information and decision taken at the health and recovery clusters.

4) Ensure greater preparedness for crises

The Global Fund could encourage PRs to strengthen contingency plans and involvement with the humanitarian response in anticipation of possible crises in the future. In case of cross border displacement (e.g. refugee populations), the Global Fund should actively engage with UNHCR and other humanitarian and development partners, to explore the modalities and options to ensure access for these populations to Global Fund supported programmes in the respective country for HIV, TB and malaria.

4.4 Stronger policy and human rights leverage and impact

The Global Fund should enhance its engagement to contribute to evidence based health policies and pro-health human rights frameworks by working effectively with partners, especially civil society.

Discussion and Options

Over the last decade, the Global Fund has played a unique and indispensable role in the fight against the three diseases. It has supported not only commodities but also programs to reduce stigma, mobilize communities, and build the service and advocacy capacity of CSOs, which is essential to the establishment of sustainable, nationally supported programs. In regions and countries with concentrated epidemics, where key populations have traditionally been criminalized and excluded, the Global Fund has supported programs to protect human rights and ensure full inclusion in service provision.

The Global Fund has increased its emphasis on human rights and inclusion through its *Strategy 2012-2016: Investing for Impact*¹⁷, the *Gender Equality Strategy*, the *Strategy in Relation to Sexual Orientation and Gender Identities (SOGI)*, the *Key Populations Action Plan 2014-2017*, and the *Community System Strengthening (CSS) Framework*. Moreover, as a major financial instrument, the Global Fund uses its political leverage to engage in policy dialogues with countries, find ways to implement effective programs, and include civil society and community representatives in decision-making.

The Global Fund could support domestic and international policy dialogues and, through its grant-making, expand investments in advocacy, health and community systems strengthening to ensure adequate domestic investments and enabling environments to achieve strong public health impact.

This will help to promote political ownership of disease programs. This requires that countries have clear sustainability policies at each stage of program development, such as clear policy frameworks including: legal regulatory frameworks; policies on equitable access to services; and policies on private sector and civil society engagement. It also requires the political will to maintain investments in health, and in particular, the gains made in HIV, TB, Malaria, RMNCH, and health systems.

Civil society in a country should have the capacity to conduct effective advocacy, foster social acceptance, create demand for services, as well as participate in service delivery. Civil society should also hold government accountable for service delivery quality and coverage, including services for key affected populations.

Finally, coordination and harmonization with other partners is critical to mitigate the risks and challenges of the country transitioning from Global Fund financing. Countries must conceive of and follow a coherent strategy for resource mobilization, including strategies related to government funding, local authority funding, civil society fundraising and donations from the private sector and international partners.

¹⁷ Global Fund Strategy 2012-2016: investing for impact specifies that the Global Fund will i) integrate human rights considerations throughout the grant cycle, ii) increase investments in programs that address human rights-related barriers to access, and iii) ensure that the Global Fund does not support programs that infringe human rights.

Options for consideration

1) Promote pro-health policy change

The Global Fund could advocate from grant inception for changes to repressive policies that will affect health outcomes. The Global Fund finances programs in a number of countries where socio-cultural factors limit the government's support for programs targeting key populations. The Global Fund could use its funding as leverage and push governments to change these policies. This is often imperative to ensure some measure of sustainability of programs currently funded by the Global Fund; and may directly influence the trajectory of an epidemic in a particular country.

The Global Fund should retain and strengthen its focus on human rights and gender. It should assist CCMs and service providers in understanding why human-rights centered approaches to the three diseases are essential. Rights-based programming must include effective mechanisms for contracting CSOs and CBOs where they are best placed to deliver services and drive advocacy for policy and legal change.

2) Emphasize gender based programming

There should also be ongoing support for translation of gender analysis into evidence-based, effective gender-responsive programming. An adequate budget and appropriate technical co-operation should be provided for gender analysis and identifying the right interventions for adolescent girls and young women, as well as addressing gender-based violence.

3) Engage civil society and key populations

Through its model of inclusive participative governance, both at the Board and through CCMs at the country level, the Global Fund has succeeded in highlighting the importance of civil society in many countries. As countries become ineligible for Global Fund grants, programs which were previously administered by CSOs and funded by development partners may disappear, putting the Global Fund's investments at risk. These programs are often targeted towards key populations and their perilous position raises questions around both sustaining the gains and protecting human rights. The Global Fund must evaluate how to continue accelerating social and political change in many countries, even after its funding obligations have ceased.

Civil society, particularly key affected populations, are usually most affected by the transition process, and therefore should be the ones supported to pressure governments to change policies, to monitor that governments stick to the principles of responsible and ethical transition and follow-through on their commitments. There is now a growing consensus that strengthening the civil society and community responses is essential for longer-term impact, sustainability, and greater effectiveness of national programs.

4) Promote inclusive dialogue

Additionally, the Global Fund can promote dialogue between all key stakeholders – including bi-lateral donors, other multilaterals, national governments, civil society and private sector to collaboratively influence policy change by:

- Coordinating plans for responsible transition and program sustainability. Specifically, this means ensuring that countries transitioning from Global Fund support do so in a way that maintains and builds on impact to date and engages with both recipient country governments and civil society in the transition plan's implementation;
- Formulating and committing to principles of responsible engagement in transitioning countries so that civil society and community involvement in

human rights and legal reform advocacy continues after the country transitions from international development assistance;

- Providing clear guidance and financial support to relevant government bodies and non-state actors of recipient countries to strengthen systems and make relevant policy decisions to develop and implement fundable transition and sustainability plans;
- Promoting maximum coordination and partnership and keeping relevant UN technical partners accountable for provision of coordinated technical assistance to sustain coverage and service quality gains.

Going forward, while remaining true to the Framework Document, the Global Fund's broad partnerships should enable it to continue to play a critical role in ensuring that there is political will to prioritize health investments at international, regional and country levels.

Political will ensures that policy makers prioritize investment in health, and more specifically investment in HIV/AIDS, TB and Malaria, and allocate sufficient resources to these programs. Political will should ensure sound policies and legal frameworks that facilitate provision of appropriate and quality HIV/AIDS, TB and Malaria services for all people, particularly key populations.

5) Utilize regional cooperation to address challenges

Regional and sub-regional cooperation and efforts can play a critical role in addressing a range of policy challenges. Such programs can address the three diseases amongst migrant and mobile populations, and are particularly important in responding to health issues associated with cross border movement of populations – including those displaced by conflict and other humanitarian disasters.

Global Fund investment could be used to strengthen health data and information systems to better monitor cross-border health issues, promote health cooperation among countries, and contribute to the development of migration-responsive health care programs and policies across migration corridors.

Regional investments can be epidemiologically and programmatically important, such as the Global Fund's existing investments in the Mekong through the Regional Artemisinin Resistance Initiative. Regional investments may be particularly important for addressing regional policy gaps and strengthening regional-level advocacy to support transitions and key and vulnerable populations.

Annex A: Development Continuum Working Group membership

Group	Name	Organization	Position
SIIC Members	Jason Lane	Department for International Development, United Kingdom and Australia	Senior Health Advisor (TB)
	Timothy Poletti	Australian Permanent Mission, Department of Foreign Affairs and Trade	Health Adviser
	Philippe Meunier	Ministry Foreign Affairs, France	Ambassador for the fight against HIV/AIDS and communicable diseases
	Mbulawa Mugabe	UNAIDS	Director, Country Impact and Sustainability
	Abdalla Sid Ahmed Osman	Federal Ministry of Health, Sudan / WHO EMRO	Under Secretary General
World Bank	Christoph Kurowski	World Bank	Lead Health Specialist
Technical partners	Hakan Bjorkman	UNDP	Manager, UNDP Global Fund Partnership
	Mandeep Dhaliwal	UNDP	Director of HIV, Health and Development Practice
	Adrien de Chaisemartin	Gavi, the Vaccine Alliance	Head of Performance Management
	Judith Kallenberg	Gavi, the Vaccine Alliance	Head of Policy
	Flavia Bustreo	WHO	Assistant Director-General Family, Women's and Children's Health
	Frederik Kristensen	WHO	Senior Adviser
Civil society	Sergey Votyagov	Eurasian Harm Reduction Network	Executive Director
	Michael Matthews	Communities Delegation to the Global Fund Board	Delegation Member
	Nadia Raffif	Global Forum on MSM and HIV	Senior Policy Advisor
	Alvaro Bermejo	International HIV/AIDS Alliance	Executive Director
	Mike Podmore	International HIV/AIDS Alliance	Policy Manager

	Lola Dare	Centre for Health Sciences Training, Research and Development	Chief Executive Officer
Private sector/Private Foundations	Kieran Daly	Bill & Melinda Gates Foundation	Deputy Director: Program Advocacy and Communications – HIV, TB, Malaria, and the Global Fund
Technical Expert/Academic/Think Tank	Homi Kharas	The Brookings Institution/Post-MDG	Senior Fellow
	Dean T. Jamison	Senior Fellow in Global Health Sciences at UCSF and Emeritus Professor of Global Health at the University of Washington	Senior Fellow
Implementers	Abduljelil Reshad	Federal Ministry of Health, Ethiopia	Director, Partnership and Resource Mobilization Directorate
	Pe Thet Khin	Myanmar President Office, The Republic of the Union of Myanmar	Adviser
	Ana Filipovska	Country Coordinating Mechanism (CCM) Macedonia	General Secretary
	Mark Blecher	South African National Treasury	Chief Director for Health and Social Development
	Kelechi Ohiri	Federal Ministry of Health Nigeria	Senior Adviser to the Honourable Minister
Donors	Anders Nordström	Ministry Foreign Affairs Sweden	Ambassador for Global Health
Secretariat	Mark Dybul	The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)	Executive Director
	Marijke Wijnroks	The Global Fund	Chief of Staff
	Harley Feldbaum	The Global Fund	Head, Strategy and Policy
	Kate Thomson	The Global Fund	Head, Community Rights and Gender
	David Traynor	The Global Fund	Advisor Key Populations
	Heather Doyle	The Global Fund	Senior Technical Advisor, Gender

Annex B: Development Continuum Sub-Working Group membership

We are thankful to these Sub-Working Group participants who provided quality input into this process. The resulting report remains the sole responsibility of the Working Group and their names do not imply endorsement of the final report.

Sub-working Group	Chair	Members
1. Health Financing and Financial Sustainability	<ul style="list-style-type: none"> • Christoph Kurowski (WB) 	<ul style="list-style-type: none"> • Mark Blecher (South African National Treasury) • Timothy Poletti (DFAT) • Ana Filipovska (CCM Macedonia) • Sergey Votyagov (Eurasian Harm Reduction Network) • Tomas Lievens (Oxford Policy Management) • Joe Kutzin (WHO) • Mead Over (CGD) • Rodrigo Salvado (BMGD) • Nadia Rafif (Global Forum on MSM and HIV) • Santiago Cornejo (Gavi, the Vaccine Alliance) • Marelize Gorgens (World Bank) • Hong Wang (BMGF) • Camila Vamalle (OECD) • David Wilson (World Bank) • Nertila Tavanxhi (UNAIDS)
2. Programmatic Sustainability	<ul style="list-style-type: none"> • Kelechi Ohiri (MoH, Nigeria) 	<ul style="list-style-type: none"> • Bess Miller • Nani Nair (WHO) • Mbulawa Mugabe (UNAIDS) • Abdalla Sid Ahmed Osman (WHO-EMRO) • Abduljelil Reshad (MoH Ethiopia) • David Wilson (World Bank) • Peter Hansen (Gavi, the Vaccine Alliance) • Viroj Tangcharoensathien (Ministry of Public Health, Thailand) • Judith Kallenberg (Gavi, the Vaccine Alliance)

		<ul style="list-style-type: none"> • Peter Berman (Harvard) • Joe Kutzin (WHO) • Ana Filipovska (CCM, Macedonia) • Tim Poletti (DFAT)
3. Communities, Gender and Political Will	<ul style="list-style-type: none"> • Sergey Votyagov (EHRN) 	<ul style="list-style-type: none"> • Mike Podmore (Aids Alliance) • Alvaro Bermejo (Aids Alliance) • Mick Matthews (Communities Delegation to the Global Fund) • Nadia Rafif (Global Forum on MSM and HIV) • Mandeep Dhaliwal (UNDP)
4. Challenging Operating Environments	<ul style="list-style-type: none"> • Hakan Bjorkman (UNDP) 	<ul style="list-style-type: none"> • Philippe Meunier (France) • Mandeep Dhaliwal (UNDP) • Jason Lane (DFID) • Christoph Kurowski (World Bank) • Alvaro Bermejo (Aids Alliance) • Marian Schilperoord (UNHCR) • Teresa Zakaria (IOM) • Nnette Motus (IOM)

Annex C: Examples of ensuring sustainability

A number of partners have developed approaches to enhancing the sustainability of programs that they currently fund. The Global Fund has an opportunity to learn from these experiences, utilize already developed tools, and work in partnership when appropriate. Some of these partners include Gavi, the Vaccine Alliance, PEPFAR, and the Bill and Melinda Gates Foundation under the Avahan project.

- a) Gavi, the Vaccine Alliance utilizes a clear eligibility and co-financing policy based on GNI per capita with differentiated co-financing requirements based on income classification. Any applications and subsequent contracts for Gavi support always require signature by both the Ministry of Health and Ministry of Finance to assure enforcement of the government promises to co-financing. At the highest income level, co-financing requirements ramp up to the full cost of vaccines over a 5-year time period which Gavi considers to be the graduation period. Gavi engages with countries on transition planning prior to and during graduation. This engagement includes:
 - Comprehensive assessments to identify potential bottlenecks for sustainability to mitigate them during transition
 - Development of transition plans with clear targets and timeline
 - Utilization of a monitoring plan to ensure implementation of required activities to move towards graduationHSS support continues for its planned duration through the end of the 5-year graduation phase. Countries with immunisation coverage below 90% can also apply for new HSS support during this time.
- b) *PEPFAR* is currently inviting countries to complete sustainability indices and dashboards to evaluate the sustainability of their national HIV responses. These dashboards will produce a matrix which details where a country needs to strengthen key components to ensure sustainability. *PEPFAR* COP countries will use these findings to determine funding priorities for their programs going forward. Historically *PEPFAR* has also asked countries to complete Partnership Frameworks which are 5-year joint strategic frameworks for cooperation between the USG, the partner government, and other partners to combat HIV/AIDS in the country which clearly detail the responsibility of each party.
- c) *The Bill and Melinda Gates Foundation* funded a project called the India AIDS Initiative or Avahan in 2003 which is held up as one of the most successful models of transition from donor to government support in the development world. The Avahan Project was unique as it utilized a business approach to dealing with a health problem and focused on picking individuals with strong management skills as implementers of the program, treating technical skills as supportive skills that could be acquired more easily. Analysis of the Avahan model results in a number of important key lessons for the Global Fund including:
 - The Avahan program transition process extended for nearly 8 years. The process was organized into multiple tranches and gave time for the government to ensure that the necessary budgetary and management systems were in place prior to the full program's transition.
 - A large portion of the program's implementation budget, 28%, was used for transition activities. The program and government jointly assessed that the government's implementation and management systems needed to be strengthened; support was provided for developing skills in data-driven management and field supervision, community mobilization, guideline development and costing.

- The Avahan program found that transition is essentially a “front-loaded” process. The bulk of the work occurred before the actual transfer of programming and funding. The actual transition was quite a complex process and required monitoring, course correction, and risk mitigation.
 - There were challenges to developing contractual agreements between the government and NGOs or CBOs, and those that were developed took longer than anticipated, delaying the transition.
 - A collaborative and coordinated approach in policy development and planning were critical. The program’s focus, goals, and priorities were aligned with those of the government.
- d) *UNITAID* decreases prices, improves quality, and improves acceptability of medicines and diagnostics. Its market based approaches allow for the benefit of its intervention to impact all countries, not only those receiving direct UNITAID support. The Global Fund and Unitaid signed a memorandum of understanding in June 2014 to allow for more collaboration in :Market shaping and access interventions
- Market intelligence
 - Scale-up
 - Transition
 - In-country engagement
- Combined efforts on those areas will further enhance the sustainability of programs.

¹ UNODC World Drug Report 2014