2013

Sustainability Review of Global Fund Supported HIV, Tuberculosis and Malaria Programmes

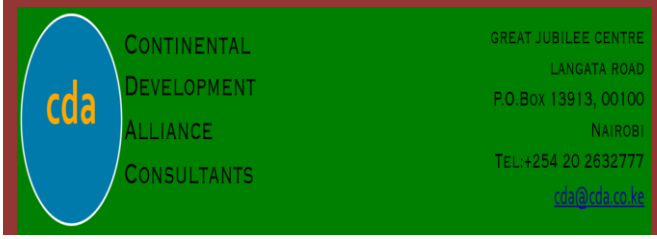
April, 2013

Final Report

Commissioned by the Technical Evaluation Reference Group (TERG)

Of the

Report submitted by



Review team
Tom Mogeni: Team Leader, CDA
Nyamache Nyachienga; CDA
Charles Stover; IDEAS Inc.
Ilena Fajardo; IDEAS Inc.

The following people from the Global Fund contributed to this report

Simon-Pierre Tegang
Sai Kumar Pothapregada
Silvio Martinelli
Atsuko Aoyama (TERG)
Ruyichi Komatsu
Daniel Low-Beer

Table of contents

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordinating Mechanism
CHAI	Clinton Health Access Initiative
CHARES	Centre for HIV and AIDS Research Education Services
CSOs	Civil Society Organizations
CSWs	Commercial Sex Workers
DFID	Department for International Development
DOTS	Directly Observed Treatment, Short-course
EU	European Union
FLHE	Family Life Health Education
FP	Family Planning
FSP	Financial Sustainability Plan
FSW	Female Sex Workers
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GF	Global Fund
GNI	Gross National Index
GoJ	Government of Jamaica
HICs	High Income Countries
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IATA	International Air-travel Association
IDEAS	Innovative Development Expertise & Advisory Services, Inc.
JABCHA	Jamaica Business Coalition on HIV/AIDS
JASL	Jamaica AIDS Support for Life
JCCM	Jamaica Country Coordinating Mechanism
KAPBS	Knowledge, Attitude, Practice and Behaviour Survey
LAC	Latin America and Caribbean
LIC	Low Income Countries
LMICs	Lower Middle Income Countries
MARPS	Most at Risk Populations
MOE	Ministry of Education
MOF	Ministry of Finance

MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSF	Medicines Sans Frontiers
MSM	Men having Sex with Men
NAC	National AIDS Council
NACC	National AIDS Control Council
NASA	National HIV/AIDS Spending Assessment
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHF	National Health Fund
NHIF	National Health Insurance Fund
NHP	National HIV/STI Programme
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PEPFAR	Presidential Emergency Plan for HIV and AIDS Relief
PLWHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
RH	Reproductive Health
RHAs	Regional Health Authorities
SANAC	South Africa National AIDS Council
STI	Sexually Transmitted Infections
TB	Tuberculosis
TTT	Transition Task Teams
UMIC	Upper Income Countries
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children Education Fund
UNITAID	International Drug Purchase Facility
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Acknowledgements

The Global Fund sustainability review assignment was guided by a high level team from the Impact, Results and Evaluation Department of the Global Fund Secretariat comprising Dr. D. Low-Beer, Dr. R. Komatsu and Mr. Simon-Pierre Tegang. The review team is profoundly grateful for the guidance and support provided throughout the review period.

This review would not have been successful without the invaluable contributions received from key departments of the Global Fund Secretariat, Regional managers, Fund Portfolio managers, WHO, UNAIDS, UNITAID, GAVI and PEPFAR. Specifically we are indebted to the Asia, Europe, Latin America and Caribbean Department; Strategy and Policy team; Fund Raising Strategy and Innovation team; Access to Funding team; and Donor Relations team. We are also indebted to the Regional Managers and Fund Portfolio managers for High Impact Asia 1; Africa 1 High Impact and Africa 2 High Impact, Latin America and Caribbean as well as Eastern Europe and Asia.

Our visits to Kenya, Jamaica and South Africa were made possible by the respective Country Coordinating Mechanisms (CCM) members, Ministries of Health Managers and the respective countries' national disease programmes as well as the National HIV/AIDS Authorities. The review team most sincerely thanks all those who provided inputs to the review process.

Executive Summary

Introduction

The Global Fund was established in 2002 to mobilize and disburse funding to countries to fight HIV/AIDS, TB and, Malaria through implementing prevention, treatment, care and support programmes. It also funds health systems strengthening interventions necessary for effective implementation of the designed programmes. While countries usually aim to renew financial support from the Global Fund at the end of program grants, some countries have opted to substantially increase their domestic financial contribution in order to reduce financial support from the Global Fund. In addition, as the eligibility criteria for Global Fund support include country's income category, some countries have already become ineligible upon attaining high income (HI) or upper middle income status (UMI), and over time, others will follow. The Global Fund is concerned that countries are becoming ineligible for funding or increasing their domestic contribution to the programmes without clear sustainability or transition mechanisms and, therefore, risks negating the gains through the supported interventions.

Objective of the review

The Global Fund commissioned a review aimed at identifying issues related to sustainability of Global Fund supported programmes; provide lessons for countries in similar situations and to inform the development of a "sustainability strategy" for Global Fund supported programmes going forward. The main issues to be addressed included: i) identifying triggers, enablers and challenges to the transitions; ii) other criteria for Global Fund to transition countries in addition to income level; iii) Level of collaborations with other development partners, iv) identify strategies and approaches used by other development partners and countries to transition for replication by the Global Fund and v) recommend sustainability strategies that the Global Fund could develop.

Review methodology

The review was carried out through extensive document review for a sample of 12 countries selected by the Global Fund, interviews at the Global Fund in Geneva and country visits to Jamaica, Kenya, and South Africa. The document review included data and reports on financial, programmatic, health systems, and disease burden to identify patterns between countries, Global Fund grant documents, and other reports on experiences and practices of other donors regarding sustainability.

Key findings

(i) Income level as a criterion of transition

Income classification of a country alone is not a sufficient criterion for transitioning a country from the Global Fund in a sustainable manner. Other factors that should be considered include demographic, economic, financial and disease burden.

(ii) Implementation of sustainability plans for HIV, TB and Malaria

There is no country found to be having a documented comprehensive sustainability plan. However, in the case of HIV programs, several countries were found to have in place or to be considering initiatives for financial sustainability which include establishing AIDS trust fund, tax levies, increase of budgetary allocation to the national HIV programme, private sector funding of the HIV programme, use of national health insurance, review of the unit cost of delivering HIV services and improving cost efficiency and effectiveness. All these initiatives are either in conceptualisation, planning or are in early stages of implementation and, therefore, it is too early to assess whether they are working or not. Review of documents and interviews conducted at country level did not identify specific initiatives being taken to sustain TB and malaria programmes currently supported by the Global Fund beyond requests to government for increasing budgetary allocations to the 2 diseases.

(iii) Approaches used by GAVI and PEPFAR

PEPFAR sustainability plans are in the early stages of implementation. In the case of GAVI, financial sustainability plans for immunization services have enabled countries to rationalise unit costs of the vaccines and immunization services and improve cost efficiency and effectiveness as well as strengthen programme management. However, increase of government funding to immunisation programmes has not progressed to levels expected.

(iv) Preparation of countries to assume financial responsibility for services supported by Global Fund

There were no deliberate steps taken on the part of Global Fund to prepare countries that have become inelligible to apply for Global Fund funding to assume financial responsibility of the programmes. Likewise, there was also no deliberate development of sustainability plans by countries to guide their transitioning from Global Fund.

(v) Trigger for transition

This review defines triggers as conditions that put a country in a better position to take up greater responsibility for their HIV/AIDS, TB and malaria programmes. This review therefore identified the following triggers:

- *Population growth rate and GDP growth rate*: The existence of low population growth rate and high GDP growth show that a country is ready to increase domestic financing for most of its sector services including health sector.
- *Per-capita income*: Per capita income is a measure of the standard of living across the population; it demonstrates whether a country is able to finance its basic services including health. The higher the per capita income the more willingness and ability of the country to take up financial responsibility for its programmes, other factors being favourable. The distribution of income should also be taken into account. For example, South Africa has the second highest GINI quotient, meaning the income distribution is the second most unequal in the world. Oil rich countries including Equatorial Guinea and Nigeria also have very skewed income distributions and large numbers of very poor people with high disease burden.
- *Disease burden*: Countries with a lower disease burden (HIV, TB and Malaria) have lower demand for services and therefore low financial investment is required to meet such demand. A low disease burden is a strong basis for sustainable financing of HIV/AIDS, TB and Malaria services.
- *Proportion of external financing as a percentage of total funding to HIV/AIDS, TB and Malaria programmes:* It is easier for a country with low external funding than one with large external funding to transition.
- *Services being supported by Global Fund:* Cases where Global Fund is supporting commodities/drugs becomes difficult for countries to sustain because they require huge financial resources whereas programmes where Global Fund is funding health systems and prevention activities would be easier to sustain given low financial requirements.
- *Proportion of Global Fund funding as proportion of external funding:* Where Global Fund funding as % of external funding to HIV/AIDS, TB and Malaria is low, the transition of the country from Global Fund is easier than where this proportion is significant (over 30%).

(vi) Enablers of sustained transitions

Enablers are the actions the country should undertake to sustainably transition from Global Fund. 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 identified by the review include:

- *Health financing*: Countries that demonstrated high per capita expenditure on health, high health expenditure as % of GNP, and high government expenditure on health as % of total government expenditures found it easier to transition.
- *Health systems*: Countries should invest in health systems in a manner that improves access to services by the key target populations. Therefore, countries should have clear policies and strategies for strengthening both public and community health systems. Governance and leadership in the health sector is also critical and require attention in terms of investments
- *Political will:* Political will as an enabler ensures that policy makers prioritize investment in health and more specifically investment in HIV/AIDS, TB and Malaria and therefore allocate sufficient resources to these programmes. Secondly, the political will should ensure sound policies and legal framework that facilitates HIV/AIDS, TB and Malaria service delivery to the key populations. Ensuring that there is political will to prioritize health investments require that the Global Fund collaborate with other partners that are in a position to lead policy dialogue with government policy decision makers and national leaders.
- *Institutional framework for coordination, management and implementation of these programmes*; Effective institutional systems as an enabler ensures that countries' HIV/AIDS, TB and Malaria programmes can deliver the services required. Countries with strong coordination and management mechanisms for the three programmes have demonstrated effective delivery of the services while those who had weaker coordination mechanisms cannot deliver the services effectively.
- *Collaboration with other development partners*: The review established that where countries rely heavily on external funding but the development partners do not collaborate during transitions; countries find it difficult to take up financial responsibility for the programmes previously supported by the Global Fund.
- *Involvement of the Global Fund*: Involvement of the Global Fund in guiding countries during planning, implementation and monitoring of the transition enables countries to transition more smoothly.

(vii) Challenges of country transitioning from Global Fund

The review found out three key challenges facing countries transitioning from the Global Fund: 1) limited expertise in development of sustainability plans; 2) allocation of limited domestic funding to prevention services especially for HIV targeting key populations and delivered through the community health system and 3) poor coordination of development partners in development and implementation of sustainability plans.

(viii) Processes adopted by countries transitioning from Global Fund

The review found out that countries that have transitioned from the Global Fund did not adopt a clearly defined process. Most of the countries took financial responsibility for provision of drugs and other phamaceutical commodities while prevention interventions especially those that are implemented through the community health systems were not sustained. Governments also found it easier to take up responsibility for services provided through the public health system.

(ix) How Global Fund can facilitate transitioning of countries

The review found out that other development partners are playing an active role in supporting countries to develop plans to sustain external support to programmes. However, Global Fund has not been playing a similar role.

(x) Sustainability strategies and approaches

The review identified strategies and approaches used by other development partners and countries in planning and executing sustainable transitions. These strategies include a clear definition of sustainability, identification of triggers for sustainability beyond country income level, commitment by stakeholders to develop and implement sustainability plans, effective communication between the development partner and the country, integration of sustainability plans into the programmes and monitoring of the sustainability plans.

Lessons Learned

The following lessons emerged from the review:

- Whereas income classification is the dominant criterion for identifying countries that should transition from Global Fund, it should be applied in combination with the trigger factors.
- Investment in enabling factors over a long period is a pre-requisite for successful transitioning from the Global Fund by countries.
- A deliberate effort to develop and implement sustainability plans increases the possibility of successful transitioning from Global Fund.
- Countries tend to apply a combination of strategies to improve financial sustainability
- Effective coordination of development and implementation of sustainability plans enhances a country's ability to assume financial responsibility for its programmes.
- Support by development partners to countries to prepare and implement sustainability plans contributes to successful transitioning of countries.

Key recommendations

Recommendations based on the findings and lessons learnt during the review are outlined below. These recommendations focus on the policies, processes and mechanisms for managing sustainability of Global Fund supported programmes in countries.

(i) Policy recommendations

Policy guidelines are required in the following areas:

- *Operational definition of sustainability planning:* Global Fund should establish a clear operational definition of sustainability. A consensus with countries on the operational definition of sustainability plan within the context of the Global Fund is necessary for commitment, ownership and implementation of sustainability plans.
- *Complementing the income criteria*: The review has identified factors that determine a country's willingness and ability to take up a sustainable transition from the Global Fund. The Global Fund should develop a policy that requires review of these factors to determine the timing and support required to ensure the country embarks on a sustainable transition.
- *Setting and achieving country counterpart financing thresholds:* The Global Fund should set a time frame for countries to attain their counterpart contribution thresholds (currently at 60% for UMICs) and monitor the counterpart contribution.
- *Development of sustainability plans:* A policy on development of sustainability plans by countries should be developed.

- *Sign sustainability compacts/agreements with countries*: A sustainability compact or agreement signed by the highest level of government proceeded with technical discussions on implications of the sustainability planning for the country and rigorous policy and political level engagement will raise the profile and ensure commitment on the part of the country and Global Fund. The Ministry of Finance should be a signatory to the agreements.
- *Addressing concentrated infections in UMICs and HICs*: A large number of lower middle income countries will become classified as Upper Middle Income countries in the next several years. Many of these countries, such as India and Nigeria, have very large unserved populations with high disease burden. A policy on health services strengthening for vulnerable, marginalised and most-at-risk populations in UMICs and HICS should be developed in collaboration with partner organizations. Equatorial Guinea has very high average income from oil revenues, very unequal income distribution and high disease burden. It no longer receives Global Fund support, but the poor health conditions remain.
- *Establishing a transition fund:* The Global Fund should set aside funds to provide financial and technical support to the countries to implement sustainability plans. The fund can support countries to develop sustainability plans and implement activities identified in the sustainability plan.

(ii) Process of development of a sustainability plan

- *Development of sustainability planning guidelines:* The guidelines will outline the process and procedures to be followed, content of the sustainability plan, stakeholders to be involved and their roles, the role of the Ministry of Finance and the Global Fund, budgeting of the sustainability plan, approval and timelines.
- *Initiation of sustainability planning with the country:* It is recommended that sustainability plans are developed soon after grant signing and commencement of grant implementation.
- *Timeframe for the sustainability plan:* Global Fund timeframes may vary from country to country depending on the complexity of the sustainability plan activities and number of implementers. At the minimum sustainability plans should be implemented for 3 years.
- *Scope of the sustainability plan:* A sustainability plan should include clear rationale, specific services to be sustained and strategies for transferring responsibility to countries, coordination and management and strategies for raising funds to support the selected services. Other aspects are Global Fund role, budget, funding mechanism, monitoring mechanism and recourse for non-compliance.
- *Collaboration with other development partners:* The Global Fund should involve other development partners supporting health programmes to develop a sustainability plan. Where a country must phase out its support the Global Fund would take up the responsibility to support the country during transition to ensure gains are not lost. In this case the Global Fund could extend its grant.
- *Role of the Global Fund:* Global Fund should provide the guidelines and play an advisory and capacity building role in the development of the sustainability plans. This would involve guidelines on the definition and scope of the sustainability plan, who should be involved, timelines, and reviewing the sustainability plans and working with countries to mobilize resources and technical support from other development partners
- *Management of the sustainability plan:* The plan should establish mechanisms for coordination and management which involves close links between stakeholders in the country.
- *Monitoring:* The sustainability plan should include a robust monitoring and evaluation and reporting framework linked to the overall reporting system for the national programmes funded by Global Fund.

1. Introduction

1.1. Background

The Global Fund was established in 2002, reflecting a shared global commitment to fighting three of the world's most deadly epidemics. It has since become the main financier of HIV/AIDS, tuberculosis and malaria across more than 150 countries, approving US$ 22.6 billion in grants by December, 2011 Its investments have contributed to significant declines in deaths and infections from the three diseases by providing AIDS treatment for 3.3 million people, DOTS treatment for 8.6 million people and 230 million insecticide-treated nets for the prevention of malaria. The Global Fund has also helped bring about a strong link between funding and results, and a paradigm change on how communities are engaged in health planning and delivery[1].

The Global Fund provides funding to HIV/AIDS, TB and, Malaria programmes for prevention, treatment, care and support programmes. It also funds health systems strengthening interventions necessary for effective implementation of the three disease programmes. To access Global Fund support countries design programmes based on their national priorities and owned by all stakeholders. Countries are guided by the Global Fund guidelines and eligibility criteria in the development of programmes.

In 2011, the Global Fund introduced the eligibility criteria for its support. Countries that are classified as High Income Countries (HICs) or Upper Middle Income Countries (UMICs) and have low disease burden[2], are ineligible for Global Fund support. UMIC countries with high, severe or extreme disease burden may be funded.

While programs in countries usually aim to renew financial support from the Global Fund, some countries have opted to substantially increase domestic financial support while reducing financial support from the Global Fund. In addition, as the eligibility criteria include a country's income category, upper middle income and high income countries became ineligible to receive Global Fund support[3].

The Global Fund has put in place mechanisms to mitigate the change in financial responsibilities for countries becoming ineligible for funding. First, Continuity of Services policy (COS) is applied to ensure continuity of life saving support for up to two years when countries cannot identify alternative sources of financial support. Second, a new counterpart funding policy requires countries to allocate domestic funding to match funding Global Fund at different ratios depending on income categorisation of a country. Third, the Transitional Funding Mechanism[4] allows continuation of essential prevention, treatment and care services upon expiry of a grant, while countries focus their resources in scaling up these services to fill the gap. These mechanisms are meant to sustain the gains achieved by countries while allowing time for countries to take financial responsibility for the programmes.

The Global Fund is concerned that countries are becoming ineligible for funding or increasing their domestic contribution to the programmes without clear sustainability or transition mechanisms, and, therefore, risks negating the gains made by the programmes.

[1] The Global Fund Strategy 2012 – 2016: Investing for Impact
[2] This excludes South Africa, which is part of the G20 but has extreme disease burden.
[3] This excludes South Africa, which is part of the G20 but has extreme disease burden.
[4] Transitional Funding Mechanism was established by Global Fund Board decision GF/B25/DP16 in November 2011

1.2. Objectives of the review

This review aimed at identifying issues related to sustainability of Global Fund supported programmes; provide lessons for countries in similar situations and to inform the development of a "sustainability strategy" for Global Fund supported programmes going forward.

1.3. Review questions

The review set out to answer the following questions:

- How did countries prepare to assume financial responsibilities to take over certain activities or health products supported by Global Fund financing? What were the triggers, enabling factors, challenges and processes adopted for the transition?
- What may facilitate eligible countries to assume financial responsibilities to take over certain activities or health products supported by Global Fund financing? What are common factors? How can the Global Fund facilitate processes in countries?
- What are the lessons for the Global Fund, to enable smooth transition, both as transitional grant support and non-financial support to countries and programs (ex. advocacy, partner engagement etc.)?
- What would be other criteria for Global Fund transition, in addition to income level?
- What are the fundamental pillars demonstrating/suggesting the sustainability of the Global Fund support which would enable its transitioning and alleviate the phasing-in of national entities?
- Does (or can) improved coordination and harmonization with other donors that may also be transitioning out (e.g. PEPFAR), mitigate the risks and challenges of the Global Fund transitioning?
- What transitional/ sustainability strategies should Global Fund develop? (objective and convincing criteria, feasible timeframe, technical support during transition, and risk mitigation)

1.4. Dimensions of the review

On the basis of the questions outlined above, this review provides analytical insights and recommendations on policy and development of sustainability plans for Global Fund supported programmes along the following dimensions:

- Triggers for financial responsibility by countries beyond income classification of countries: Triggers are defined as the events that set in motion the countries' transition to greater financial responsibility. Income classification was underscored as a base criterion applied by Global Fund to determine eligibility of countries for funding. Triggers are not part of the eligibility criteria but factors that propel a country to be better placed to increase domestic funding to the programmes. The issue is to what extent do demographic, economic, programmatic and institutional and/or systemic factors act as triggers for sustainability of the Global Fund programmes? How have these factors influenced countries to prepare to assume financial responsibilities to take over certain activities or health products supported by Global Fund?
- Enablers for financial sustainability by countries: Enabling factors make it possible for countries to achieve greater financial responsibility. These are factors that positively influence or facilitate countries to sustain domestic financial responsibility for the HIV, Malaria and TB programmes. These factors can also be economic, institutional and systemic and

programmatic in nature. Triggers reflect a country's readiness, while enablers a country's ability to sustainably meet financial responsibility for programmes and also sustain the gains achieved by the programmes in the long run.

- Development of sustainability plans: this dimension focused on approaches that can be adopted in development of sustainability plans by countries within the context of Global Fund supported programmes. The main issues addressed include the policy imperatives for development for the sustainability plans, the possible content and processes for development of these plans.

1.5. Review methodology

In order to address the questions and expound on the three review dimensions, an exploratory research approach was applied which involved extensive documents review and interviewing of key informants.

Country coverage

The countries covered by this review were selected by Global Fund based on their categorisation as Upper Middle Income or High Income Countries. Countries that do not have on-going Global Fund grants were considered to have transitioned out of the Global Fund. The countries, therefore, provided a basis for understanding factors that trigger and enable countries to take up financial responsibility for their programmes. The countries covered by the review are listed in the table below.

Table 1: Selected Countries and Global Fund grant portfolio status

Country	Income classification	Year of country income classification	No. of grants awarded by Global Fund	No. of on-going Global Fund grants	Cumulative spending on all Global Fund grants through 2012 in US$ '000
Algeria	UMIC	2008	1	0	6,945
Argentina	UMIC	2001	3	1	27,014
China	UMIC	2010	13	5	761,558
Croatia	HIC	2008	1	0	4,945
Equatorial Guinea	HIC	2007	2	0	30,502
Estonia	HIC	2006	1	0	10,483
Jamaica	UMIC	2007	2	1	57,509
Romania	UMIC	2005	4	1	64,482
Russian Federation	UMIC	2004	5	3	368,469
South Africa	UMIC	2004	12	6	348,827
Thailand	UMIC	2010	18	12	320,622
Ukraine	LMIC	2002	11	6	300,122

Sources: Global Fund web site- country grants; World Bank Development Databank http://databank.worldbank.org

Algeria, Croatia, Equatorial Guinea and Estonia are the four countries that have fully transitioned from Global Fund grants. The first three countries became high income countries, while Algeria became UMIC. Equatorial Guinea had received two grants, and the other three had one grant each. Equatorial Guinea received $30.5 m. in total, while each of the other three received less than $10.5 m. each.

Documents review

The review relied on relevant documents on these countries available through websites, Global Fund and specific databases accessed on line. Particularly, World Bank, UNDP, Global Fund, WHO, UNAIDS, GAVI, PEPFAR and Stop TB Partnership databases were a source of economic and programmatic data and sustainability planning.

Key informant interviews

In-depth discussions were conducted with the Global Fund, WHO and GAVI in Geneva in October 2012. Key informants interviewed included executive managers, division heads, departmental heads, managers, technical and programme staff. The consultations aimed at understanding the perspectives of the Global Fund and technical partners on sustainability of the Global Fund programmes and the approaches for development of sustainability plans. The second set of consultations were conducted during visits to Jamaica (November 26-30, 2012), South Africa (December 3-7, 2012, and Kenya (January 14-18, 2013). Stakeholders including Country Coordinating Mechanisms (CCM) members, Ministry of Health senior staff; National AIDs Coordinating Authorities and National disease programme managers were interviewed.

Data analysis

The analytical framework for this review comprised three dimensions:

The first dimension is demographic, economic, financial and programmatic. The type of data analysed during this review is summarised in the table below.

Table 2: Analytical Framework for demographic, economic, financial and programmatic dimension

Variable description	Indicator data
Demographic data	• Total population • Population growth rate
Economic data	• Gross Domestic Product GDP growth rate. • Gross National Income (GNI) • Income per capital
Health financing data	• Per capita total expenditure on health • Health spending as % of GNP • Government spending on health as % of total health spending. • Donor spending on health as % of health spending • Government spending on health as % of total government expenditure • Country spending on HIV, TB and Malaria programmes • Total Global Fund financing as a proportion of total programme spending and as proportion of development partners funding
Programmatic data	• HIV prevalence among adults aged 15-49 years • Number of people living with HIV • Incidence of TB per 100,000 populations

	• Malaria cases per country

The second dimension of analysis involved health systems. The state of a country's health system is a determinant of the quality of and access to health services and can trigger and/or enable sustainability of disease programmes. A rapid assessment of the six health systems building blocks - governance and leadership, health financing, human resources for health, pharmaceutical management, and service delivery - was undertaken. The data was collected from country health system assessment reports and the most recent proposals submitted to the Global Fund. The Global Fund proposals provided limited descriptions of the country's health systems including gaps that would affect delivery of the proposals interventions. The data collected for each of the health system building blocks was analysed into the strengths and weaknesses to determine how health systems might have impacted implementing country's decisions to take up financial responsibilities for activities and products.

The third dimension of analysis focused on the strategies and approaches used to develop and implement sustainability plans for programmes by countries and by development partners. Data was collected on how the three countries visited- Jamaica, South Africa and Kenya are approaching sustainability of HIV and AIDS, TB and Malaria programmes. In addition, data was collected on the approaches and processes for development and implementation of sustainability plans for PEPFAR and GAVI supported programmes.

1.6. Limitations of this review

This was a rapid exploratory review to learn from 12 countries selected from Africa, Asia - Eastern Europe and Latin America and Caribbean (LAC) countries about what had triggered and enabled these countries to take up financial responsibility for activities and products supported by the Global Fund, plans developed to sustain the gains from Global Fund supported programmes and lessons learnt. The review was designed to involve visits to only three countries: Jamaica, South Africa and Kenya. This limited the information available to the review team for the other 9 countries not visited considering that relevant documents were not readily available.

Secondly, the review relied on experience of countries and other development partners in developing sustainability plans for other programmes to develop lessons on planning, implementation and monitoring of sustainability plans. However, most of the countries had not developed sustainability plans for the Global Fund programme and, therefore, had limited experience in addressing the issues being explored by the review. In addition information on other development partners notably the World Bank was not readily available.

2. Financial, programmatic and health system analysis and findings

2.1 Introduction

This section identifies demographic, economic, financial, programmatic and health systems triggers and enablers for sustainable transitions from Global Fund. Selected indicators related to these variables were analysed to determine their influence on the decision by countries to take up and sustain financial responsibilities for services and programs previously supported by the Global Fund.

2.2 Demographic trend analysis

Two demographic indicators, population size and population growth rate, were reviewed because of the role they can play in enabling a country to take up greater and sustainable financing responsibilities for health services and programs funded by the Global Fund. A country's population size partly determines the level of funding it requires for developing adequate health systems that can facilitate access to health services for all. Large population size requires more investment in health facilities, equipment, drugs and medical supplies and healthcare professionals and workers. A high growth rate of population on the other hand requires a country to increase investments in the health delivery system to cope with increasing population.

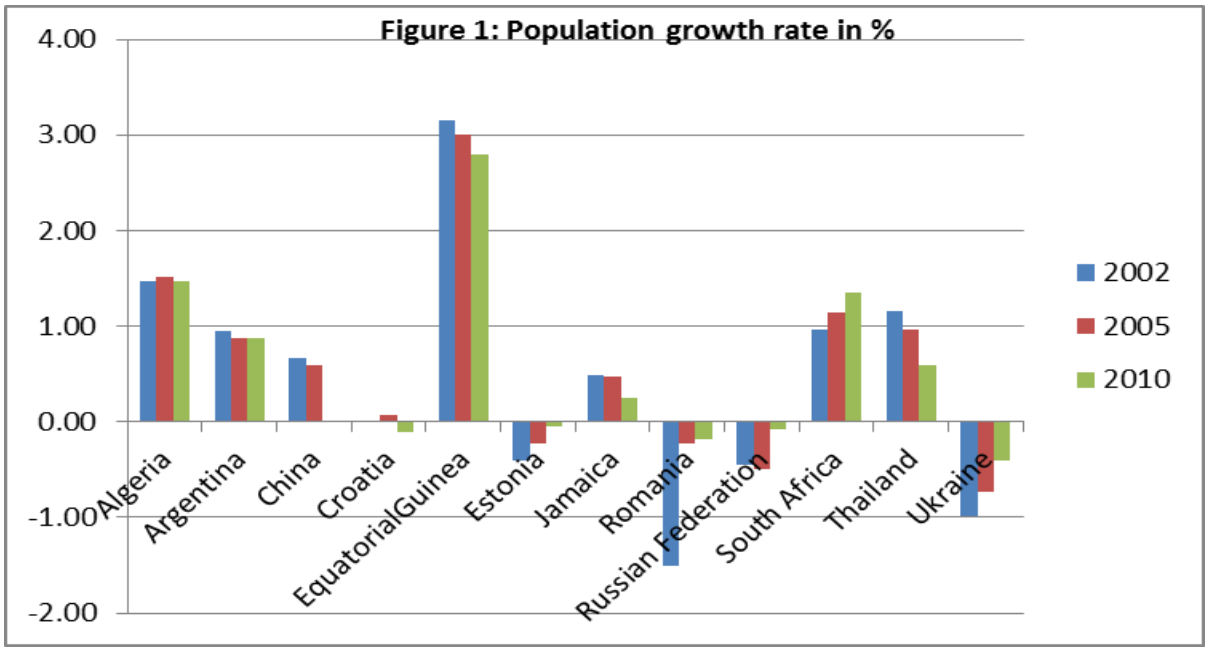
Population size

A large population means that a country has huge demands for health services and may be a factor in a country's decision not to take up financial responsibilities for the HIV/AIDS, TB and malaria programmes considering that it will require substantial resources. Other factors such as GDP growth rate and per capita income being favourable, countries with small populations are likely to take up financial responsibility for their HIV/AIDS, TB and Malaria programme.

Table 3: Population size of the selected countries		**Average annual % change 2002-2010**
Country	**Population 2009**	
Algeria	34,950,000	1.50
Argentina	40,062,000	0.89
China	1,331,380,000	0.57
Croatia	4,429,000	-0.04
Equatorial Guinea	681,000	2.95
Estonia	1,340,000	-0.20
Jamaica	2,695,000	0.41
Romania	21,480,000	-0.35
Russia	141,850,000	-0.33
South Africa	49,320,000	1.14
Thailand	68,706,000	0.84
Ukraine	46,053,000	-0.66
Average		0.56
Source: World Bank Development Databank http://databank.worldbank.org		

Population growth rate

Population growth rate partly determines the level of investment that a country needs to put into all sectors to achieve sustainable development in the long run. Health is one of the key sectors. Hence population growth rate determines the level of GDP growth rate that is needed to sustain development; with effective provision of basic services. Countries with high population growth rate potentially have more challenges in sustaining provision of basic services than those with low population growth rate. This implies that high population growth rate, as was the case in South Africa, Thailand, and Argentina may have influenced these countries decision not to fully take up financial responsibility for Global Fund supported programmes.



Source: World Bank Development Databank http://databank.worldbank.org

2.3 Economic trend analysis

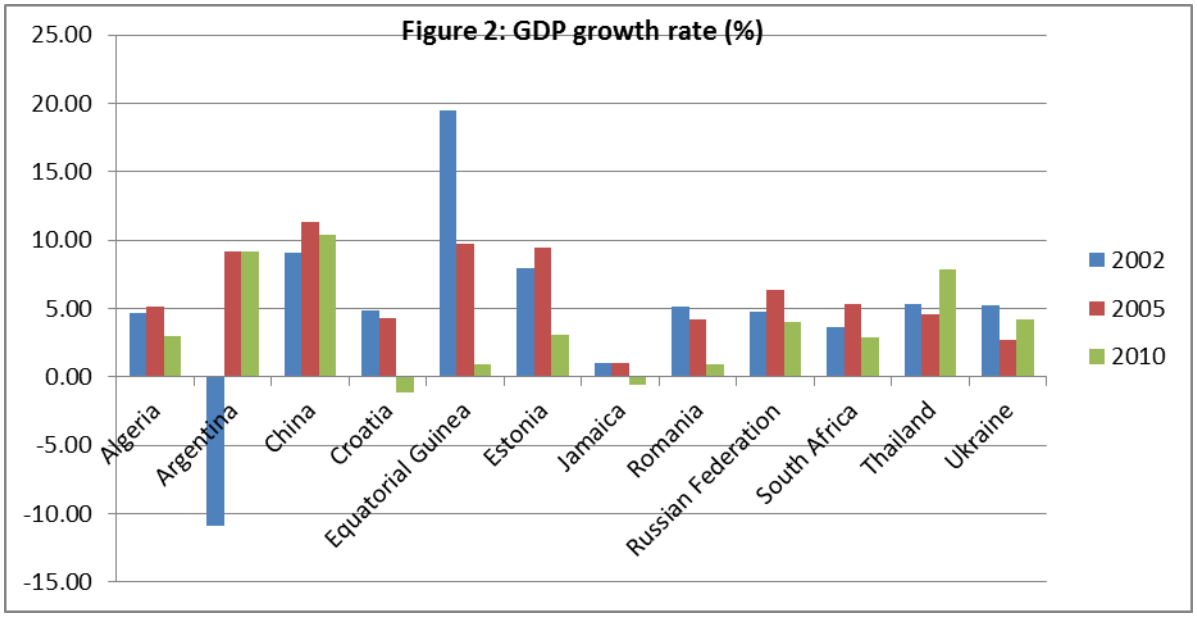
The economic performance of a country determines the financial capacity to fund health budgets and expenditures at national and individual levels. Gross Domestic Product (GDP) is an indicator of the financial capacity of a country to meet its budgetary obligations. High GDP increases government revenue thereby enhancing financial sustainability of health services through increased budgetary allocations and spending. Gross National Income per capita on the other hand determines the financial capacity of individuals to spend. High income per capita increases individual disposable income that can be spent on various services including health. The review team reviewed the trends of the two indicators from 2002 to 2012 to determine how the selected countries performed and the implications on taking up financial responsibility for the HIV, TB and Malaria programmes.

Gross Domestic Product (GDP)

GDP growth rate over the period 2002-2010 was mixed with several countries showing a declining trend. On average, the twelve countries' GDP grew at 5.2% between 2002 and 2010. Equatorial Guinea (13.4%), China (10.7%) and Argentina (5.6%) grew the most rapidly. Seven other countries achieved between 3-5% annual growth: Croatia (2.6%) and Jamaica (0.9%) showed the lowest growth. After adjustment for population growth, net GDP growth was lowest in Jamaica (0.52), South Africa (2.46) and Croatia (2.67). Central European countries showed the most rapid decline in 2009 from the financial crisis including Estonia (-13.9%), Ukraine (-14.8%), Romania (-8.5%), Russia

(-7.8%) and Croatia (-6.0%). Although the GDP growth rates in Argentina, China and Thailand exceeded 5%, these countries still applied for Global Fund support.

The GDP growth rate over the period exceeded population growth rate in all the selected countries, a situation that should be favourable for economic development. Such economic situation should lead to higher per capita income and higher government budgetary allocations to sectors other factors being favourable. In the case of the health sector, higher GDP growth rate than population growth should result in higher per capita expenditure on health and increased domestic financing of health services including HIV/AIDS, TB and malaria. All selected countries show increased per capita income as well as per capita expenditure on health although Algeria, Jamaica, South Africa, Thailand and Ukraine with GDP growth rate of less than 5% over the period show relatively low growth in per capita expenditure on health. Other than Algeria these countries have substantial external funding for the HIV/AIDS, TB and malaria programme. This suggests that GDP is a trigger for taking up financial responsibility.



Source: World Bank Development Databank http://databank.worldbank.org

Income per capita

Income per capita (Atlas method)[5] is the standard used by the Global Fund for determining eligibility for grants. The comparative level of income is an important indicator of relative wealth between countries. For example, the highest per capita incomes in 2011 were Argentina, Russia, Croatia, Equatorial Guinea and Estonia all over $10,000. China, Algeria, Thailand were between (US$4,000-US$5,000), while Jamaica and Ukraine were between ($3,000-4,000). Table 4 shows details. Per capita incomes grew by factors of 1.77 to 6.83 between 2002 and 2011. Ukraine, Romania, China, Russia and Equatorial Guinea all increased by over 4 times. Jamaica had the lowest increase at 1.8 times.

[5] GNI per capita (Atlas Method)

Table 4: GNI per capita, Atlas method (current US$)

Country	2002	2005	2008	2011
Algeria	1, 750	2, 720	4, 260	4, 470
Argentina	4, 040	4, 480	7, 190	9, 740
China	1, 100	1, 740	3, 040	4, 940
Croatia	5, 390	9, 690	13 750	13, 850
Equatorial Guinea	2, 130	5, 220	14, 410	14, 540
Estonia	4, 730	9, 730	15, 030	15, 200
Jamaica	2, 130	2, 700	3, 300	3, 780
Romania	1, 930	3, 920	8, 290	7, 910
Russian Federation	2, 100	4, 460	9, 710	10, 400
South Africa	2, 620	4, 850	5, 850	6, 960
Thailand	1, 870	2, 560	3, 640	4, 420
Ukraine	790	1, 540	3, 220	3, 120

Source: World Bank Development Databank http://databank.worldbank.org

High and sustained growth in per capita income means countries have a wider tax base for raising more revenue guaranteeing better financial capacity to provide services. Countries with high per capita income should therefore take up greater financial responsibility for their HIV/AIDS, TB and Malaria programmes. During the period Argentina, Croatia, Equatorial Guinea, Estonia and Russia Federation had the highest growth in per capita income and were in a better position to take up financial responsibility than the rest of the countries. This was the case with Croatia, Equatorial Guinea and Estonia. Argentina and Russia Federation did not take up full responsibility for their programmes. Factors that may have influenced the decision by Argentina and Russia Federation may include:

(i) Income distribution

Per capita income may mask inequalities in income distribution. A country may therefore have a large segment of the population that cannot afford health services despite high per capita income. In such cases a government may delay its decision to take up financial responsibility. Marginalised, vulnerable groups and MARPS are most affected by HIV/AIDS, TB and Malaria and belong to the poor in society

(ii) Access to health services:

Per capita income may mask inequalities in access to health services. Marginalised populations and most-at –risk populations are usually disadvantaged in some countries in terms of access to health services. Countries, despite high per capita income may not be ready to take financial responsibility of interventions targeting these populations.

(iii) Level of funding for HIV/AIDS, TB and malaria and health system development:

Countries may have high per capita income but undeveloped health systems due to low allocations to the health sector and specifically HIV/AIDS, TB and malaria. These countries are unlikely to be ready to take up sustainable financial responsibility until after several years of investment in health systems. Equatorial Guinea is an example.

2.4 Health financing trends

The level of health financing in a country is a function of the financial capacity of the country, prioritization of health services and health seeking behaviour of the citizens. Countries with high GDP, per capita income need to deliberately prioritize health services as a basis for increased domestic funding of health services. High health financing therefore is a manifestation of a country's commitment to investing in the health of its people, a prerequisite for taking up financial responsibility.

The analysis of health financing focused on per capita expenditure on health, health spending as % of gross national product (GNP), government spending on health as % of total health expenditure, donor spending on health as % of health spending and government spending on health as % of total government spending. The combination of these factors determines the country's capacity to sustain or take up financial responsibility for providing health services.

Per capita expenditure on health

Per capita expenditure on health measure the average amount a country is spending on a person's health services. Countries with higher per capita expenditure on health are more likely to sustain a transition has they already cover a significant proportion of the health needs of its citizens and need less investment to meet total needs than those with low per capita expenditure on health. Argentina, Croatia, Equatorial Guinea, Estonia, Romania, Russia Federation, and South Africa have relatively higher per capita expenditure on health per person than the other five countries whose per capita expenditures on health range between US$ 308 to US$ 445. High per capita expenditure acts as an enabler for sustainable transitions.

Table 5: Per capita expenditure on health at international dollar rate

Country	2002	2005	2009
Algeria	222	243	388
Argentina	647	915	1,387
China	135	191	308
Croatia	788	1,071	1,553
Equatorial Guinea	532	420	1,383
Estonia	582	827	1,373
Jamaica	293	286	383
Romania	399	517	773
Russian Federation	481	618	1,038
South Africa	613	744	862
Thailand	197	240	345
Ukraine	246	387	445

Source: WHO: Global Health Expenditure Database http://apps.who.int/nha/database

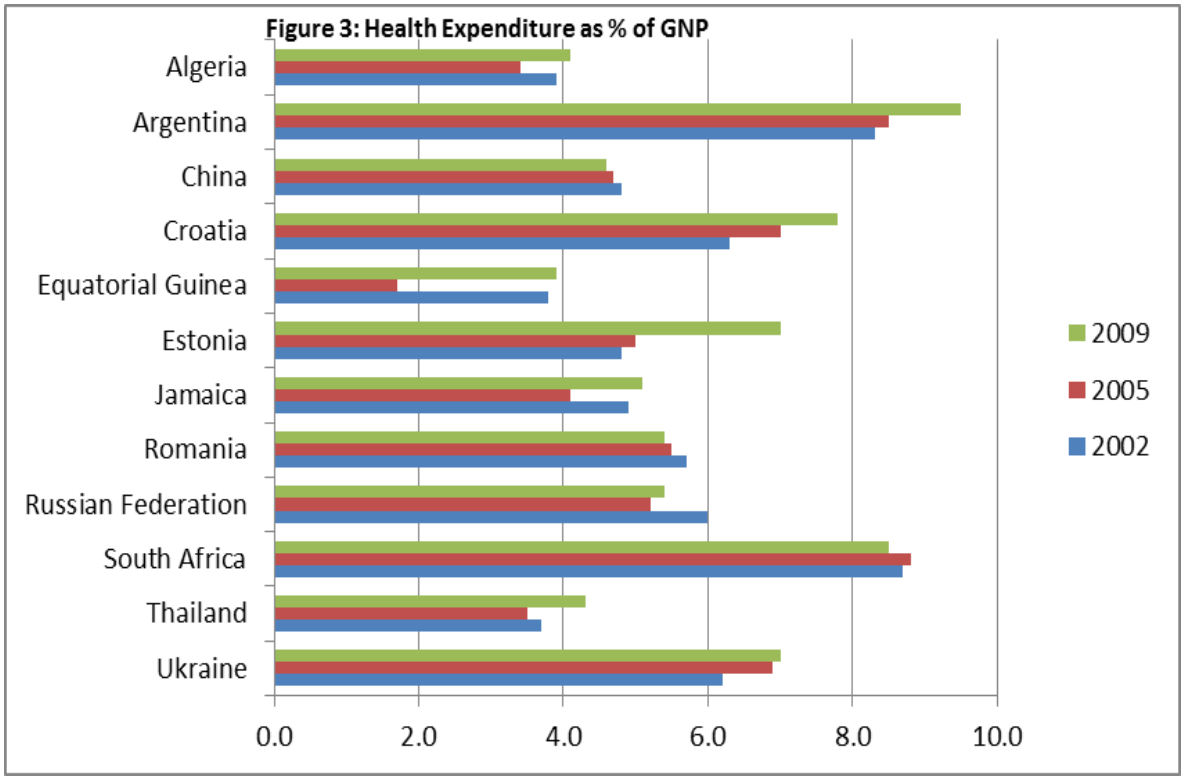
Health expenditure as a percentage of gross national product

The percentage of GNP a country spends on health shows the relative effort of that country in supporting its health programmes. The higher the percentage of GNP spent on health the higher the resources available for health services including HIV/AIDS, TB and Malaria. Countries spending the highest % on health are Argentina (9.2%), South Africa (8.5%), Croatia (7.8%), Estonia (7.0%) and

Ukraine (7.0%) as shown in Figure 4. At the other end of the range are Equatorial Guinea (3.9%), Algeria (4.1%), Thailand (4.3%) and China (4.6%). Three countries increased their % share of health in GNP during 2002-2009: Estonia (2.2%), Croatia (1.5%) and Argentina (1.2%).

Of the five countries with the highest health expenditure as % of GNP, two countries - Croatia and Estonia - do not have on-going grants while Argentina, South Africa and Ukraine do have on-going grants. This would suggest that health expenditure as % GNP is not a conclusive factor for a decision to take up financial responsibility for services and programs supported by the Global Fund but rather an enabler.

Argentina, Croatia, South Africa and Ukraine show the highest health expenditure as a percentage of GNP over the period. This signals their commitment to providing health services and the resources they have continued to set aside for health services enables the countries to take greater financial responsibility for the countries' HIV/AIDS, TB and malaria programmes.



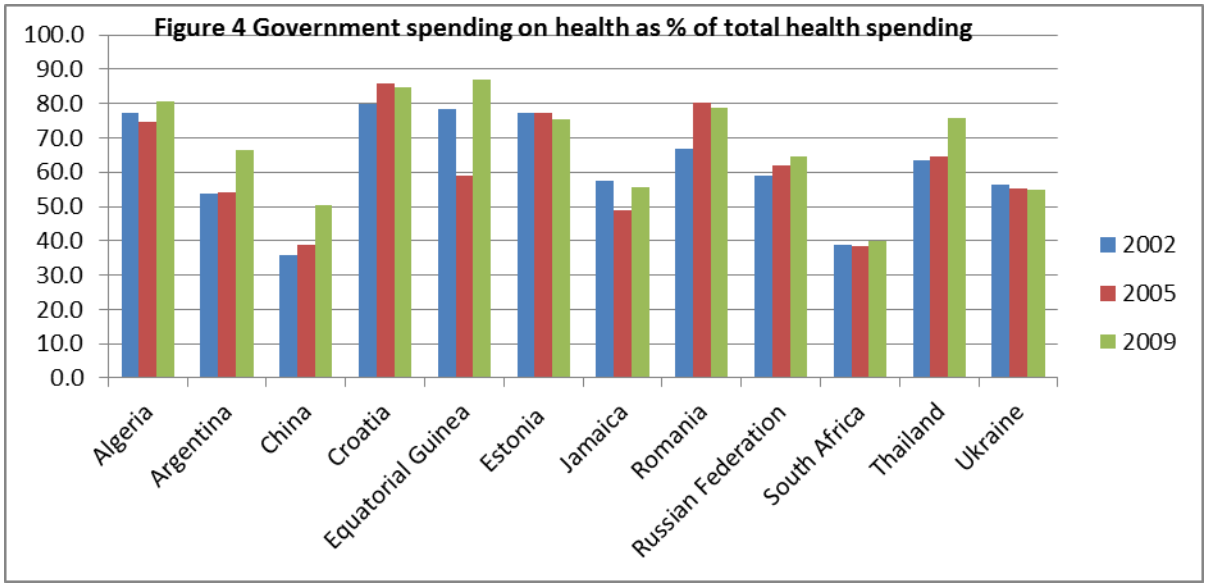
Source: WHO: Global Health Expenditure Database http://apps.who.int/nha/database

Government spending on health as a percentage of total health spending

Higher government spending on health as percentage of total health spending means that the government funds most of the health services in the country. Other factors being favourable, countries with higher government spending on health are more prepared to take full responsibility for health than those with less percentage. High government spending on health should therefore enable a country to take up sustainable transition than a country with low government spending. However, one should be cautious in interpreting this indicator as it may be misleading if for instance health coverage is low.

Algeria, Croatia, Equatorial Guinea, Estonia and Romania show higher government spending on health as a percentage of total expenditure on health (ranging between 62.1% and 84.9%).

The other countries (Argentina, China, Jamaica, Romania, Russia Federation, South Africa, Thailand and Ukraine) still funded by Global Fund show lower government spending on health as % of total health expenditure (ranging between 44.1% and 75.0%).



Source: WHO: Global Health Expenditure Database http://apps.who.int/nha/database

Government spending on health as a percentage of GDP

By multiplying the % health of GDP by % government spending of total health, the government spending on health as a % of GDP results, as shown in the right hand column below. This statistic shows the share of GDP controlled by the government health system and financing. The larger the resulting percentage, the greater the potential resources that the government manages and the greater its leverage in the health system.

Table 6: Share of Government Spending on Health

	Health as % of GDP	Government Spending as % of total health	Government spending on health as % of GDP 2009
Country	**2009**	**2009**	
Algeria	4.1	80.6	3.3
Argentina	9.5	66.4	6.3
China	4.6	50.3	2.3
Croatia	7.8	84.9	6.6
Equatorial Guinea	3.9	86.9	3.4
Estonia	7.0	75.5	5.3
Jamaica	5.1	55.8	2.8
Romania	5.4	78.9	4.3
Russian Federation	5.4	64.4	3.5
South Africa	8.5	40.1	3.4
Thailand	4.3	75.8	3.3
Ukraine	7.0	54.7	3.8
Average	6.1	67.86	4.03

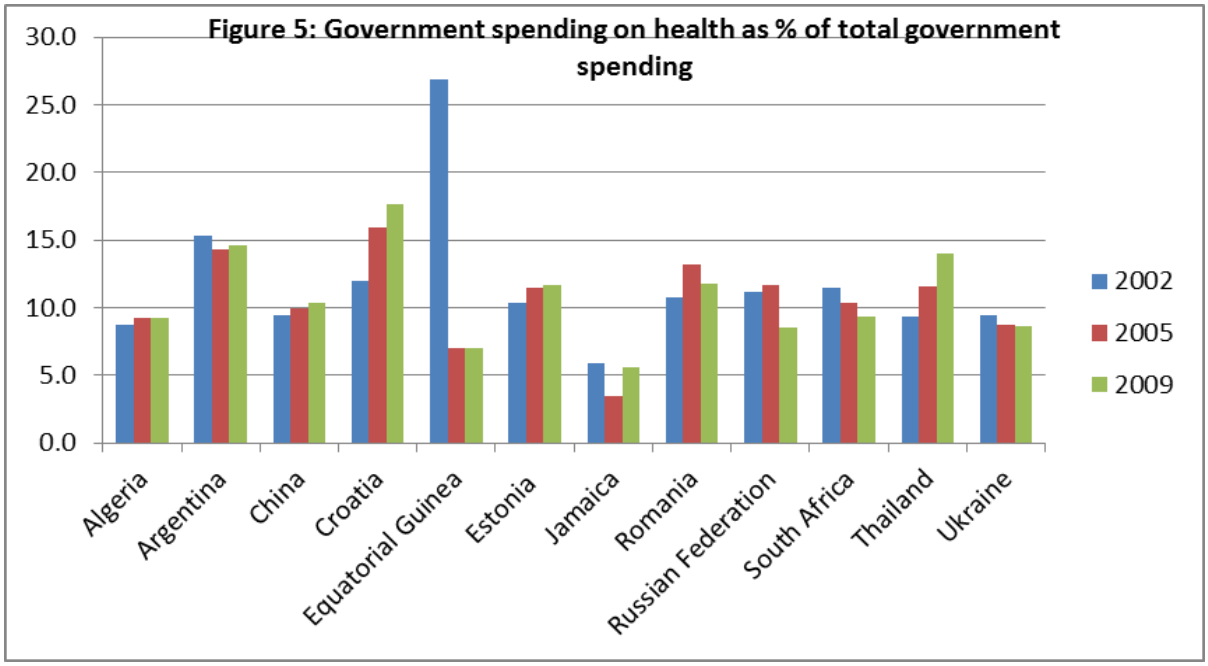
Source: WHO: Global Health Expenditure Database http://apps.who.int/nha/database

Croatia (6.6), Argentina (6.3) and Estonia (5.3) all have above average resources for health and significant control over these resources. China (2.3), Jamaica (2.8), Algeria (3.3), Thailand (3.3), Equatorial Guinea (3.4) and South Africa (3.4) have the lowest resources for health managed by the government. Greater control of health resources means that the government is able to direct resources to areas where they are needed most in a sustainable manner.

Government spending on health as a percentage of total government spending

Argentina, Croatia, and Estonia spent over 10% of the total government expenditure on health. China, Romania Russian Federation, South Africa, and Ukraine spent between 5% and 10% in 2009. The other two countries that have no on-going grants, Algeria and Equatorial Guinea spent between 6% and 10%. Notably Equatorial Guinea's government expenditure on health as percentage of total government expenditure declined dramatically after 2002 perhaps explained by rapid increase in total government expenditure (GNI per capita increased sevenfold between 2002 and 2008) without a corresponding increase in health expenditure (per capita expenditure on health increased by only 23% over the same period). In addition the country graduated to HIC in 2007and received no further funding from the Global Fund after 2007.

High and increasing spending on health as percentage of total government means the government is gradually putting in place policies that favour investment in provision of health services to its people a condition necessary for taking up financial responsibility for HIV/AIDS, TB and Malaria programmes.



Source: WHO: Global Health Expenditure Database http://apps.who.int/nha/database

Donor expenditure as a percentage of total health expenditure

In 2009, donor contributions for health were highest in Estonia (3.9%), Equatorial Guinea (3.2%), South Africa (1.9%) and Jamaica (1.8%) in 2009. The biggest changes between 2002 and 2009 were in Estonia (+3.9%), South Africa (+1.5%), Jamaica (+1.4%), Romania (-3.9%) and Equatorial Guinea (-5.0%). Estonia's increase is most likely the result of subsidies received from the European Union. High donor expenditure means a country relies heavily on external funding for its HIV/AIDS, TB and Malaria programmes. This is likely to present difficulties to these countries when transitioning from the Global Fund as they require large outlays to finance the activities and services previously funded by donors.

2.5 Funding of HIV/AIDS, TB and Malaria programmes

A review of countries' spending on HIV, TB and Malaria programmes and Global Fund financing as a proportion of total programme spending and as proportion of development partners funding was completed. The level of spending on the 3 diseases and the sources of funding should influence the decision to take up financial responsibilities and the extent of sustainability of services and activities supported by the national programmes. Comparative data for country spending on disease programs has been difficult for the international agencies (WHO, UNAIDS, Stop TB, and Roll Back Malaria) to collect on a consistent basis across countries over time. As a result, the data in this section are available for only limited points in time. In addition, the data underestimates the country expenditures for the disease. Government health staff and facilities contributing to the disease programs are usually not accounted for.

HIV funding

The analysis of spending on HIV and AIDS programme shows that Algeria increased its spending on HIV/AIDS considerably between 2009 and 2011 with little external funding. Romania increased its funding while Global Fund financing decreased from 4% to 0% between 2009 and 2011. Thailand increased its domestic funding over the same period while Global Fund grant spending increased from 5% to 11%. In 2009, Equatorial Guinea depended on the Global Fund for 55% of its funding, although the country's GNI per capita increased dramatically from 2007. This high dependence may be explained by the short time lag in the incriment of domestic resources[6], low prioritization of health sector in allocation of domestic resources, poor planning or lack of political will to support the three diseases. In 2010, Jamaica received 66% of its funding from the Global Fund, and Ukraine received 37%. It is unlikely that a country with such a high dependency can rapidly transition away from Global Fund support. Table 6 shows a recent trend toward domestic funding of the HIV/AIDS programme except in Jamaica which remains heavily donor dependant. Three of the countries with no on-going grants show no external funding.

Table 6: HIV/AIDS spending by Country in US$ '000[7]

Country	Year	Total funding	Domestic funding	External Funding	Global Fund	GF as % of Total	GF as % of External
Algeria	2009	2, 708	2, 537	171	0	0	0
Algeria	2010	5, 795	5, 326	468	0	0%	0%
Algeria	2011	8, 921	8, 069	851	0	0%	0%
Argentina	2009	287, 100	286, 371	728	0	0%	0%
China	2010	583, 626	497, 309	86, 317	40, 436	7%	47%
China	2011	589, 373	529, 376	59, 997	27, 664	5%	46%
Croatia	2009	10, 367	10, 177	189	0	0%	0%
Equatorial Guinea	2009	2, 797	918	1, 878	1, 547	55%	82%
Jamaica	2009	15, 146	3, 437	11, 708	9, 986	66%	85%
Jamaica	2010	14, 620	3, 848	10, 771	9, 680	66%	90%
Romania	2009	84, 255	80, 101	4, 154	3, 324	4%	80%

[6] This study was conducted in 2012

[7] Note that reported data understate the government's actual spending on salaries and facilities in its programs due to difficulties in costing out partial programmes. Data before 2009 was not available

Table 6: HIV/AIDS spending by Country in US$ '000[7]							
Romania	2010	95, 508	91, 512	3, 995	1, 417	1%	35%
Romania	2011	108, 135	102, 458	5, 677	0	0%	0%
Russia	2008	777, 021	700, 861	76, 159	65, 616	8%	86%
South Africa	2009	2, 195, 592	1, 930, 462	265, 130	22, 239	1%	8%
Thailand	2009	209, 106	195, 119	13, 986	10, 735	5%	77%
Thailand	2010	236, 177	200, 251	35, 926	26, 021	11%	72%
Thailand	2011	314, 362	267, 932	46, 430	35, 359	11%	76%
Ukraine	2009	64, 611	38, 052	26, 558	22, 079	34%	83%
Ukraine	2010	71, 931	38, 054	33, 877	26, 858	37%	79%
Source: UNAIDS National AIDS Spending Assessment (NASA) http://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports							

Tuberculosis funding

Tuberculosis programme spending by countries rose steadily between 2005 and 2009. China quadrupled its domestic spending, and Global Fund financing reached a peak of 30% of the total program in 2011 (up from 15% in earlier years) as the GF funding transitioned out. Romania also quadrupled its public spending, and the Global Fund share decreased from 41% to 13% of the total. Russia's spending varied, from a low of $861milion in 2010, to a peak of $1.6 million in 2009. Global Fund financing remained at roughly 1%. Thailand doubled its domestic spending while the Global Fund share remained at 2%.

Table 7[8]: TB Program Spending by Country by Year and Source of Funding in US$ '000							
Country	**Year**	**Total funding**	**Domestic funding**	**External funding**	**Global Fund**	**GF as % of Total**	**GF as % of External**
China	2006	148, 949	124, 594	24, 355	22, 347	15%	92%
China	2007	188, 343	150, 093	38, 250	37, 550	20%	98%
China	2008	200, 619	168, 660	31, 958	31, 130	16%	97%
China	2009	224, 986	189, 798	35, 188	35, 188	16%	100%
China	2010	208, 381	179, 219	29, 161	28, 356	14%	97%
China	2011	278, 466	195, 748	82, 717	82, 717	30%	100%
Romania	2006	5, 998	3, 526	2, 471	2, 471	41%	100%
Romania	2007	6, 178	3, 632	2, 546	2, 546	41%	100%
Romania	2008	18, 957	16, 940	2, 017	2, 017	11%	100%
Romania	2009	18, 880	16, 865	2, 015	2, 015	11%	100%
Romania	2010	15, 570	13, 600	1, 970	1, 970	13%	100%
Romania	2011	16, 037	14, 008	2, 029	2, 029	13%	100%
Russian Federation	2006	1, 048, 977	1, 048, 977	0	0	0%	NA
Russian Federation	2007	990, 998	977, 808	13, 190	10, 220	1%	77%

[8] Algeria, Argentina, Croatia, Equatorial Guinea, Estonia, Jamaica, South Africa, and Ukraine do not have TB grants.

Table 7[8]: TB Program Spending by Country by Year and Source of Funding in US$ '000							
Russian Federation	2008	996, 640	969, 580	27, 060	26, 936	3%	100%
Russian Federation	2009	1, 589 581	1, 579 891	9, 689	9, 631	1%	99%
Russian Federation	2010	861, 839	848, 020	13, 819	12, 401	1%	90%
Russian Federation	2011	883, 050	871, 971	11, 079	9, 618	1%	87%
Thailand	2006	38, 742	37, 641	1, 100	907	2%	82%
Thailand	2007	40, 070	38, 931	1, 138	938	2%	82%
Thailand	2008	40, 238	39, 095	1, 143	942	2%	82%
Thailand	2009	47, 529	46, 166	1, 363	1, 124	2%	82%
Thailand	2010	48, 444	47, 640	803	803	2%	100%
Thailand	2011	60, 335	59, 328	1, 007	1, 007	2%	100%
Source: WHO Stop TB – compiled by Global Fund staff							

Malaria funding

From 2009 to 2011, China tripled its domestic funding for malaria and Global Fund financing increased from 18% to 28%. Thailand's domestic funding decreased dramatically for some reason from $2.8 million to $440,000. The Global Fund share was at 55%.

Table 8[9]: Malaria Program spending by country by Year- Source of Funding in US$ millions							
Country	**Year**	**Total funding**	**Domestic funding**	**External funding**	**Global Fund**	**GF as % of Total**	**GF as % of external**
China	2008	51,665	42,532	9,133	9,133	18%	100%
China	2009	167,080	157,179	9,901	9,901	6%	100%
China	2010	182,009	131,135	50,874	50,874	28%	100%
Thailand	2008	6,340	2,827	3,513	3,513	55%	100%
Thailand	2009	7,716	509	7,207	5,087	66%	71%
Thailand	2010	5,913	439	5,473	3,279	55%	60%
Source: WHO/RBM except China government which is from R10 proposal							

Global Fund Financing Expenditures by Service Category

The way Global Fund financing is allocated to the various HIV, TB and malaria service categories plays a role in influencing sustainability of the national programmes. There is now increased emphasis on allocating more funding to prevention interventions, health system strengthening and community system strengthening as a better approach towards building the capacity of countries to sustain the national HIV/AIDs, TB and malaria programmes.

9 Algeria, Argentina, Croatia, Estonia, Jamaica, Romania, Russia Federation, South Africa, and Ukraine do not have TB grants.

During transitions the country's challenge is to identify funding for the interventions previously funded by external resources. This review revealed that whereas a larger proportion of Global Fund finances is allocated to prevention, supportive environment and HSS, countries transitioning from the Global Fund are focusing on taking up cost of treatment and health workers previously supported by the Global Fund. In South Africa, the government has prioritised ARV procurement instead of prevention. The 2012/13- 2014/15 budget has not provided adequate funding for prevention services. In Jamaica, the government has prioritized ART treatment and health- workers. This is also the case in Thailand. This presents a challenge to future funding of prevention services.

Global Fund expenditure on HIV by service category

Table 9 shows the proportion of Global Fund financing spent on HIV prevention, care and support, treatment, supportive environment and health system strengthening. Sixty five (65%) per cent was spent on prevention (33%), supportive environment (13%) and HSS (19%). A large proportion of Global Fund financing is therefore being invested in prevention and capacity building which is appropriate for long term sustainability of the national HIV response.

Table 9: Global Fund expenditure on HIV by service category in US$'000

	Prevention	Care and support	Treatment	Supportive Environment	HSS	Total
Algeria	3,076		1,446	1,598	823	**6,943**
Argentina	13,504	2,184	73	2,222	7,178	**25,161**
China	65,740	12,326	8,585	48,486	5,498	**140,635**
Croatia	820			457	3,666	**4,943**
Equatorial Guinea	927		2,691	3,668	367	**7,653**
Jamaica	13,149	2,666	16,836	6,789	5,575	**45,015**
Romania	21,288	9,293		3,069	60	**33,710**
Russia Federation	83,742	20,950	103,925	37,570	14,585	**260,772**
South Africa	61,908	34,322	56,481	37,951	38,785	**229,447**
Thailand	34,004	11,137	6,684	26,230	29,058	**107,113**
Ukraine	44,559	35,604	42,367	32,835	32,777	**188,142**
Total	**342,717**	**128,482**	**239,088**	**200,875**	**138,372**	**1,049,534**
Percentage	**33%**	**12%**	**23%**	**19%**	**13%**	**100%**

Source: Global Fund Strategy, Investment and Impact Division

All the 12 countries spent over 50% of the Global Fund financing on prevention, supportive environment and HSS. This shows that there is appropriate allocation of Global Fund resources towards interventions that are likely to sustain the HIV national response.

Global Fund expenditure on TB by service category

Fifty one (51%) of the Global Fund financing was spent on supportive environment and Health Systems Strengthening (HSS) showing that the countries are allocating significant resources towards building the national capacity to sustain the TB national response. Countries such as China and Thailand allocated more than 50% of the Global Fund financing to strengthening the supportive environment and health systems while Russia and Romania spent less than 50%. The table below provides a summary of Global Fund expenditure on TB programmes by service category.

Table 10: Global Fund expenditures by TB service category				
Country	**TB detection and Treatment**	**Supportive Environment**	**HSS**	**Total**
China	65,155	121,155	12,470	198,780
Romania	10,905	6,450	2,752	20,107
Russia Federation	80,346	21,678		102,024
Thailand	12,910	15,497	395	28,802
Total	**169,316**	**164,780**	**15,617**	**349,713**
Percentage	**48%**	**47%**	**4%**	**100%**
Source: Global Fund Strategy, Investment and Impact Division				

Global Fund expenditure on malaria by service category

Seventy five per cent of the Global Fund finances were allocated to prevention (75%), supportive environment (11%) and HSS (9%). More resources were used towards prevention and building the capacity of the country to sustain the malaria response.

Table 11: Global Fund expenditure on malaria by service category					
Country	**Prevention**	**Treatment**	**Supportive Environment**	**HSS**	**Total**
China	24,526	12,945	23	6	37,500
Equatorial Guinea	9,676	1,825	7,873	2,684	22,058
Thailand	9,926	5,126	1,082	4,184	20,318
Total	44,128	19,896	8,978	6,874	79,876
Percentage	**55%**	**25%**	**11%**	**9%**	**100%**
Source: Global Fund Strategy, Investment and Impact Division					

Global Fund grant spending by implementing agency

Table 12 below summarizes grant spending for HIV/AIDS by country by implementing agency.

The data is cumulative spending by Principal Recipients and Sub-Recipients, whether Ministry of Health, NGO/CBO/Academic, UNDP and other. Two of the 4 countries without current grants, Algeria (65%) and Croatia (54%) had the highest shares of spending by the MOH. Data from Estonia was not available. Equatorial Guinea had only 2% by the Ministry of Health. Several hypotheses are possible.

First, grant spending by the MOH is likely to be easier for the government to replace with its own funds, since the MOH is already funded by government. Second, a large share of spending by NGO/CBO/Academic organizations is likely to be harder for governments to fund since there may not be established precedents or policies for governments to fund NGOs/CBOs directly. Third, NGO/CBO/Academic programmes may focus their attention on prevention and treatment of special groups, including MSMs, CSWs and IDUs. In many countries, governments have a difficult time

serving these groups, because of negative attitudes about these groups, and in many cases policies and legal frameworks that criminalize the behaviour of these groups. Fourth, countries where UNDP is a PR present challenges because it indicates lack of national capacity to take up and manage national programmes. Generally, countries with greater participation by NGO/CSOs and UNDP in provision of services present a challenge to Governments during transition because funds are required to support these organization hitherto supported by Global Fund.

Thus, the spending composition of a country's grants may be a good predictor of the ease or difficulty of the path to programme sustainability. This data is certainly available within the Global Fund. It should prove useful in identifying the programme components that are most difficult for governments to fund, and thereby provide focus and realistic timeframes for sustainability planning.

Table 12: Global Fund spending by implementing agency

Country	MOH	NGO/CBO	UNDP[10]	Other
Algeria	65%	27%	2%	6%
Argentina	0%	63%	36%	0%
China	29%	71%	0%	0%
Croatia	54%	36%	0%	9%
Equatorial Guinea	2%	9%	83%	6%
Romania	3%	78%	0%	19%
Russia	9%	89%	0%	1%
South Africa	46%	33%	0%	21%
Thailand	30%	65%	0%	5%
Ukraine	0%	98%	0%	2%

Source: Global Fund Strategy, Investments and Impact Division

2.6 HIV and TB disease burden

The level of the disease burden determines the resources a country requires to establish and maintain health system that ensures access to health services by those who need them. The level of disease burden will therefore play a role in the decision to take up financial responsibilities for by the country as well as sustainability of services.

HIV disease burden

Four countries (Algeria, Croatia, Equatorial Guinea, Estonia,) that have no on-going grants show lower HIV prevalence rates among adults aged 15-49 at between 0.1% -1.2 per cent except in Equatorial Guinea with HIV prevalence of 5% (Table 13). Argentina, Jamaica, Russia Federation, South Africa, Thailand and Ukraine still funded by Global Fund had higher HIV prevalence rate of between 0.5% and 17.8%. Though China and Romania have low disease burden they still have on-going Global Fund grants. This may be explained by other factors such as population size, disparities

[10] UNDP was the PR in Argentina for 1 HIV grant amounting to US $ 24 million and Equatorial Guinea for the only HIV grants the county received.

in income distribution, government unwillingness to provide services to MARPS for legal or cultural reasons. China with a high population may not be fully ready to take up financial responsibility while Romania with a special case of high incidence among orphaned children is not ready to take up the financial and program responsibility. Lower disease burden requires fewer investments and is therefore a trigger for assuming financial responsibility for HIV/AIDS, TB and malaria programmes. An equally important factor to consider across countries are disparities between the poor and rich, urban and rural, ethnicity and gender that tend to mask disease burden concentrated in specific populations within countries generally categorized as low disease burden countries. These disparities need to be identified and strategies to address the affected populations resolved as part of the transition process. Support by the Global Fund and other development partners to CSOs to conduct advocacy within governments for legislation and policies that promote human rights to ensure access to health services by vulnerable, marginalised and MARPS may be necessary.

Table 13: Prevalence of HIV among adults aged 15-49 (%)

Country	2002	2005	2009
Algeria	<0.1	0.1	0.1
Argentina	0.4	0.4	0.5
China	<0.1	<0.1	<0.1
Croatia	0.1	0.1	0.1
Equatorial Guinea	2.3	3.6	5.0
Estonia	0.7	1.1	1.2
Jamaica	1.9	1.8	1.7
Romania	0.1	0.1	0.1
Russian Federation	0.6	0.9	1.0
South Africa	17.7	18.1	17.8
Thailand	1.6	1.5	1.3
Ukraine	1	1.1	1.1

Source: WHO Global Health Observatory http://apps.who.int/gho/data

Tuberculosis disease burden

TB prevalence rate among the countries was mixed. South Africa had the highest prevalence rate of over 700/100000 since 2005. Jamaica had the lowest prevalence rate of less than 10/100000. All other countries had prevalence rates of less than 200/100000. Argentina, Croatia, Estonia and Jamaica with the lowest disease burden did not have HIV grants suggesting that they have taken financial responsibility for the TB programme.

Table 14: Prevalence rate of TB/100,000 population

Country	2002	2005	2009
Algeria	130	142	134
Argentina	50	45	41
China	159	140	112
Croatia	47	35	28
Equatorial Guinea	118	137	122
Estonia	65	50	37
Jamaica	8	9	8

Table 14: Prevalence rate of TB/100,000 population			
Romania	250	237	172
Russian Federation	152	144	136
South Africa	692	788	809
Thailand	195	193	188
Ukraine	117	124	133
Source: WHO Global Health Observatory http://apps.who.int/gho/data			

2.7 Health system analysis

The review team conducted an assessment of the health system to determine the extent to which existing systems have enhanced/inhibited delivery of health services with a focus on delivery of HIV, TB and Malaria services. The assessment focused on the six health system building blocks namely governance and leadership, health financing, health service delivery, human resources for health, pharmaceutical management and health information systems in the selected countries. The findings are discussed in this section.

i) Governance and leadership

The governance structures and systems, policy formulation and planning processes, the extent to which civil society organizations and health service beneficiaries were involved in health policy development, implementation and accountability mechanisms were reviewed for selected countries.

The civil society voice: Strong CSOs influence policy decisions that improve sustainability of Global Fund investment in transitioning countries. In Estonia and Ukraine advocacy and activism influenced the decision of the government to take up financial responsibility for ARV treatment for all patients. In Thailand strong civil society advocacy for *MARPs human rights* is gradually influencing government policy. As a result of this advocacy, methadone, a drug used by IDUs has been included in the country's list of essential drugs. Owing to persistent advocacy from IDUs network in Thailand, interventions for MARPs were included in Round 8 application to the Global Fund. This is a signal that the role played by CSOs is essential and the Global Fund model of a multi-sectoral approach is important to sustainable transitions.

The majority of countries selected for the review have established HIV, TB and Malaria programmes within the Ministries of Health that are responsible for service delivery. The national programmes have developed strategic plans that guide programmes aimed at improving service delivery. The National disease programmes and national diseases strategic plans are components of good governance and require support for sustained delivery of services.

Progressive legislation and policies: Policies that respond to HIV/AIDS needs have improved provision and access services. The "four free and one care" policy in China provides for free ART, free education for AIDS orphans, free VCT free PMTC, and care and support. The Government of Croatia funds stigma and discrimination interventions. The National Health Security Office (NHSO) in Thailand approved methadone as a health benefit under the insurance scheme programme thus improving access and quality of services to the IDUs population in Thailand. In Estonia, free ART to HIV positive pregnant women, distribution of free condoms in prisons, local government support to CSOs and NGOs contributed to the smooth transition from Global Fund in that country.

Weak systems: Weak national HIV/AIDS programmes at national and provincial levels in the areas of *financial management, M&E, epidemiological surveillance* are affecting service delivery in China and Equatorial Guinea). Lack of a regulatory and coordination framework of health service providers has a negative impact in service delivery in China. In Thailand *conflict between public security agencies and public health agencies* led to underutilization of health service delivery as MARPs avoided operating openly for fear of being arrested.

The *decentralization* of health services in Thailand has affected the level of funding for interventions targeting MARPs as well as funding supporting CSOs involved in providing health services in HIV prevention. This is mainly because provincial government prioritize clinical service for other diseases and lack of strategic information required to help them plan.

ii) Health Financing

The level of resource allocated to the health sector is addressed in section 2.3. This section provides findings on the soundness of the processes used to allocate resources to the sector needs and priorities with a view to ensuring allocative efficiency.

A number of the selected countries showed high commitment towards increasing investments to the health sector as discussed in section 2.3. There is commitment to continued investment on health services to achieve universal access and full provision of ART from the national health budget, large investments in HIV/AIDS both by the central and local government, direct local government financial support to HIV/AIDS related programmes implemented by NGOs all playing a big role in the successful transitions witnessed in Croatia and Estonia.

However, there are challenges in *rationalising budget allocations* to ensure resources flow to interventions with the most impact. In South Africa informants were concerned that the government had reduced funding to HIV prevention interventions for the period 2012/2013 to 2015/2016 when increased investment was needed. Lack of data on the costs of delivery of prevention services is a major handicap in determining cost effective strategies for prevention thus limiting decision making in resource allocation to high impact intervention[11]. The National AIDS Spending Assessment (NASA) reports for South Africa and Jamaica did not provide expenditure figures on certain services because of lack of disaggregated. These shortcomings point to a need for improved allocative efficiency, budgeting, expenditure accounting and reporting; to be facilitated by better information management.

Over reliance on external funding of the national HIV response has hindered Jamaica from taking up responsibilities for Global Fund supported activities and products. Jamaica's ability to finance health programmes is severely limited by its high burden of external debt with debt service payments that take up a large share of the national budget. Similarly, Ukraine and Equatorial Guinea showed high dependence on Global Fund support, making transition more difficult. Equatorial Guinea, as a high income country, should have adequate resources, while Ukraine, still a LMIC, most likely does not.

iii) Human resources

Health professionals and other healthcare service providers is a crucial component of the health delivery system especially sustainability which is the subject of this review. The decision to take up financial responsibility for services and activities supported by the Global Fund will need to address not only the availability of healthcare workers in terms of numbers, distribution and quality but also how to absorb those paid by the Global Fund grants.

At national level, countries studied exhibited different human resource challenges. Russia's and Ukraine's struggles to *transform a model of care* that is inpatient oriented, over staffed with professional personnel, yet providing a poor standard of care is a familiar challenge to former Soviet. Shortages of health professionals are the opposite problem in the majority of developing countries,

The human resource issues noted at national level are mirrored at the national programme level; Ukraine was overburdened by over-establishment while Jamaica lacked some appropriate staff in certain cadres. Low remuneration was an issue that affects retention of staff in the public sector. In Jamaica the Global Fund had to fund employment of staff to support the Global Fund programme

[11] The long-run costs and sustainability financing report, South Africa, 2012

services. The challenge being addressed, as part of the transition, is how the government can absorb these staff within its budget at the end of the Global Fund support.

Good public and community health systems are enablers of taking up financial responsibilities of Global Fund supported activities and health products. This factor manifests itself in several ways in the countries studied. For health manpower, physicians per 1,000 populations were above the average of 1.98 in Romania (2.3), Croatia (2.6), Argentina (3.16), Ukraine (3.3), Estonia (3.3) and Russia (4.31). The highest density of nurses and midwives per 1,000 showed the same pattern, except for Argentina with a very low ratio.

iv) Pharmaceutical management

Assessment of the pharmaceutical and supply chain was done to determine its effectiveness to procure pharmaceuticals and health products at competitive prices and ensure there was no stock-out. Areas of focus included the review of the national procurement structures and policies, selection of drugs processes, tendering processes, forecasting, quantification and inventory management.

Well established procurement and supply chain management systems within the government agencies that respond to effective selection of products, forecasting, quantification, tendering, quality assurance, and inventory management to support HIV prevention and treatment services was noted in China and Jamaica. ART regimens that follow WHO guidelines, selection of drugs from the WHO prequalification list, and drug price negotiated with Clinton foundation has improved access to ARVs in Jamaica. High costs of ARVs, ARV supply interruptions, poorly equipped referral centres; lack of PSM system has affected service delivery in Algeria and Argentina...

Overall procurement and supply management is often a serious problem, including purchasing that results in high cost and low quality products, poor storage and distribution that result in stock-outs and losses through theft or expiration, as well as lack of trained manpower in critical functions.

v) Health information system

The review covered the capacity of the HMIS to collect quality data, analyse the data, produce reports and utilize the information for decision making.

A strong M&E system that supports routine data collection, analysis and reporting on HIV service delivery activities and aligned to the national M&E system, together with an effective epidemiological surveillance survey have facilitated the National STI/HIV/AIDS programme in Jamaica to develop evidence based prevention interventions.

Under-reporting by provinces and prisons institutions (Argentina, Equatorial Guinea), lack of quality control mechanism to ensure national and provincial information is accurate (Algeria, Argentina, Equatorial Guinea), inappropriate data collection tools (Algeria), lack of integrated databases (Algeria), lack of trained personnel (Equatorial Guinea) and inadequate sentinel surveillance sites (Algeria, China, Equatorial Guinea) have constrained service delivery.

vi) Health service delivery

HIV/AIDS: Prevalence of HIV in the 12 countries between 2002 and 2009 varied considerably. South Africa remained by far the highest at 17.8% (17.7% in 2002), Equatorial Guinea at 5.0% (2.3% in 2002), Jamaica 1.7% (1.9% in 2002), Thailand 1.3% (1.6% in 2002), Estonia 1.2 and (0.7% in 2002), Russia at 1.0% (0.6% in 2002) and Argentina at 0.5% (0.4% in 2002). Prevalence in the other five countries remains at less than 0.1. In terms of numbers of HIV cases, South Africa has the largest number with 5,600,000 followed by Russia with 980,000 (590,000 in 2002), China (740,000), Thailand 530,000 (610,000 in 2002), Ukraine 350,000 (310,000 in 2002) and Argentina 110,000 (84,000 in 2002). While prevalence has dropped in South Africa (-0.1), Jamaica (-0.2), Thailand (-0.3), the total number of cases has increased in all countries except for Thailand where it has decreased by 80,000.

ART coverage in six of the selected countries; Argentina, Jamaica, Kenya, Romania, South Africa and Thailand ranged between 60-79% while Algeria, Russia and Ukraine had the lowest coverage ranging between 20-39% in 201112 . Late diagnosis, cost of therapy and availability of drugs are some of the challenges that need to be addressed to improve ART coverage and make services available to those in need. People living with HIV need to be diagnosed early in the course of infection through testing services that are simple and easy to access and those who test positive must be linked to care services. Drug supply systems must become more reliable, programmes must leverage opportunities to link treatment to other programmes such as counselling and testing and communities need to be better engaged in supporting treatment initiatives. Reducing cost of ART treatment especially of second and third-line regimen will be essential.

PMTCT coverage reached 57% in 2011 according to UNAIDS report of 2011. Caribbean countries had highest coverage among the middle income countries with PMTCT coverage of 67%-97%. Sub-Sahara Africa coverage ranged between 53-63% while North Africa lags far behind with 6-9% coverage.

Tuberculosis: Overall average TB incidence in the 12 countries decreased by an average of between 10%-40% over the period except in Algeria, Equatorial Guinea, Jamaica, South Africa and Ukraine. South Africa had the highest incidence with 971 reported incidence cases in 2009, an increase of 24% from 2002. The next highest, Thailand at 137, showed no change, while China, Romania, Argentina, Estonia, and Croatia showed decreases of at least 20%, and Russia a decrease of 5%. Average TB prevalence decreased by 11% over the period, although South Africa increased by 17% from 692 to 809. Thailand at 188 decreased 4% by .

The treatment success rate (% of registered cases) varied around an average of 72.1%. The highest rates were China (96%), Algeria (89%), Thailand (85%) and Romania (84%), while the lowest were Argentina (48%), Russian Federation (52%) and Ukraine (60%). Jamaica's figures varied from 41% to 70% over the period, making the data seem unreliable. Equatorial Guinea made the largest improvement (+19 percentage points), followed by South Africa and Thailand (+11) and Romania (+10). Russia (-14 percentage points) and Argentina (11 percentage points) showed the largest declines in treatment success. Treatment success for TB requires not only rigorous application of the DOTS methodology for at least 6 months, but also good diagnostic services and a regular supply of the appropriate medicines.

Malaria: The reported cases of malaria were greatest in Equatorial Guinea (33,830), Thailand (24,892), Algeria (12,165) and South Africa (9,866). The incidence rate (notified cases per 100,000 population) varied dramatically from 27,726 for Equatorial Guinea to Thailand (322) and South Africa (80). Data for Algeria was not complete. Successful management of malaria requires a large supply of IT bed nets, targeted residual spraying and availability and use of appropriate medications.

[12] UNAIDS Global Fund Report 2012

3. Sustainability planning

3.1 Sustainability approaches by other development partners

The guidelines and strategies used by five key development partners were reviewed to identify lessons on financial sustainability of programmes especially in the health sector. These devleopment partners included United States Government Presidential Emergency Plan for AIDS Relief (PEPFAR), Global Alliance for Vaccine and Immunisation (GAVI), World Bank and Department for International Development. This section outlines the guidelines and lessons learnt.

i) Presidential Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR is a United States of America (US) Government initiative launched in 2003 as an emergency response to the HIV and AIDS epidemic to provide support in 23 most affected countries. In its first phase 2003-2008, the initiative provided support to 2 million people, care to 10 million people and Prevention of Mother to Child Transmission of HIV during 16 million pregnancies. The US Government reauthorized funding of PEPFAR in 2008 with a broadened mandate to promote a sustainable approach, characterized by strengthened country capacity, ownership, and leadership. This approach represents a shift from emergency to sustainability of PEPFAR funded initiatives[13].

The implication of the new mandate is that sustainability becomes a central focus of the PEPFAR support to countries. PEPFAR defines sustainability as "supporting the partner government in growing its capacity to lead, manage and ultimately finance its health system with indigenous resources (including civil society), rather than external resources, to the greatest extent possible"[14]. This means that PEPFAR supported programmes are expected to take steps to progressively shift from directly implementing programmes and services to providing technical assistance and support to build government and local capacity to plan, oversee and manage programmes, deliver quality services and ultimately take financial responsibility.

PEPFAR recognises that every country is at a different stage on the sustainability continuum and therefore adopts a country specific approach to sustainability. However, there are also core principle guidelines for developing the sustainability plan for PEPFAR which include Crafting partnership frameworks in a way that ensures national responses to HIV and AIDS are moving toward sustainability while sustaining or improving quality; supporting country government to develop capacity to support all relevant components of a multi-sectoral health system; and continued support to partner countries to effectively coordinate multiple sources of financial and technical assistance.

Two partnership frameworks that have integrated sustainability were reviewed to assess the application of this mandate at country level. These are the partnership frameworks for South Africa and Caribbean region.

In South Africa, the partnership framework addresses sustainability by mainstreaming the response to HIV and TB in the health systems, addressing cost efficiency of operations, diversifying funding sources, investing in proven and scalable interventions, and improving coordination across all partners. The partnership framework has adopted three strategies to promote sustainability:

- Strengthening prevention of new HIV and TB infections: Given South Africa's epidemiology of the HIV epidemic as well as its resource constraint, it cannot afford to only focus on HIV and TB treatment. Sustainability is reliant on reduction of new HIV and TB infections. The PEPFAR partnership framework lays emphasis on prevention as a long term strategy of achieving a sustainable national response.

[13] Guidelines for developing PEPFAR frameworks with emphasis on sustainability, 2011

[14] Guidelines for developing PEPFAR framework with emphasis on sustainability, 2011

- Financial sustainability: PEPFAR is supporting the Government of South Africa to improve cost efficiency in all HIV and TB interventions. SAG and USG initiatives are underway to effectively cost programme operations and identify where savings can be achieved. Central among these are commodity procurement and human resource management. In addition the partnership framework is supporting the SAG to build capacity to budget, allocate and manage financial resources efficiently.
- Community systems strengthening: The partnership framework is facilitating strengthening of community systems – social and professional networks, governance structures and leadership – and working to build linkages between communities, civil society and public sector to ensure a single comprehensive and coordinated national response. Effective community health systems are essential for scaling up prevention services.

The Partnership Framework (PF) for South Africa has prioritised the transition of PEPFAR care and treatment programme to the SAG. The PF is focusing on shifting the focus of PEPFAR support from providing clinical services to strengthening service delivery platforms. PEPFAR investment is investing in the health system strengthening that drives efficient delivery of HIV treatment services. The PF also take into account the need to ensure the quality and continuum of care is not compromised during the transition, transition of patients from the non public to public health facilities is carefully coordinated and there is timely and transparent sharing of information between PEPFAR and SAG for a smooth transition. The PF has established a Technical Task Team to oversee the implementation of the transition of treatment and care services to the SAG.

Lastly funding of the sustainability strategies is integrated within overall programme funding. The capacity development, systems strengthening, human resources and equipment required for government to take over PEPFAR supported treatment services are financed under the framework.

In the Caribbean Region, The PEPFAR HIV and AIDS Partnership Framework is a collaborative effort of the USG, the Caribbean Community, The Organisation of Eastern Caribbean States and the Governments of Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname and Trinidad and Tobago. The sustainability component of the PF aims at improving the capacity of Caribbean national governments and regional organisations to effectively lead, finance, manage and sustain the delivery of quality HIV prevention, care, treatment and support services at regional, national and community levels over the long term[15].

Sustainability is one of the goals agreed on between the Caribbean national governments and the USG. This selection of sustainability as a priority was as a result of specific recommendation by Caribbean partners during the framework development. The partners define sustainability as the ability of national governments and regional partners to increasingly assume full strategic and financial responsibility for their HIV and AIDS response over the long term. The sustainability strategies adopted by the national governments in the Caribbean region are to:

- Coordinate with national governments to develop more robust financial management through strengthened financial planning; improved coordination, effective deployment and expenditure of existing resources; and mobilization of an array of diversified domestic and international resources
- Increase the capacity of national agencies and non-governmental and civil society organizations to fully deploy their respective strengths to improve the efficiency and cost-effectiveness of their respective contributions to the national HIV and AIDS response

[15] Caribbean Regional HIV and AIDS Partnership Framework 2010-2014

- Promote creative, multi-sectoral arrangements among the public, private and non-governmental sectors to increase the effectiveness of resource utilization and the efficiency of HIV-related service delivery
- Collaborate with partner national governments to design specific strategies for sustainable HIV and AIDS programs and support governments to assume full responsibility and leadership for their on-going national HIV and AIDS response
- Build capacity in national agencies, non-governmental and civil society organizations as well as regional partners to assume leadership roles in the national and regional responses to HIV and AIDS

The overall guidelines and the South Africa and Caribbean PFs reviewed show that PEPFAR has fully integrated the planning, financing, management, implementation and monitoring of sustainability strategies within its overall partnership negotiations and the programmes supported. There are clear guidelines and processes for sustainability planning.

The partnership frameworks are in the second year of implementation. In South Africa, PEPFAR and The Government are in preparatory stage and are currently developing transitional plans at provincial and health facility levels.

ii) Global Alliance for Vaccine and Immunisation (GAVI)

GAVI was founded in 2000 by a group of international organizations (World Bank, WHO and UNICEF among others) to provide access to new and underutilized vaccines to the world's 75 poorest countries. GAVI assistance to countries includes supply of new vaccines, commodity assistance for safe injection technologies, or grants to strengthen immunization service delivery.

GAVI defines financial sustainability as follows: "Although self-sufficiency is the ultimate goal, in the nearer term sustainable financing is the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity"[16]. By adopting this definition, GAVI moves away from equating financial sustainability with self-sufficiency in vaccine procurement and towards the idea that financial sustainability is a shared concern and a shared responsibility of both government and their development partners, it requires matching financing of evolving programme objectives, it includes concepts for adequate and reliable financial resources, focusing not only on quantity of funds but on how well funds reach the levels where they are needed and it is related to both mobilisation and efficient use of financial resources.

GAVI introduced the development of Financial Sustainability Plans (FSP) in 2004 in order to address financial sustainability in a systematic way. All countries receiving GAVI grants were required to prepare a detailed Financial Sustainability Plan (FSP) mid-way (2 ½ years) through the funding period detailing how they will manage the transition and finance the immunization services after the end of the initial commitments from GAVI Fund.

The FSP are designed to improve reliability and sufficiency in long term financing by serving as a source of information that can be used for health sector planning, generating a clear picture of the financial situation and challenges in funding immunization programmes, development of relevant, realistic and specific strategies and actions that lead to financial sustainability, identifying processes and outcome indicators to measure progress towards objectives and serving as an advocacy tool guiding discussion among the Ministry of Health, Ministry of Finance, NGOs, Private Sector and Development Partners about how well the current and future financial arrangements can meet the programme objectives.

[16] Guidelines for preparing a national immunization programme financial sustainability plan, 2004

GAVI has developed comprehensive guidelines for the development of the FSP. First set of guidelines were developed in 2004 focusing on developing FSPs as stand alone documents submitted to GAVIs separate from the immunization multiyear plan. However, financial sustainability is viewed as part and parcel of setting priorities, mobilising resources and using resources effectively throughout the health sector. Due to this view, the FSP has been integrated into the mutli-year plan for immunization, therefore, fully integrating financial sustainability within programme planning.

The use of the financial sustainability guidelines and tools has assisted countries to understand the cost of delivering immunization programmes, to project forward both future costs and prospects of financing and to define and initiate implementation of strategies for resource mobilisation, reduce unnecessary costs and make the flow of future funding more reliable.

The guidelines define the content, process and monitoring of the FSP. Content of the GAVI FSP includes statement of programme objectives, assessment or diagnosis of the immunization programme financing challenges, programme costs and source of funding, projected gap in resources during and after GAVI support, strategies for financing sustainability, based on a diagnosis of financing challenges, short and medium term actions for financial sustainability and indicators for monitoring progress towards the objectives for financial sustainability[17].

The process for development of the plan involves all national programme managers, other relevant ministries, especially the ministry of finance, private sector and non-government organisations. The development of the FSP is data-intensive exercise requiring major commitment of time and effort. However, programme managers in countries supported by GAVI reported that the effort was more than equalled by the benefits. Most indicated that they had not previously had an understanding of their own programme costs and financing structures or fully comprehended challenges of introducing new vaccines supported by GAVI Fund[18].

The development partners PEPFAR/USG and GAVI demonstrate that sustainability planning is critical for thinking about service delivery in a cost efficient and cost effective manner and in the long term. Sustainability is a concept inextricably intertwined with programme development and ensures programmes objectives and strategies are effective and can be sustained in the long run. The focus on financial sustainability is, thus, a window through which sustainability of overall health service delivery can be planned given that financial resources are an input in ensuring service delivery is maintained.

An evaluation of the implementation of GAVI sustainability plans covering 50 countries found out that[19]:

- The development of sustainability plans provided countries an opportunity to assess the cost of immunisation and identify funding gaps. This had been a weakness prior to development of these plans.
- The sustainability plans were used as advocacy tools to mobilise funding from government. They formed a basis for policy level discussion by the Ministries of Health and Finance. Most of the countries integrated the sustainability plans into broader planning and budgeting for the health sector.
- Most of the countries (82%) identified strategies to address volatility of funding immunisation programmes- which included improving budgeting and financial management, obtaining long term commitments from donors and improving funds disbursement to decentralised structures.

[17] Guidelines for preparing national immunization programme financial sustainability plan, 2004.
[18] Financial Sustainability: The Gavi Experience, Kaddar, M and Levine, R.
[19] Strategies for financial sustainability of immunisation programme: a review of the strategies from 50 national immunisation programme financial sustainability plans, Kamara et al. 2008.

- In terms of increase of domestic funding, only one country successfully transitioned out of GAVI while 7 countries[20] increased funding using HIPC but not to the required levels. However, government funding of immunisation programmes has not increased significantly to levels expected.
- Countries have mainly adopted a combination of three strategies – mobilisation of additional resources (which have been mainly from HIPC initiative), improving programme efficiency and improving reliability of funding. The last strategy was found to have been the least implemented.

Overall, GAVI has been instrumental in introducing sustainability planning into the heath sector. However, economies of countries are not growing at a rate that can adequately finance basic services and funding to immunisation is consequently constrained. Those that had increased domestic funding to immunisation have been largely due to HIPC initiative.

iii) World Bank

The World Bank and the country work use Country Operational Plans (COPs) to guide the loans and grants for overall budget support and for specific infrastructure or human development projects. The terms of the loans and grants are negotiated based upon the country's economic and fiscal situation. The WB provides the funding on schedules using the overall performance framework of the plan. The country implements the projects following detailed WB policies and requirements. Sustainability planning is included in the framework when appropriate. The COPs provide detailed information on all aspects of countries' economic and social structure and performance measurements in most sectors. Review of documents and interviews with WB staff however did not provide adequate information on the sustainability planning and execution.

iv) USAID

Bilateral and centrally funded projects are generally 5 years with a possibility for 2 additional funding years. It is clear from the start that the technical assistance, commodities and other support to the country or countries will be terminated at the end of the specified period of time. There may or may not be follow up projects. The completion date of the project is known from the very start. Preparing and implementing a sustainability plan is an integral part of any successful project.

v) DFID

DFID provides general and project-specific financial support to its priority countries using 5-year country strategies that include a performance framework. The funding period is anticipated from the onset of the plan. DFID also pools funding with that from other donors in specific situations. DFID works in 27 focus countries in sub-Saharan Africa, south, central and Southeast Asia, Middle East and the Caribbean basin

3.2 Sustainability planning by selected countries

Six countries covered by this review -Algeria, Croatia, Equatorial Guinea, Estonia, Romania, and The Russian Federation- have transitioned from the Global Fund by virtue of not having any active grant. Of these countries, only Estonia developed a sustainability plan that was implemented and followed through. Estonia sustained gains of Global Fund investment through the Government taking up financial responsibility for the services that had been supported by the Global Fund grant. Although the other countries did not develop sustainability plans, they took steps to sustain some of the HIV services funded by Global Fund as shown in Table 15.

The Global Economic crisis triggered low income countries to start developing sustainable financing strategies for HIV, Malaria and TB programmes among other health priorities[21]. Some of these

[20] Tanzania, Rwanda, Ghana, Cameroon, Mali, Malawi and Zambia

[21] The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact, UNAIDS, 2009

countries include Jamaica, Kenya and South Africa. Lastly, countries also have experience in developing sustainability plans under the Family Planning, GAVI and PEPFAR programmes. These plans aim at ensuring sustainability of health outcomes are achieved through increase in domestic financing and capacity development.

Development of sustainability plans is, therefore, not a new phenomenon; countries have varied experience in developing and implementing sustainability plans. This review explored the processes involved in development, implementation and monitoring sustainability plans and transitions from Global Fund among the review countries.

Table 15: Financial responsibilities taken up by selected countries

Country	**Services and activities prioritised for domestic funding**	**Services which financial responsibility is not taken up by countries**
Algeria	• HIV treatment • HIV prevention activities targeting youth and general population	
Argentina	• Procurement of antiretroviral drugs	
China	• Increased budgetary allocation for HIV treatment • Increased budgetary allocation for treatment of malaria • Increased budgetary allocation for TB treatment	• HIV prevention services targeting MARPs
Croatia	• HIV treatment • HIV prevention activities targeting youth and general population	
Estonia	• HIV treatment, care and support • HIV prevention activities targeting youth and general population	
Equatorial Guinea	• HIV treatment, care and support • HIV prevention activities targeting youth and general population	
Jamaica	• Procurement of antiretroviral • Private sector funding of prevention activities targeting the youth	• HIV prevention services targeting MARPs • Funding of CSOs operations
Romania	• HIV treatment, care and support • HIV prevention activities targeting youth and general population	
Russian Federation	• Procurement of antiretroviral drugs	• HIV prevention services targeting MARPs • Funding of CSOs operations
South Africa	• Increased funding for procurement of antiretroviral drugs	• HIV prevention services • Funding of CSOs operations
Thailand	• Increased funding for procurement of antiretroviral drugs	• HIV prevention services targeting MARPs
Ukraine	• Government taken up HIV treatment, care and support	

3.3 Findings on planning, implementation and monitoring of sustainability of programmes

(i) Development of programme sustainability plans

Definition of sustainability plan

The starting point for sustainability planning is developing a common definition and understanding by the Global Fund and countries which is not in place. Left without clear definition countries are likely to have diverse interpretation of what sustainability entails resulting in varying scope, content and expectations. This issue came up during discussions and the Global Fund will have to work with countries to define and clarify the scope of the sustainability plans countries will be required. Arising from the consultation with the stakeholders the report proposes a definition in section 4.2(i) that should be a starting point for discussions and refinement.

Knowledge of ineligibility and need to develop a sustainability plan

The development of sustainability plans, in the context of Global Fund, starts with a country being aware of its funding eligibility status as well as the need or requirement for developing a sustainability plan. Countries learn about their ineligibility through the Global Fund's eligibility list for funding published at the time of the call for proposals and/or letters issued to the country by the Global Fund Secretariat. However, the practice has so far been that middle and high income countries learn about their ineligibility for Global Fund financing too late, by which time the active Global Fund grants are in the final phase. On the other hand, PEPFAR and GAVI have a clear process integrating sustainability planning into programme planning which is communicated to countries at the start of the planning process.

Commitment from key stakeholders

Currently the Global Fund agreements are signed between the Global Fund Secretariat and the PRs. The Ministry of Finance and the Sub-recipients are not signatories. Introduction of sustainability plan will require commitment from these stakeholders to implementing the sustainability efforts. GAVI and PEPFAR require key stakeholders to sign the grant agreements/partnership agreements. Specifically, GAVI requires the Ministry of Finance to sign; agreements and sustainability plans. Key stakeholders at the Global Fund recommended that Ministry of Finance be signatories to the sustainability plans. There should be no problem in achieving this requirement. In most countries the Ministry of Finance is usually a signatory to all external grants and loans.

Integration of sustainability plans in proposal development and grant agreements

At the time of proposal development countries are required to include a sustainability plan in the programme proposal. The review revealed that during proposal development countries do submit sustainability strategies they intend to put in place to ensure that interventions supported by the Global Fund will be sustained beyond the grant period. What has not been done is to embed the sustainability plans in grant agreements so that they are implemented and followed through.

Monitoring of the counterpart funding policy of the Global Fund

The counterpart funding policy of the Global Fund sets out the proportion of country contribution to the programme budget as a condition of Global Fund grant support. Low Income Countries (LICs) are expected to contribute 5%, Lower Low Middle Income Countries (Lower LMICs) 20%, Upper Low Middle Income Countries (Upper LMICs) 40% and Upper Middle Income Countries (UMICs) 60%. The policy encourages UMCIs to increase contributions to 90% during the implementation period to facilitate smooth graduation from the Global Fund. The purpose of these contribution thresholds is, partly, to prepare countries to develop sustainability strategies for their programmes over time and to ensure readiness for transition by the time the countries attain high income status. The counterpart funding policy can be a strong basis for countries to develop and implement sustainability strategies. So far, an effective mechanism for verifying and monitoring counterpart contribution by the Global

Fund is lacking. Monitoring of the implementation policy is currently difficult because there are no time bound targets to be achieved over the implementation period. The report recommendation time-bound targets for purpose of monitoring UMICs implementation of the thresholds in section 4.2(i) in line with the practice by GAVI. Another challenge to implementing and monitoring of counterpart funding is governments' constrained resources. Governments are unable to increase resources beyond the staff and facilities provided.

Development of sustainability plans is an intense process that requires clear policy direction and commitment by countries

A review of the development of sustainability plans by Estonia and Jamaica under the Global Fund, PEPFAR and GAVI programmes found out the following:

(a) Development of sustainability plans is propelled by agreement and consensus at policy levels. Countries that have developed sustainability plans under the Global Fund, GAVI and PEPFAR started with a policy decision to develop such plans. This is important because most of the strategies for sustainability of programmes require clear policy guidelines.

(b) Guidelines for development of a sustainability plan: This review found out that specific guidelines on the content and process for developing a sustainability plan are necessary to guide countries. Global Fund has so far not developed such guidelines. Estonia and Jamaica developed sustainability plans for the Global Fund programmes without such guidelines and therefore the two plans differ in content and process. However, PEPFAR and GAVI have detailed guidelines that guide the development of sustainability plans shown in Table 16 below.

Table 16: Guidelines for development of sustainability plans

GAVI	PEPFAR
Definition: Emphasis on the ability of a country to mobilize and efficiently use domestic and external resources to achieve current and future targets rather. Seeking self-sufficiency is not the emphasis in the short run. *Approach*: Financial sustainability plan developed mid-way through to show how a country will manage the transition and finance immunization services after the end of GAVI support. Guidelines developed to guide the countries. *Content of the FSP:* Statement of programme objectives; assessment of the immunization programme financing challenges; programme costs and sources of funds; projected gap in the response during and after government support; strategies for financial sustainability; indicators for monitoring performance towards objectives. *Process:* involves all program managers, relevant ministries, Ministry of Finance, private sector and NGOs. *Role of GAVI*: Participates in the process, conducts advocacy with MoF, reviews and approves the FSP	*Definition:* Emphasis on supporting partner government to build capacity to lead, manage and finance their health systems with domestic resources rather than external resources. Full financing is not an emphasis in the short run. *Approach:* The Partnership Framework(PF) and the Partnership Implementation Plan (PFIP) is developed to show how the country will work towards sustainable national responses including transition plan and the resources requirements. *Content of the PF and PFIP*: Principles guiding collaboration with the country; components of the partnership ; sustainability strategies; components of the sustainability plan, development of transition plan, players and their roles. *Process*: In-country partners drawn from government, private sector, NGOs. PF is developed followed by PFIP and transition plans. The documents are signed by representatives of all implementers. Role of PEPFAR: Supports the process, implementation and monitoring

(c) In-depth analysis of programmatic aspects that should be sustained: The planning processes commences with an analysis of specific aspects of institutional, capacity development and

services that should be sustained. For instance, the PEPFAR sustainability plan for South Africa identifies human resources for health paid by the programme, staff training, CSOs interventions targeting populations as components that should be sustained. Jamaica developed a plan to sustain ART services, HIV services targeting the youth and populations.

(d) Process for development of sustainability plans varies from country to country: the process for developing sustainability plans depends on the country context. Some countries have a strong civil society and networks of people affected by the diseases as well as private sector and these players demand to be involved in the process such as in South Africa and Kenya while others have relatively young or weak civil society and weak networks as is the case in most of eastern European countries. Whatever the context of a country, the review found out that principles that should be adhered to in developing sustainability plans are:

Involvement of all stakeholders: Involve stakeholders especially those implementing the programme to identify the sustainability requirements, appropriate sustainability strategies and ensure sustainability of their interventions are addressed. This has been the case in Jamaica where stakeholders drawn from the public sector, CSOs, the private sector and development partners are involved in the development of a financing plan for the HIV programme. Stakeholders involved include; The Ministry of Finance, Ministry of Health, the World Bank, PEPFAR and UNAIDS. In South Africa, the Ministry of Finance and the provincial governments are engaged in developing sustainability plan for the national HIV and TB responses. In Kenya NACC has established a national sustainability technical working group drawing members across the stakeholders to steer the process to develop a sustainability plan. Conversely, in Russia, where CSOs and networks of affected persons were not involved making the decision to transition from Global Fund, services provided to Injecting Drug Users and Men Having Sex with Men by CSOs lacked funding after Global Fund support ended.

Involvement of Global Fund: The Global Fund has not played a visible role in supporting countries transitioning from Global Fund support. Consequently most countries that have transitioned or reduced Global Fund financing did not develop a sustainability/transition plan; except in Eastern Europe and LACs where a few countries took the initiative. Policy and technical level engagement between the Global Fund and these countries on sustainable transitions was however limited. During interviews with informants, it was observed that the role of Global Fund should be visible at all stages of the transition process.

Harmonisation and coordination with other development partners: when developing sustainability, other development partners should be involved to ensure coordination with other programmes. However, in both Jamaica and South Africa there was no evidence that the development partners harmonized and coordinated their transitions with a view to ensure the national responses were not affected. Informants observed that this scenario existed in several countries especially in LACs where the Global Fund, World Bank and USAID have in recent years transitioned at the same time.

Involvement of ministries of finance in critical stages of the process: Ministry of finance play a role in macro-economic management and in resource allocation. These ministries should be involved to advise on the realism of the financial responsibility required to implement the sustainability plan. The ministry of finance is involved in this process in Kenya and Jamaica.

(e) Content of the plan: the content of sustainability plans differ from one programme to another and even from country to country. However, common content for sustainability plans – based on the review of the plan for Estonia, the sustainability framework for Jamaica and the PEPFAR and GAVI plans – include an analysis of programmes to identify components that should be sustained, implementation structures, implementation strategies, work plans and cost of the plan.

(f) Timeframe for sustainability plans: In Estonia planning for transition started in 2005, 2 year ahead of the end of the grant, with the integration of the Global Fund supported services into the

national HIV and AIDS strategic plan for 2006-2015. Global Fund supported activities were included in the Government budget for 2007 and the transition plan was developed in 2007 when the Global Fund grant was ending. In Jamaica, key informants proposed that transition planning should start during the design of the program to ensure sustainability strategies are embedded in the grant agreement. GAVI and PEPFAR sustainability plans are developed at the start of the program and implemented over a five year period. Key informants at the Global Fund recommended 3 year period for sustainability planning and implementation, perhaps to coincide with phase 2 of grant implementation. Overall, the timeframe for sustainability plans depends on the complexity of interventions targeted for sustainability.

(ii) Implementation of sustainability plans

Approaches for implementation of sustainability plans adopted by countries are a function of the type of services and interventions that are to be sustained, availability of funding, commitment of policy makers and effectiveness of programme governance and management. Several cases studied provide evidence for the influence of these factors in the implementation of sustainability plans.

(a) Countries prioritise services for sustainability based on relevance to prevailing policy, importance of service to saving lives and extent to which the government controls the service delivery system. For instance, 7 of the selected countries (China, Croatia, Estonia, Jamaica, The Russian Confederation, South Africa, Thailand and Ukraine) started transitioning by taking financial responsibility to procure ARVs. Governments have tended to avoid support to CSOs, interventions targeting MARPs and prevention interventions. In China and Russia, the Global Fund continues to support interventions targeting MARPs and to support the CSOs operations despite the country having transitioned from the Global Fund. In Jamaica and South Africa, the governments have committed to taking up financial responsibilities for ART treatment while reducing budgetary allocations to prevention interventions. Owing to resource constraints Global Fund beneficiary countries are not likely to assume financial responsibilities for prevention interventions, interventions targeting MARPs and funding of CSOs providing health services in the 3 diseases. In the foreseeable future development partners including the Global Fund will continue to be relied on by countries to finance these interventions. Table 17 shows services and activities prioritised by the selected countries.

(g) The level of domestic funding available determines the extent of financial responsibility that countries can bear. Various components of a programme are phased into implementation depending on funds available. In this scenario, interventions whose outputs are not tangible and do not contribute to easily quantifiable outcomes have difficulties being prioritised. For instance, provision of treatment and care services, testing persons for HIV, TB and Malaria and provision of ITNs among others is given higher priority than community based activities such as awareness campaigns and interventions targeting populations such as female sex workers, MSM and IDUs. This approach to implementation of sustainability plans has been demonstrated in Russia where MSM and IDUs were not prioritised and in Jamaica where both Government and Private Sector have shown reluctance in funding interventions targeting FSWs and MSM.

(h) Coordination and implementation structures: Structures to implement sustainability plans are also country and programme specific. In Jamaica, the Country Coordinating Mechanism steered the development of the sustainability framework in 2011. Responsibilities for implementation and follow up were allocated to different partners including MoH and private sector. However, there has been little progress towards implementing the plan. The initiative lacked ownership and commitment from some of the partners. The National Health Programme (NHP) is currently spearheading national efforts to develop a sustainability plan for the national HIV response. The process is still at the development stage and institutional arrangements for implementation are yet to be addressed. In South Africa, the Government established Technical Task Teams (TTT) to implement specific components of sustainability. In Kenya the National AIDS Control Council (NACC) is spearheading the development of the sustainability plan supported by other partners.

NACC has established a sustainability technical working group comprising members from partners that is guiding the process. In Estonia the transition plan was spearheaded by the Principal Recipient. A transition plan implementation team was constituted. Implementing partners were assigned specific responsibilities.

(i) Financing: The funding of sustainability plan for PEPFAR and GAVI is integrated in the programme budget. This enables countries to effectively manage and implement the sustainability plan. However, Global Fund does not have a fund to support sustainability of the Global Fund grants.

(iii) Monitoring

This review revealed weaknesses in monitoring the implementation of the strategies the Global Fund has put in place for sustainable transitions. Unlike PEPFAR and GAVI who integrate monitoring of sustainability plans within the monitoring system for their funded programmes, on the part of the GF, there is no mechanism to monitor countries' compliance to the additionality principle and the recently introduced counterpart financing policy; There is no clear monitoring mechanism to ensure that countries continue to increase investment in the 3 diseases in line with the countries programmatic and financial needs.

4. Summary of Findings, Lessons and Recommendations

4.1 Summary of Findings

Key findings of the review are as follows:

(i) Income level as a criterion of transition

This review established that income classification of a country alone is not a sufficient criterion transitioning a country from the Global Fund in a sustainable manner. Some countries that transitioned had challenges sustaining financing of programmes. The review identified demographic (population growth rate), economic (GDP growth, per capita income and income distribution, health financing and disease burden as additional factors that complement the income classification criteria in determining a country's readiness to take up financial responsibility of the HIV/AIDS, TB and Malaria programmes that should be taken into account before a country embarks on a transition.

(ii) Implementation of sustainability plans for HIV, TB and Malaria

Almost all the 12 countries reviewed were found to be focusing on sustainability of the HIV and AIDS programme and to a less extent the TB programme. However, there was limited evidence of discussion on sustainability of the malaria programme, due to the limitation of countries selected for the study- only China, Equatorial Guinea and Thailand had malaria grants. None of these countries were visited. The review did not find a country with a documented comprehensive sustainability plan. However, several countries were found to have in place or to be considering initiatives for financial sustainability of the national HIV programme. These countries include South Africa, Jamaica, Kenya, Botswana, Thailand, Tanzania, Estonia, Russia Federation and Zimbabwe[22]. Initiatives under discussion are establishment of AIDS Trust Fund (Botswana, Kenya, South Africa and Tanzania). The trust fund is operational in Zimbabwe although it has been affected by the downturn of the economy. Tax levies specific for funding the HIV programme are under discussion in Jamaica, South Africa and Kenya and, therefore, not operationalized. Governments in Estonia, Jamaica, Kenya, South Africa, Russia Federation and Thailand have been increasing their budgetary allocation to the national HIV programme. The challenge has been the actual release of the funding allocated. Private sector funding of the HIV programme was found to be taking place only in Jamaica. Use of the national health insurance has been initiated in 9 districts in South Africa. The other initiative is the review of the unit cost of delivering HIV services to improve sustainability in South Africa and Kenya. However, the unit cost analysis has not been completed in Kenya while in South Africa implementation of findings has commenced. Cost efficiency and effectiveness is also a key strategy that is being applied in Jamaica and South Africa while in Kenya, the Government has commissioned the cost effectiveness study. All these initiatives are either in conceptualisation, planning or are in early stages of implementation and, therefore, it is too early to assess whether they are working or not.

(iii) Approaches used by GAVI and PEPFAR

The review found out that PEPFAR sustainability plans are in the early stages of implementation. Countries are developing transition plans for specific services. However, it will take time to assess whether these plans will achieve their objectives. In the case of GAVI, countries have been implementing sustainability plans since 2002. Evaluations carried out indicate that the sustainability plans have enabled countries to rationalise vaccine unit costs and improve cost efficiency and effectiveness in immunization services as well as strengthen programme management. However, increase of government funding to immunisation programmes has not progressed to levels expected. In any case, domestic funds allocated to immunisation in most of the countries were sourced from the HIPC initiative.

[22] Refer to annex 1 of this report

(iv) Preparation of countries to assume financial responsibility for services supported by Global Fund

There were no specific guidelines on how countries should prepare themselves for assuming financial responsibility for services supported by the Global Fund once they become ineligible and what role the Global Fund could play. However, examples were cited on how countries in LAC and Eastern Europe had prepared to assume financial responsibility. According to key informants, countries in LAC had prepared absorption plans for ARVs and staff which were implemented. Belize, Peru and Suriname have no Global Fund dependency for ARV therapy. El Salvador, along with Ecuador, Honduras and Paraguay have only "low dependency". These countries worked with the Global Fund to take over financial responsibility for ART. In Eastern Europe some countries prepared transition plans for taking up financial responsibility for ARV. The transition plans clearly outlined the responsibilities to be played by each partners during the transition. Overall though Global Fund has put in place instruments that facilitate transitioning of countries (counterpart funding policy, transition funding mechanism and continuity of services policy), the framework for preparing countries to transition by utilising these tools has not been developed.

(v) Trigger for transition

Triggers are conditions that put a country in a better position to take up greater responsibility for their HIV/AIDS, TB and malaria programmes. This review identified the following triggers:

- *Population growth rate and GDP growth rate*: If a GDP growth rate of a country can sustain its population growth rate, such a country is able to have resources to provide basic services including health. The existence of the low population growth rate and high GDP growth show that a country is ready to increase domestic financing for most of its services including health. Croatia and Ukraine transitioned from the Global Fund partly because of low population growth rate and high GDP over the period.
- *Per-capita income*: Per capita income is a measure of the standard of living across the population. Given that per capita income is an average of total income of a country over total population, it does not show the distribution of the income among individuals. Thus it masks the income inequalities. Per capita income can demonstrate whether a country is able to finance its basic services including health on the basis of three perspectives: i) higher per capita income presents potential to increase government revenue collections from citizens with high per capita income. A country can therefore increase budgetary allocations to support social services such as health, ii) higher per capita implies that there is high disposable income that individuals can use to meet basic needs including health. This means that the people at a high quartile of income level can meet the health needs "out-of-pocket". iii) Given a high per capita income, governments can direct resources to meet the basic needs of the people in the lower quartile of income: poor, marginalised and key populations. This was evident in most of the countries selected for the study. These countries were providing free or subsidized ART services and malaria treatment in public health facilities. Thus, higher per capita income is a trigger for countries to increase domestic financing of health services by putting in place relevant policies that promote persons in high income quartile to meet their costs for health needs leaving the government to invest in providing such services to the poor. Argentina, Croatia, Equatorial Guinea, Estonia, Romania and Russia Federation are examples of these countries.
- *Disease burden*: Countries with a lower disease burden (HIV, TB and Malaria) have lower demand for services and therefore low financial investment required to meet such demand. A low disease burden is a strong basis for sustainable financing of HIV/AIDS, TB and Malaria services. If this is correlated with high per capita income and high GDP growth rate, the country even has a stronger basis for sustaining its national HIV/AIDS, TB and Malaria programmes. However a challenge to UMIC and HIC governments is how to deal with

concentrated epidemics within specific groups when governments do not reach these groups due to legal, political or cultural considerations. In the case of UMIC The Global Fund's targeted funding pool channel is in place. However, in HICs the Global Fund could support advocacy interventions by CSOs to promote human rights by government policy reforms.

- *Proportion of external financing as a percentage of total funding to HIV/AIDS TB and Malaria programmes:* It is easier for a country with low external funding than one with large external funding to transition. The level of funding is partly related to the disease burden. Hence countries with large grants are likely to have high disease burden and therefore may not be ready to transit from Global Fund. There are also exceptions of countries with low disease burden and small GF grants but have difficulties to transit due to weak health system or a system that does not prioritise or target key populations, Jamaica and Russia being examples.
- *Services being supported by Global Fund:* Cases where Global Fund is supporting commodities/drugs etc becomes difficult for countries to sustain because they require huge financial resources whereas programmes where Global Fund is funding health systems and prevention activities would be easier to sustain given low financial requirements.
- *Proportion of Global Fund support as proportion of external funding*; Where Global Fund funding as % of external funding to HIV/AIDS, TB and Malaria is low, the transition of the country from Global Fund is easier than where this proportion is significant (over 30%). Jamaica, South Africa and Thailand are struggling to transition from the Global Fund owing to relatively high Global Fund support as % of total external funding.

These factors should be viewed in combinations to establish the readiness of a country to transition from Global Fund.

(vi) Enablers of sustained transition from Global Fund

If a country has attained the triggers, enablers are the actions the country should undertake to sustainably transition from Global Fund. 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:

- *Health financing*: Countries that demonstrated high per capita expenditure on health, high health expenditure as % of GNP, and high government expenditure on health as % of total government expenditures found it easier to transition. Countries should make deliberate effort to invest more resources in the health sector to facilitate taking over financial responsibility for their health programme. Huge resources are needed to set up the health systems required to support HIV/AIDS, TB and malaria programme.
- *Health systems*: Countries should invest in health systems in a manner that improves access to services by the key target populations. In the case of HIV/AIDS, TB and Malaria, these are FSWs, MSMs, IDUs, Women, Children under 5, Pregnant women, etc. Therefore, countries should have clear policies and strategies for strengthening both public and community health systems. Governance and leadership in the health sector is also critical and require attention in terms of investments.
- *Political will:* Political will as an enabler ensures that policy makers prioritize investment in health and more specifically in HIV/AIDS, TB and malaria therefore allocate sufficient resources to these programmes. Secondly, the political will should ensure sound policies and legal framework that facilitates HIV/AIDS, TB and Malaria service delivery to the key populations and paying attention to human rights international conventions. The review found this to be a challenge in Romania, Russia Federation and Jamaica whereas countries like South Africa and Thailand have shown political will to provide services to these populations.

The Global Fund may have to consider supporting in-country partners in their effort to advocate for political will.

- *Institutional framework for coordination, management and implementation of these programmes*; Effective institutional systems as an enabler ensures that countries' HIV/AIDS, TB and Malaria programmes can deliver the services required. Countries with strong coordination and management mechanisms for the three programmes have demonstrated effective delivery of the services (South Africa, Thailand). However, those who had weak coordination mechanisms e.g. Equatorial Guinea cannot deliver the services effectively. These enabling factors ensure that a disease burden is not reversed.
- *Collaboration with other development partners*: The review established that high reliance on external funding exposed countries during transitions if development partners did not collaborate in planning such transitions. Without planning countries –found it difficult to take up financial responsibility for the programmes previously supported by the Global Fund. It is also noted that Global Fund and other development partners could leverage on their support to encourage government commitment to sustaining existing programs
- *Involvement of the Global Fund*: Involvement of the Global Fund in planning, implementation and monitoring of the transition enables countries to transition more smoothly.

(vii) Challenges of country transitioning from Global Fund

The review found out the following challenges in transitioning from the Global Fund by countries:

- Countries have limited expertise in development of sustainability plans. Of the 12 countries reviewed, only 2 have developed sustainability plans. Other development partners developing such plans provide technical assistance to countries.
- There was limited domestic funding allocated to prevention services especially for HIV interventions targeting key populations and delivered through the community health system. This was the case in Jamaica and Russia.

Coordination of development partners in planning and implementing sustainability plans is a challenge. UMIC tend to have a limited number of development partners. Global Fund is viewed by most UMIC as a more sustainable funding source compared to the other development partners. Thus, coordination of other development partners has to be handled carefully to avoid a phase-out of support by other development partners at the same time a country is transitioning from Global Fund. For instance, in South Africa and Jamaica PEPFAR is currently implementing a sustianability plan aimed at these governments taking up financial responsibilities for most services funded by PEPFAR by 2017. The two countries are UMICs and are generally ineligible for Global Funding from 2012 and should be transitioning from the Global Fund. The timing of these transitions will impact negatively on sustainability of programs previously supported as it puts pressure on the country to take up huge financial responsibilities occasioned by multiple phase-outs

(viii) Processes adopted by countries transitioning from Global Fund

The review found out that countries that have transitioned from the Global Found did not adopt a clearly defined process. Most of the countries took financial responsibility for provision of drugs and other phamaceutical commodities while prevention interventions especially those that are implemented through the community health systems were not sustained. It was found out that governments find it easier to take up responsibility for services provided through the public health system.

A deliberate attempt to develp a plan to sustain Global Fund supported services has been done by a few countries – Jamaica and Estonia. Lessons from these countries show that the process of developing sustainability plans brings together all stakeholders to identify strategies for sustainability. In such cases the visibility of government leadership is high and there is a detailed analysis on the cost

implications of the sustainability plan and identification of financing sources. However, even in these countries, there were challenges in identifying financing sources for prevention services targeting key populations and implemented through the community health system.

(ix) How Global Fund can facilitate transitioning of countries

This review found out that other development partners are playing an active role in supporting countries to develop plans to sustain external support to programmes. However, Global Fund has not been playing a similar role. Taking into consideration lessons learnt from other development partners and the challenges faced by countries in transitioning from Global Fund, the Global Fund would assist countries to prepare and implement the transitioning plans through the following measures or approaches:

- Ensuring a balanced support for provision of services and investment in key enabling factors to enable the country build the necessary capacity as it progresses towards becoming an upper middle income country. This will ensure that such countries attain readiness to transit by the time they attain upper middle income status.
- Providing technical assistance to countries to enable them develop sustainability plans. Technical assistance should focus both on development and implementation of the sustainability plan.
- As is the case with other developong partners, Global Fund should adopt a country specific approach to sustainability planning and implementation. Though a broad framework for sustainability planning and country transitioning can be developed, implementation of such a framework should be flexible to accommodate country specific issues.

(x) Sustainability strategies and approaches

The review has identified various strategies and approaches used by other development partners and countries in planning and executing sustainable transitions. These strategies provide a basis for developing policy, content and process guidelines for development and management of future sustainability plans. The Global fund needs to develop policy guidelines around the following areas to guide sustainability planning processes:

- *Definitions and scope of sustainability*: The Global Fund has not provided the definition, scope and type of the sustainability it seeks to achieve with countries. This is a necessarily pre-requisite to the success of the envisaged sustainability strategy.
- *Other triggers complementing the income level criteria*: The income level as the only criteria to transition countries from the Global Fund was found to be deficient. The Global Fund needs to use other factors that determine the country's readiness to transition from the Global Fund without losing the investment.
- *Commitment from key stakeholders*: Country sustainability efforts require participation and commitment by key national stakeholders involved in management of the various disease programme. Currently the Global Fund has legal relationship with PRs only. There will be need to commit other stakeholders to the sustainability efforts and processes. Currently grant agreements are signed by the PR and witnessed by the CCM Chairperson. Once sustainability plan is integrated into the grant agreements, other key stakeholders including the Ministry of Finance and all Sub-Recipients could be signatories to the grant agreement. Alternatively, Sub-agreements will be modified to include a sustainability plan.
- *Knowledge of ineligibility and need to develop a sustainability plan*: As soon as possible, countries need to know when they could be transitioning from the Global Fund so that they can prepare well in advance.

- *Integration of sustainability plans in proposal development and grant agreements:* In the past, the Global Fund has not required that sustainability plans be integrated into the grant agreements signed with all countries. This has affected early engagement by countries on sustainability planning and implementation of sustainability activities as the grant is implemented.
- *Monitoring of counterpart funding policy of the Global Fund:* The Global Fund has not developed a mechanism to monitor progress by countries to fulfil the counterpart financing policy obligation. There is need for a mechanism for monitoring compliance to this policy and that could be part of the grant agreements.
- *Funding of sustainability activities:* Sustainability requires significant financial and technical resources to support transition activities. There is need for a policy on funding of future transitions.
- *Support to countries to develop sustainability plans:* The development of sustainability plans is an intense process that requires clear policy direction and commitment by countries regarding when sustainability plans should be prepared, implemented, scope of the plan and stakeholder involvement among other guidelines

4.2 Lessons

Key lessons on the development and implementation of sustainability plans identified are as follows:

(a) ***Whereas income classification is a key criterion for identifying countries that should transition from Global Fund, it should be applied in combination with the trigger factors identified above:*** Income classification should be a base criterion for identifying countries that should transition from Global Fund. However, the decision whether a country should transition or not (after attaining the UMIC or HMIC status) should consider the trigger conditions – demographic, economic, disease burden and programme financing factors. This will ensure that a HMIC or UMIC has also attained readiness to transition.

(a) ***Investing in enabling factors over a long period is key for successful transitioning from the Global Fund.*** Transitioning of high middle income countries from the Global Fund cannot be successfully implemented within a short period. Such countries ought to have prepared over a period (perhaps more than five years) by investing in the enabling factors such as increasing funding to health, strengthening health systems for delivering the three programmes and improving overall health sector governance.

(b) ***A deliberate effort to develop and implement sustainability plans increases the possibility of successful transitioning from Global Fund:*** Countries that did not have a sustainability plan did not manage their transitioning from Global Fund effectively.

(c) ***Countries tend to apply a combination of strategies to improve financial sustainability:*** Increase of government funding to the national programmes is not the only sustainability strategy that countries are applying. Sustainability is being approached in a mutli-dimensional manner – focusing on increase of domestic funding, unit cost rationalisation, cost efficiency and cost effectiveness. For instance countries are prioritising prevention as a long term sustainability strategy for the treatment programme.

(d) ***Effective coordination of development and implementation of sustainability plans enhances a country's ability to assume financial responsibility for its programmes:*** Coordination with other development partners enables the country to take financial responsibility for certain services without impacting negatively on services supported by other development partners. For instance, if Global Fund is supporting HIV test kits and another development partner is supporting laboratory infrastructure and training health workers to provide quality HIV testing, there has to be a coordinated approach to ensure continued funding for HIV test kits to ensure no interuption

in the other donor funded programme. Secondly, it ensures that countries are not passing the financial responsibility to other development partners.

(e) ***Support of sustainability plans by development partners contributes to successful transitioning of countries:*** The development partners reviewed – PEPFAR/USG and GAVI provide financial and technical support to countries for development and implementation of sustainability plans and this has contributed to effective implementation of these plans. This support could start with development partners supporting policy dialogue initiatives to influence government commitment to providing health services to the vulnerable, marginalised and MARPS, as well as allocating resources for prevention services.

4.3 Recommendations

Recommendations based on the findings and lesson learnt of the review, are outlined below. These recommendations focus on the policy, processes and mechanisms for managing sustainability of Global Fund supported programmes in countries.

i) Policy recommendations

Policy guidelines are required in the following areas:

Operational definition of sustainability planning

Global Fund should establish a clear operational definition of sustainability. Currently, proposal development guidelines require countries to indicate sustainability strategies for programmes but there is no clear definition accompanying these guidelines. A consensus with countries on the operational definition of sustainability plan within the context of the Global Fund is necessary for commitment, ownership and implementation of sustainability plans. The following operational definition is recommended for consideration by the Global Fund: *"A long term plan for assurance that programmatic, financial and organizational gains at national and community levels as a result of the Global Fund support will be maintained or increased as Global Fund financing is reduced".*

Complementing the income criteria for country transitioning

The review has identified factors that determine a country's readiness to take up a sustainable transition from the Global Fund. The Global Fund should develop a policy that considers the additional factors in making a decision on whether a country should transition from Global Fund irrespective of achieving HMIC or UMCI status. These factors, referred to as triggers, include:

(a) Population growth rate and GDP rate: Population growth rate considerably less than the GDP growth rate allows a country to improve its per capita income hence capacity to spend on health services assuming favourable health policies thus moving towards readiness to take up financial responsibilities for its HIV/AIDS, TB and Malaria programmes. In the contrary a county with higher population growth rate than GDP growth rate is likely to lack the resource capacity to take up financial responsibilities.,

(b) Health financing level: High per capita expenditure on health, high government expenditure on health as % of GDP, high government expenditure on health as % of total government expenditure signal a country that is investing in health systems and therefore ready to assume financial responsibility of HIV/AIDS, TB and Malaria programmes

(c) Disease burden: Low disease burden with minimal rural-urban, poor-rich, ethnic and gender disparities signal a country that can easily finance its HIV/AIDS, TB and malaria programme. and

(d) External funding levels for the three disease programmes: Countries with low external funding compared to domestic funding on the three diseases signal a country ready for transition.

Setting and achieving counterpart financing thresholds to facilitate transitioning

The current Global Fund counterpart funding policy encourages UMICs to achieve a counterpart financing threshold of 90% over the implementation period but fails to provide a mechanism to enforce the threshold. To enhance commitment and monitoring, the Global Fund should set and monitor a time frame with annual targets for achieving the 90% threshold. It is suggested that starting at 60%, UMIC will target an annual increment of 5% each year for the 6 years so as to reach 90% threshold by the end of the life of the grant. This mechanism would at the same time ensure Global Fund resources are not used to substitute government contributions to HIV/AIDS, TB and Malaria programmes.

Sign sustainability compacts/agreements with countries

A sustainability compact or agreement signed by the highest level of government preferably by the Ministry of Finance, preceded by technical discussions on implications of the sustainability planning for the country and rigorous policy and political level engagement will raise the profile and ensure commitment on the part of the country and Global Fund. This is critical for successful development and implementation of a sustainability plan. For instance, this process will provide Global Fund a platform to ensure country commitment to fund community health systems.

Addressing concentrated infections in HICs

A policy on access to health services by vulnerable, marginalised and most-at-risk populations in high income countries should be developed in collaboration with partner organizations. This is a necessary measure given that some HIC that have graduated from Global Fund support based on income criteria have vulnerable, marginalised and MARPS population who cannot access HIV/AIDS, TB and malaria services due to legal, political and cultural opposition.

Establishing a transition fund

The review of sustainability plans for PEPFAR and GAVI shows that the development partners provide financial and technical support to the countries to implement the plan. In the case of Global Fund sustainability, this will also be a critical success factor for implementation of the sustainability plans. The Global Fund should set aside funds to provide financial and technical support to the countries to implement sustainability plans. The fund can support countries to develop sustainability plans and implement activities identified in the sustainability plan. The transition fund could focus on prevention interventions, health system strengthening and community system strengthening interventions as the Global Fund moves away from funding commodities and drugs. The transition fund would also fund CSOs and MARPS targeted interventions as the Global Fund support advocacy efforts for government to take up financing responsibility. Thus, a policy decision to establish such a fund should be made followed by guidelines and modalities on how the fund can be established.

ii) Process of development of a sustainability plan

The process for development of a sustainability plan are described below and summarized by Figure 6 below.

Development of sustainability planning guidelines

The guidelines will be developed by the Global Fund based on the policies discussed in (i) above and in close consultations with countries- endorsement by countries will be prerequisite. The guidelines will outline the process and procedures to be followed, content of the sustainability plan, stakeholders to be involved and their roles, the role of the Ministry of Finance and the Global Fund, budgeting of the sustainability plan, approval and timelines.

Initiation of sustainability planning with the country

It is recommended that sustainability plans are developed soon after grant signing and commencement of grant implementation. Development, implementation and monitoring of a sustainability plan is a huge investment in terms of time and resources. It has the potential of distracting the attention of

Program managers if it coincides with important grant implementation milestones such as proposal development, planning implementation and phase 2 renewals.

Timeframe for the sustainability plan

While GAVI and PEPFAR sustainability plan timeframes are same as programme funding cycle – 5 years, Global Fund timeframes may vary from country to country depending on the complexity of the sustainability plan activities and number of implementers. Sustainability plans for UMICs for instance are likely to be less demanding than those of the LMICs. Another factor to consider in determining when sustainability plan activities should start in the grant cycle is associated with project start-up. It might be prudent to postpone implementation of sustainability plan until phase 2 to allow programme managers to focus on successfully starting off the grant in phase 1. It is also advisable to allow that the transition period extend for about 2 years after the end of the grant for weak countries so as to build capacity to manage transitions. A situation analysis in the last year of implementation will help to determine additional support and time required. Overall sustainability planning should be finalized and embedded in the phase 2 grant agreement and implementation should also be started during that phase of the grant.

Scope of the sustainability plan

The sustainability plan should be designed to address issues that are likely to affect the Global Fund supported health outcomes, activities, financing and accountability, ownership and Global Fund approaches such as multi-sectoral, equity and gender equality and human rights. A sustainability plan should include clear rationale, specific services to be sustained and strategies for transferring responsibility to countries, coordination and management and strategies for raising funds to support the selected services. Other aspects are Global Fund role, budget, funding mechanism, monitoring mechanism and recourse for non-compliance.

In- country steps for development of the sustainability plan

Based on lessons learnt especially from PEPFAR and GAVI, the in-country steps to be undertaken in development of a sustainability plan could involve:

a. Situational analysis: In identifying the scope of the sustainability plan the country should conduct a situation analysis specifically focusing on program unit costs, cost efficiency and costs effectiveness, capacity, health systems, overall financing requirements for the national programme, possible impact of sustainability on the programmes and risks.

b. Development of sustainability strategy: based on the findings of the situational analysis, sustainability strategies focusing on specific services and "enablers" should be developed. This should guide how the country will effect the transition of responsibilities for various services, the specific activities to be undertaken, management of the plan, monitoring and evaluation of the plan and the cost of the activities.

c. Negotiation with Global Fund: the plan will then be negotiated with Global Fund and agreement reached on the final plan and how it will be funded.

d. Signing of the sustainability plan: the plan will be signed between the Global Fund and the country, preferably the Ministry of Finance to signing on behalf of the country. This will be a technical plan operationalising the sustainability compact signed between Global Fund and the Country at a policy/political level. The signing of this plan will, therefore, be a sign of agreements on how the compact will be operationalised to attain policy agreements agreed on.

Collaboration with other development partners

The Global Fund should involve other development partners supporting a programme to develop a sustainability plan. Where a country must phase out its support, the Global Fund would take up the

responsibility to support the country during transition to ensure gains are not lost. In this case the Global Fund could extend its grant.

Role of the Global Fund

Global Fund should provide the guidelines and play an advisory and capacity building role in the development of the sustainability plans. This would involve guidelines on the definition and scope of the sustainability plan, who should be involved, timelines, and reviewing the sustainability plans and working with countries to mobilize resources and technical support from other development partners

Management of the sustainability plan

The plan should establish mechanisms for coordination and management which involves close links between stakeholders in the country. The civil society, government and private sector should play a role. The Global Fund needs to play a technical support role to enable the country implement the plan. Lessons learned from PEPFAR show that the countries form task teams for implementing transition of specific services from PEPFAR funding to Country or domestic funding. Countries will need to develop such type of structures focusing on transitioning of specific services funded by Global Fund. The CCM would continue to oversee the implementation of the sustainability plan and working with the Global Fund and government to resolve bottlenecks during transition.

Monitoring

The sustainability plan should include a robust monitoring and evaluation and reporting framework linked to the overall reporting system for the national programmes funded by Global Fund. The plan should have clear targets and indicators and persons responsible for reporting. The M&E framework will serve as a tool for tracking implementation of the plan as well as the inherent risks. An agreement should be reached within the context of the sustainability compact to have the programmes report on progress in sustainability at policy level and also to share the reports with Global Fund. Monitoring of sustainability plans should be country led and owned and any adjustments to the plan to be made by countries themselves.

The figure below summarises the recommended process for development of sustainability plans

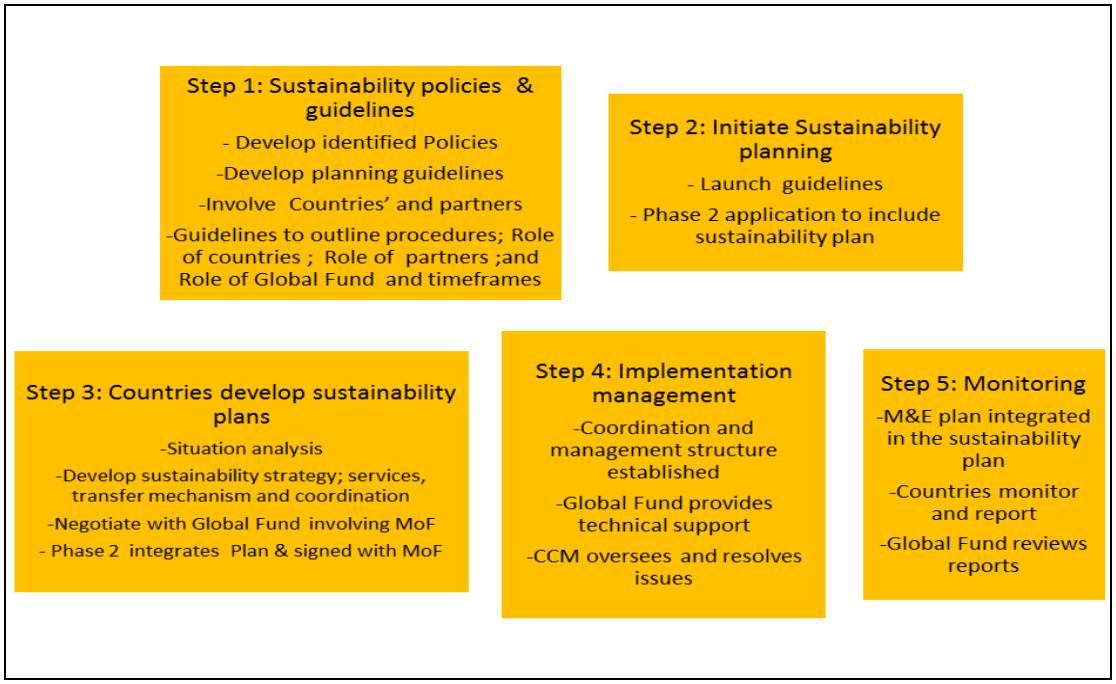


Figure 6: Process for development of sustainability plan

Annex 1: Efforts considered by countries developing or implementing sustainability plans

Multiple approaches are being used or considered by countries to take up financial responsibilities for Global Fund supported programs funded by the Global Fund. These are discussed below:

i) *Increased government allocations:* Estonia, Jamaica, South Africa, Thailand and Russia have taken up the financial responsibility for ART treatment and staff costs through increased annual budgetary allocations. In Kenya, the National AIDS Control Council (NACC) has made a proposal to the cabinet to approve increased budgetary allocations to the HIV/AIDS response as one approach towards financial sustainability of the national HIV response.

ii) *AIDS Trust Fund:* Zimbabwe introduced the National AIDS Trust Fund financed by a levy of 3% on taxable income of individuals and firms. Botswana, South Africa and Tanzania are in the process of establishing a similar fund. Kenya is considering introducing a similar trust fund. The AIDS Trust Fund may operate as unfunded scheme or funded scheme. The unfunded scheme means the government either transfers funds to the scheme from the government budget or as revenue collected that goes directly to the fund without passing through the government budget. In a funded scheme, the fund receives an initial endowment fund from government. The endowment fund is allowed to accumulate by investing in financial assets. Once a certain level of funding has been reached, the fund can then allocate the interest earned on its value each year to expenditure on HIV and AIDS.

iii) *Taxes and Levies:* Jamaica Government (GoJ) levies tax on cigarette and alcohol to support the National Health Fund. The Jamaica government is considering using the National Health Fund to fund procurement of ARVs. South Africa is also considering introducing tax on cigarette, alcohol and bank interest income to raise funds to sustain the national HIV and TB response. Kenya is considering the introduction of airline tax to support the national HIV response.

iv) *National Health Insurance Fund (NHIF).* South Africa has established a team to explore the viability of using the National Health Insurance Fund to fund treatment of AIDS patients. The approach is being piloted in 9 districts selected from each of provinces in the country. The pilot is aimed at establishing the cost of treatment when rolled out. In Kenya a cabinet paper proposing funding of the ART treatment by the National Health Insurance Fund (NHIF) has been prepared and submitted to the cabinet for approval.

v) *AIDS Bond:* In Kenya the viability of using AIDS bond as an instrument for raising funds to sustain the national HIV response was discussed by the Sustainability Technical Working Group and the private sector. This would involve the government issuing AIDS bonds at reasonable interest rates which the private sector would invest in. Already the Government of Kenya is issuing similar bonds to raising funds for infrastructure development. However it should be noted that use of this instrument is subject to country's policy on debt management. The approach may not be sustainable if it results in increasing national debt beyond acceptable limits.

vi) *Private sector:* Under the Global Fund architecture the private sector is a central pillar in the multi-sectoral approach to fighting the 3 diseases. It is expected that the CCM can tap into the private sector resources to support the interventions designed to address the 3 diseases. In Jamaica, The Jamaica Business Coalition on HIV and AIDS (JABCHA) has been tasked to spearhead efforts in the country to mobilize resources from the private sector to support HIV interventions and there has been good progress. The private sector can therefore be a source of funding for sustaining the national HIV response post Global Fund support

vii) *Strengthened Prevention*: South Africa, Kenya and Jamaica long run cost and financing sustainability review reports identify increased investment in prevention as a key strategy for sustaining the national HIV response. According to the reports new infections increase costs

and financing requirements in the long run, as more people need to be placed on ARV treatment. Increasing investment in prevention interventions that demonstrate impact in reducing new infections is therefore seen as an important strategy towards a sustainable response. In this regard the Government of South Africa is working with PEPFAR to gradually shift resources from treatment (the government is assuming financial responsibility for treatment) to prevention through strengthening health systems and community health systems.

viii) *Unit costs, cost efficiency and effectiveness*: A study conducted by Clinton Foundation in 2011 covering 161 health facilities in Ethiopia, Malawi, Rwanda ,South Africa and Zambia established that the annual cost of ARV treatment per patient ranged between US$ 200 to US$ 692 with South Africa being the highest. A similar study conducted in 2012 covering LAC countries established the ARV treatment costs to range between a low of US$ 200 in Belize and the highest of US$ 2,200 in Cuba. Following these studies Jamaica and South Africa are reviewing the costs of service delivery in particular the cost of ARV, coordination and management and service delivery processes of the programmes. This intervention has shown results in South Africa. Following a review of the tendering system for ARVs, South Africa realized substantial savings on ARV unit costs in the October 2012 tender. At the same time South Africa is promoting treatment initiated by nurses at community level as one way of reducing costs of service delivery.

The strategies and approaches being used or considered for taking up financial responsibility of HIV, TB and Malaria responses are summarised in the Table 17.

Table 17: Summary of strategies and options being considered

Financing strategy	**Countries undertaken/considering transitions**								
	Botswana	**Estonia**	**Jamaica**	**Kenya**	**South Africa**	**Russia**	**Thailand**	**Tanzania**	**Zimbabwe**
AIDS Trust Fund	X			X	X			X	X
Airline levy				X					
Tax on cigarettes			X		X				
Tax on alcohol			X		X				
Interest tax					X				
Income tax					X				
AIDS Bond				X					
Increased public budget allocations to the programmes		X	X	X	X	X	X		
Increase private sector contributions to the programmes			X						
Strengthen HIV, TB and Malaria prevention			X		X				
National Health Insurance				X	X				
Reduction of unit cost for service delivery					X				
Improiving programme efficiency and effectiveness to reduce cost			X	X	X				

Annex 2: Sustainability plan for national HIV/AIDS response in Jamaica

1. Introduction

Jamaica has a population of 2,709,000. Urban residents make up 52% of the total. The population growth rate is 0.25%. Jamaica has a very large population living outside of the country (an estimated 2.5 m. people), who provide substantial remittances. The country is at the low end of the income range for UMICs with per capita income of $4,980. Per capita income has changed very little for the past decade. The economy is still recovering from the financial crisis of 2008. The government has a high international debt burden. Debt service consumes 65% of the combined recurrent and capital budget of the government, greatly limiting its capacity to expand funding for health.

Jamaica spends 5.1% of its GDP on health, below the average for LAC and UMIC countries and $231 per capita on health, less than half of the amount in LAC and UMIC countries. The Government of Jamaica (GoJ) spends 5.6% of its budget on health, which is approximately half the share for LAC and UMIC countries. Government expenditures make up 55.8% of all spending on health thus the other 44.2% of health spending coming from the private sector and external partners. Donor spending on health is very low at 1.8%, down dramatically from 10.5% in 1995, and lower than LAC (3.66%) and UMIC (2.27%) countries.

2. HIV Epidemiological Profile

The HIV prevalence in Jamaica remains high at 1.7% in 2011 with an estimated 32,000 people living with the disease. New infections in 2011 were estimated at 2,100 people per year which is a decline of 25% over the last decade according to UNAIDS. AIDS-related deaths have decreased but remain a leading cause of death of adults aged 15-49 years with over 333 reported deaths due to AIDS in 2011 compared to 664 in 2004. Current ART coverage is 57% of the estimated population in need. Self-awareness of HIV status remains low, thus identification of those in need of treatment remains difficult. With the estimated number of people with HIV at 32,000, the treatment gap is estimated to be as high as high as 75%.

The HIV epidemic in Jamaica is mixed, both generalised and concentrated. HIV prevalence in the general population has been less than 2% over the last decade considerably lower than in the high risk population; HIV prevalence among men who have sex with men (MSM) was 32% in 2007 and 32.9% in 2011), among female sex workers (FSWs) 9%, 4.9% and 4.1% in 2005, 2008 and 2011, prison inmates 3.3% in 2003 and 2.4% in 2011, the homeless and drug users at 8.82 % in 2008 and 8.17% in 2011 (MoH, 2011).

The main risk factors fuelling the HIV epidemic are social, cultural and behavioural: early initiation to sexual activity, limited life-skills and sex education, insufficient condom use, multiple sex partners, history of STIs, crack/cocaine use, commercial and transactional sex, and men having sex with men. Homophobia and gender inequality complicate the conditions.

Four of fourteen parishes (counties), Kingston & St. Andrew, St. James and St. Catherine, with 50% of the Jamaican population, account for 56% of reported cases. These parishes include Kingston and Montego Bay, the urbanized areas and tourism centres that have the highest cumulative number of cases.

3. National HIV National Response

In 1988 Jamaica established a comprehensive National HIV/STI programme (NHP) whose mandate is to coordinate and guide the HIV national HIV response. The Ministry of Health provides technical and political leadership. The national response started with the development of the first national plan of 1988 and expanded with the development of successive 5-year national strategic plans (NSP) starting in 2004. Successive governments have supported the National HIV/STI programme and invested considerable resources. The National AIDS Committee (NAC) was established in 1988 to lead the multi-sectoral response. The Jamaica Country Coordinating Mechanism (JCCM) was established in 2003 to provide leadership and oversight for the Global Fund supported programmes.

Since its establishment in 1988, NHP has been expanded to involve the health sector's Regional Health Authorities (RHAs) as well as five other sector ministries: Labour and Social Security, National Security, Local Government, Education and Tourism.

The NHP has received substantial support from international development partners (IDPs) including the World Bank, USAID, PEPFAR, UN agencies and the Global Fund. Other donors, including DFID, have phased out their financial support. This support has facilitated the broadening of the national HIV response to include participation from sector ministries, the NAC, NGOs and Jamaica Network of Seropositives (JN+) in programme planning, implementation and review.

The NHP has a well established programming and management capacity comprising eight units that are responsible for the following programmatic and functional areas of the response: i) prevention, ii) treatment and care, iii) policy, enabling environment and human rights, iv) monitoring and evaluation, v) waste management, vi) administration, vii) Finance and viii) procurement.

The national HIV response is currently funded by the Global Fund (67%), the World Bank (17%), PEPFAR (9%) and the government of Jamaica (7%). External funding therefore accounts for 76% while the domestic resources account for 24% of the total cost of the response. Jamaica's HIV/AIDS program is therefore heavily dependent on donor financing.

4. Global Fund Support

To December 2012, the Global Fund's support to Jamaica amounts to US$ 62.9 million. The first HIV/AIDS grant of US$ 23 million was signed in 2003 and implemented between 2004 and 2008. The grant supported several components including i) prevention, ii) treatment, care and support, iii) policy environment and human rights and, iv) governance and empowerment. In Round 7, Jamaica received a second HIV/AIDS grant of US$ 39.9 million. This grant was building on the activities of the first grant. The Global Fund has just approved another US$ 4.95 of support to Jamaica under the transitional funding mechanism.

Global Fund supported programmes and particularly the ARV treatment and VCT services are largely implemented through the GoJ health facilities. Only 4 health facilities operated by CHARES and Jamaica AIDS saving Lifes (JASL) provide treatment and VCT services outside government facilities. Twenty Sub-Recipients are involved in implementation of the Global Fund programmes mainly providing community outreach services.

Key achievements of the Global Fund support include:

i) Treatment of 7500 patients on ARV

ii) Support to 18 treatment centres

iii) Procurement of 100,000 VCT test kits annually

iv) The Family Health Life Education(FHLE) programme reaching 750 schools

v) Promotion and distribution of condoms

vi) Programmes supporting MSM, CSWs, inmates and low income areas.

vii) Supporting NHP and JASL staff salaries

5. Financial Sustainability of the National HIV Response

Jamaica is in the process of working on the National HIV Strategic Plan 2012-2017. The NSP has not been finalized to determine the financial requirements for the next 5 years. Total financial requirements for 2009/2010 for all the interventions identified in the National HIV Strategic Plan 2007-2012 was US$ 13.9million. Assuming a 5% annual increase the financial requirements up to 2016/2017 have been estimated and are shown in Table 15 below.

The National HIV response in Jamaica is funded by GoJ, Global Fund, PEPFAR and the World Bank. Indications of the resources and level of funding from GoJ and development partners is shown in

Table 18. The Jamaica national HIV response shows an increasing financing gap over the period of US$ 10.8 million in 2012/13 rising to US$ 17.5million in 2016/2017. This is not surprising given that the National HIV Strategic Plan 2007-2012 was underfunded throughout the 5 years and that external support is declining.

Table 18: Projected Financing Gap for national HIV Response in US$ '000					
	2013	**2014**	**2015**	**2016**	**2017**
Financial requirements	**20,497**	**21,518**	**22,594**	**23,159**	**23,739**
Funding sources					
Government of Jamaica	5,028	5,278	5,543	5,821	6,112
Private sector	68	71	75	79	83
Global Fund	2,500	2,450			
PEPFAR/CDC	2,100	2,100			
Total	**9,696**	**9,899**	**5,618**	**5,900**	**6,195**
Financing Gap	**10,801**	**11,619**	**16,976**	**17,259**	**17,544**
Source: Projections based on 2007-2012 National Strategic plan[23]					

6. Key challenges to sustainability of the national HIV response

Key challenges identified at the stakeholders' annual review held on 27-28, November include:

i) *New infections are still high:* The current HIV incidence is estimated at 2100 people infected annually. These people will require treatment at some point in time thus increasing the cost of the national HIV response. The recent KAPB survey of 2012 shows high vulnerability among the youth due to risky sex behaviour and lifestyles that expose individuals to infection. The country requires reversing this trend through investment in cost effective prevention interventions.

ii) *Large treatment gap:* ART coverage of 57% of the estimated population of those in need is low. This means that 43% of those in need of treatment are not accessing services thus raising issues of universal access, equity and human rights.

iii) *High dependency on external funding*: Seventy six (76%) of the national response budget is funded by external donors while domestic resources fund only 24% of the budget, thus exposing the country's program to the effects of the reductions in donor funding.

iv) *Ending projects:* World Bank support ends in March 2013. The Round 7 Global Fund grant also ends in July 2013. According to the World Bank staff interviewed, it is unlikely that there will be further funding of a similar programme. The Global Fund support is also likely to decline substantially.

v) *Government resources are constrained:* The government budget is currently constrained due to the prolonged downturn of the economy and a very high debt burden. Sixty five (65%) percent of the GoJ recurrent and capital budget go towards debt servicing.

[23] The 2012-2017 National Strategic Plan has not been costed.

7. Sustainability strategies approaches and plan

Current preparations for sustainability

(i) The Global Fund sustainability framework

In preparation for taking up the financial responsibility when the Global Fund grant ends in July 2013, a sustainability framework identifying the services and activities to be supported by the GoJ, the private sector and the Global Fund was prepared. It is proposed that the GoJ takes up ARV treatment and absorbs the staff employed by the Global Fund program. The privates sector will take financial responsibility of the prevention programs while the Global Fund continues to fund interventions targeting MARPs.

(ii) The National Strategic Plan (NSP), 2012-2017

For the first time the National Strategic Plan prioritises financial and program sustainability as one of the National HIV response strategic interventions. The NSP identifies and prioritises financial resource mobilization, expanding partnerships, capacity building across all the sectors, integration of services and policy and legislative change as issues to be pursued during the plan period. The draft NSP is currently under discussion with other stakeholders and is expected to be finalized for implementation in the next financial year. The Ministry of Health and NAC are likely to update it, taking into account changes in donor support, the latest assessments of the performance of the programme to date and the updated epidemiological data.

(iii) Financial sustainability

In 2012 the Government, with the support of the World Bank and UNAIDS, commissioned a review on financial sustainability of the Jamaica's national HIV program. Preliminary findings estimate the cost of the national HIV response of 0.2-0.22% of GDP through to 2030 under various scenarios. The review concludes that at 0.2% of GDP, the country should be in a position to fund the national HIV response although not easily under the current financial constraints including Jamaica's low per capital income, stagnant economy, and high indebtedness. The preliminary report however identifies opportunities for reducing the programme costs. Past reviews of the cost of HIV services have indicated possible reduction in costs of services through taking appropriate efficiency and effectiveness austerity measures.

(iv) Sustainability plan

Following the preliminary findings that have shown the need for the country to mobilize more funding for the national HIV response, The Ministry of Health has hired a consultant to prepare a detailed sustainability plan that identifies different financing options and defines the role of the different national agencies as well as donors. The sustainability plan will be informed by the findings and recommendations of the financial sustainability. The results are expected early in the next quarter for presentation to the CCM and other stakeholder groups.

(v) Other Cost and Program Studies

The Ministry of Health has also pulled together many studies to guide the HIV/AIDS program planning and *sustainability planning. These include* the NASA study for 2009-2010, 2012 HIV/AIDS Knowledge, Attitudes, Practices and Behaviour Survey (KAPB), and Evaluation of the National Health System Response to HIV and STIs in Jamaica (with support from PAHO). These studies, all reviewed at the annual HIV/AIDS program review conference, provide a solid information base for the next phases of programme and financial planning.

8. Proposed sustainability strategies and approaches

Government funding of HIV treatment , care and support and staff , integrating HIV into the NHF package, restructuring of the institutional arrangements, strengthening prevention services, integration of services into the national health systems, improving of the environment and governance have been identified as the main approaches for a sustainable national HIV response as well as the Global Fund supported programmes

(i) *Government funding of ARV treatment*: Going forward the GoJ is taking on greater financial responsibility for purchase of ARVs and taking on the staff currently funded by the Round 7 Global Fund grant and World Bank supported program, except for prevention services to key populations. From the financial year starting April 2013, the Government is expected to finance the cost of ARVs and other drugs to a total of US$4.5 million. These commitments are included in the 2013-2014 draft budget requested by the Ministry of Health and the Regional Health Authorities (RHA). Decisions on these requests should be known early in 2013 in time for the start of the fiscal year in April.

(ii) *Programme components for treatment services now funded by the Global Fund grant*: The Ministry of Health has requested in its 2013-2014 budget (effective April 2013) that all the professional health workers, social workers, counsellors working on treatment services employed and funded by the Global Fund to be absorbed within the central Ministry of Health and the four Regional Health Authorities where they are working. Adjustments will be made to adapt to the existing job descriptions and the salary scale of the Ministry. The final decision is out of the hands of the Ministry of Health. As staff funded under the World Bank grant was absorbed during the last fiscal year, setting a positive precedent, it is hoped that the request will be accommodated.

(iii) *Integrating the HIV into the NHF package:* The NHF funds chronic disease treatment. HIV/AIDS is considered chronic and treatment of AIDS therefore qualifies for support from this fund, although the competing programme costs for other chronic diseases may place limits on the amounts and types of assistance available for AIDS treatment in the future. The GoJ is exploring the purchase of ARV drugs through the National Health Fund (NHF). Integrating HIV into the NHF package will be more sustainable because the NHF is funded by cigarette and alcohol taxes and the Health Corporation Ltd., the Ministry's procurement arm for drug purchases, has been integrated into the NHF to streamline procurement operations.

(iv) *Merger of the National HIV/STI Programme (NHP) with* the *National Family Planning Board (NFPB) under the Ministry of Health.* The Ministry of Health is completing final plans to merge the National HIV/STI program (NHP) with the National Family Planning Board to create a Sexual and Reproductive Health Authority of Jamaica. The merging of the two bodies is expected to impact positively on the national HIV response in several ways. Firs, the merge creates a single government authority responsible for FP, RH and HIV policy and programming likely to result in better coordination and coherency. Second, synergies in health education, behaviour change communication, and promotional mandates of NHP and NFPB. Third, reduction in human resource requirements. It is estimated that the number of staff will reduce realizing savings USD 1.4 million annually. Fourth improving the capacity of the HIF response to attract funding and international development assistance. Detailed implementation planning is in the process, pending a final signoff by the government.

(v) *Global Fund transition funding:* The Ministry of Health has applied to PEPFAR for a two year transition grant for funding prevention services provided by NGOs/CSOs working with key populations. PEPFAR's regional program in the Caribbean is assessing its ability to assist Jamaica in the transition. It has committed to increase its funding to a minimum of $2.1 million for 2013.

(vi) *Treatment care and support*: The government will continue to provide AIDS treatment, care and support for 10,000 patients receiving ART through the four regional health authorities. AIDS

treatment services are fully integrated into the health care system and HIV management training will be integrated into the training curricula. The only exception is 400 ARV patients from key populations being served by a CSO at present. The management of these patients will remain under the CSOs under the transition funding mechanism.

(vii) Mobilizing Private Sector resources: Jamaica has in the past mobilized resources from the private sector to finance the national HIV response. Efforts to increase funding from the private sector are on. The Jamaica Business Coalition on HIV/AIDS brings together private sector organisations to raise funds for HIV/AIDS programmes. In 2012/13 USD 4 million was raised towards supporting HIV/AIDS programmes. It is expected that this window will be part of the strategies to be used by the country.

(viii) Strengthening prevention: The NSP envisages several interventions including strengthening CSO partnerships to ensure continuity of HIV prevention services targeting CSWs, MSM, unattached youths and other vulnerable groups; strengthening HIV prevention interventions in health care settings including risk reduction conversations, risk assessment and risk management; strengthening the capacity of health care workers to reinforce prevention messages, continued roll-out of the HFLE program for schools, approval of the work place policy. These measures target reduction of new infections as one way of reducing the number of people needing ARV treatment in future. Reduction in number of people needing ARV treatment will reduce cost of treatment thus a sustainable national HIV response.

(ix) Enabling environment and human rights: A key intervention in the NSP is to strengthen the capacity of the CSOs to advocate and monitor policy changes. An enabling environment and compliance to human rights promotes universal access to HIV preventive services to the MARPs and other vulnerable groups thereby ensuring that new infections due sexual behaviour are reduced.

(x) Monitoring and evaluation: The NSP proposes integration of the HIV specific databases into the national health information system, as well as integration of the HIV specific surveys and studies into the Government systems. Reliable data is essential for planning and design of cost effective interventions are used in prevention and delivery of services, a key factor to a sustainable program.

9. Recommendations

Jamaica is making progress towards development of its national HIV response sustainability plan. Global Fund support to this process would be recommended. The support would target the following strategic interventions.

i) *Cost efficiency and Cost effectiveness* of the Response: Discussions with stakeholders seemed to suggest that improved unit costs, efficiency and effectiveness provide opportunities for improving sustainability of the national HIV response in Jamaica. Though the government has taken some measures to reduce the costs of the response such as avoided the costs of duplicated systems by mainstreaming HIV activities into the MoH, MoE to the extent possible, more needs to be done. For instance, there is no data available on the cost of the prevention programs being undertaken. It is hoped during the financial sustainability planning the stakeholders will further review the HIV program costs and continue to identify ways to reduce cost of service, improve efficiency and effectiveness of the HIV programme. The Global Fund may consider supporting these efforts.

ii) *Funding of key populations interventions*: The Global Fund has been funding the interventions targeting MSM, CSWs and IDUs. Initial discussions indicate that the government is unlikely to take up financial responsibilities for these interventions. These services are critical to the success of the prevention program for key populations to ensure reduction in new infections. The Global Fund would leverage on its relations with the Government to lobby for funding of these groups. Alternatively this groups being strategic on the overall impact on the HIV Global Fund would continue funding programme targeting these groups.

iii) *Funding of CSO implementers*: Concrete strategies on how to address funding of the CSOs implementing some of the interventions under the Global Fund programme have not been identified. In 2011, the Jamaica Business Council for HIV/AIDS, JABCHA, in consultation with other stakeholders, created a foundation for fund raising for HIV/AIDS, primarily activities managed by CSOs. The foundation has raised $68,000 much lower than what was targeted. JABCHA is revising its strategy at this time to increase the fund-raising potential. The Global Fund would support the private sector efforts.

Annex 3. Sustainability Plan for the HIV, Tuberculosis and Malaria response in Kenya

1. HIV/AIDS, TB and Malaria epidemics' profiles

The HIV epidemic peaked in Kenya in the 1990s with a prevalence of 14% among the adults. This has since declined steadily to 7.4% in 2007 and to 6.2% in 2010. New infections however remain high estimated at 132,000 among adults and 34,000 paediatric infections. HIV is by far the largest cause of adult mortality in Kenya accounting for 29.3% of the deaths. The epidemic in Kenya is geographically diverse with Nyanza, Nairobi and Coast provinces having a prevalence of 14.9%, 8.8% and 8.1% higher than the national average. HIV prevalence of 8.4% in the urban is higher than the rural prevalence of 6.7% though 70% of the HIV infected people live in the rural settings. It is estimated that 1.6 million people lived with HIV in 2010. Heterosexual, MSM, prisons, CSW and IDU are the major modes of HIV transmission in Kenya.

In 2009 the country was rated 13th among the 22 TB high burden countries. In that year there were 110, 065 reported TB cases. In the same year the case notification rate for all forms of TB was 280 per 100,000 population and 95 per 100,000 population for sputum smear-positive PTB cases. There were 10,676 treatment cases in 2009. The large burden of TB cases is attributed to high poverty levels, delay in diagnosis from both patient and health systems related factors and concurrent HIV epidemic. HIV epidemic is the major cause of TB epidemic in Kenya. Kenya started TB/HIV collaborative activities in 2004 when MOH released guidelines for HIV testing in clinical settings. Kenya is considered to be a low prevalence MDR-TB setting. In 2009 a total of 150 MDR-TB cases were identified.

Increasing evidence shows that the epidemiology and risk of malaria in Kenya declined between 1999 and 2009. It is estimated that 60-70 per cent of the Kenyan land mass has a parasite prevalence of less than 5 per cent where 78 per cent of the population live. There is also decline in the level of endemicity in endemic areas characterized by reversal in the age group with the highest prevalence between children less than five years old and those between 5-15 years of age. In 2010 clinically diagnosed malaria accounted for 34% of outpatient hospital visits. Prevalence of malaria in children below was 8%. The lake endemic zone has the highest prevalence of malaria at 38% compared to other regions at less than 5%.

2. National HIV/AIDS, TB and Malaria Responses

HIV/AIDS Response

In 1999, the government declared AIDS a national disaster and consequently established the National AIDS Control Council (NACC) to coordinate the multi-sectoral national HIV response to the epidemic. NACC, on its part, has continued to coordinate the national HIV response through development of National HIV Strategic plans that give direction on the prevention, treatment, care and support and HIV impact mitigation interventions. The 3rd national strategic plan 2009-2013 is under implementation.

Key achievements of the national HIV response include:

i) *HIV testing and counselling*: More than 4.6 million people had been tested while the numbers of testing sites were estimated at 1000 country-wide in 2007.
ii) *PMTCT*: 64% of health facilities in the country offered PMTCT services in 2006
iii) *Behaviour change*: There has been significant sex behavioural change demonstrated by increased use of condoms, delay in sexual debut, and reduction in number of sexual partners among other gains.
iv) *Blood Screening*: Up to 100% of blood supply is screened for HIV.
v) *ARV Treatment*: Between 38% and 45% of the adults in need of ARVs treatment have had been reached by 2007. It is estimated that 75% of people in need had been reached in 2010.

Between 2006/07 and 2008/9 spending on HIV/AIDS amounted to US$ 1.8 billion. External Funding was the largest source of funding contributing on average 87% of the total funding. Bilateral partners contributed on average 71% of the funding in the 3 years. US Government's President Emergency Plan for AIDS Relief (PEPFAR) was the largest international funding agent accounting for 93% of the external resources to HIV while Global Fund contributed on average 3% of the spending over the same period. Other key contributors include the Clinton HIV and AIDS Initiative (CHAI), as well as Medicine San Frontier (MSF). Public expenditure spending averaged 13%.

The National Strategic plan 2009/10-2012/13 estimated the cost of the HIV response at US$ 3.5 billion for the 5 years. Taking into account total public and development partners' resources available over the same period, a financing gap of US$ 1.6 billion was projected over the 5 years. The Sustainability Financing for AIDS in Kenya Report of July 2012 estimates the HIV response financing gap between 2010/2011 to 2019/20 at US$ 1.6 billion. Projections made for up to 2029/2030 show a financing gap of about between 0.2% and 0.4% of GDP and 0.2% and 1.5% of government expenditure.

Tubercolusis Response

Achievements of the TB program include:

i) Establishment of 930 diagnostic centres and 2,280 treatment centres in both public and private institutions.
ii) Achievement of the Global target of 70% TB case detection rate
iii) Achievement of the Global target 85% case treatment success rate.

The national DLTLT strategic plan, 2011-2015, estimated the budget requirement for the programme at US$ 292 million. The Government is expected to be the main source of funding. External support is expected from the program's main traditional development partners including the Global Fund, USAID, CDC and JICA.

Malaria Response

Key achievement of the national malaria program includes:

i) In 2010, 57% of the household owned at least one bed net[24]
ii) Overall ITN use by pregnant women and children and children of under five years of age was 4% and 42% in 2010
iii) Sixty (60%) per cent of children with fever sought treatment from health facilities or health care providers in 2010

The national malaria strategic plan 2009- 2017 estimates the total financial requirement of US$ 1.6 billion over the period. External partners led by the Global Fund, PMI, DFID are projected to contribute over 90% of the funding requirements during the 1st four years of the plan. The government will contribute the balance. The plan anticipates a financing gap of in excess of 50% annually.

4. Key Challenges to the National HIV/AIDS, TB and Malaria Responses

Challenges facing the HIV responses include:

i) *High new infection rate among adults and paediatric infections:* In 2010 it was estimated that there were 132,000 and 34,000 new infections. This calls for more investment in prevention interventions. High levels of new infections will have implications on financial outlays on treatment in the coming years.

ii) *Mismatch between service provision and geographical prevalence*: Approximately 70% of PLWHIV live in the rural areas but services are concentrated in the urban/peri-urban areas. There is need to expand provision of services to reach the rural areas.

[24] Kenya Malaria Indicator Survey 2010

iii) ARV coverage: Only 35-45% of adults in need of ARV treatment have been reached with only 15% of children in need reached in 2007. Tough this coverage is now estimated at 75% there is need to cover the other 25% of patients in need.

iv) MARPS: Funding of interventions targeting MARPS in Kenya has in the past largely been funded by the Global Fund and other partners. The government of Kenya does not support interventions specifically targeting these groups.

v) Financing gap: The HIV response continue to be underfunded. According to the NSP 2009/2010-2012/2013 the total financing gap was US$ 1.6 billion over the period. A recent review on sustainability of the national HIV/AIDS response also estimates a financing gap of US$ 1.6 billion to 2019/20.

vi) Declining external support: PEPFAR, CHAI and MSF, currently leading funding partners of the HIV/AIDS response have indicated plans to gradually reduce their funding.

The national TB programme on the other has the following challenges:

i) Delays in TB diagnosis due to logistical challenges, unequal access to TB services and inadequate knowledge and skills in TB leading to transmissions.

ii) Inadequate involvement of community in TB care

iii) Lack of coordinated efforts to provide targeted services to specific population and vulnerable populations that are known to be high risk transmission

iv) Unresponsive M&E system that does not capture new interventions that are undertaken by the TB program.

Key challenges identified in the national malaria strategic plan include:

i) Net coverage and use of malaria prevention and treatment services are below targets

ii) Children seek treatment from health facilities/healthcare provider later than 24 hour after the onset of symptoms

iii) Only 29% of patients with fever receive the recommended ACT treatment

iv) The uptake of IPTs remain low at 13% of pregnant women receiving two doses of SP

v) Frequent stock-out of malaria commodities especially at the use facilities

vi) Malaria programme is heavily dependent on external funding

vii) Shortage of health workers across cadres compounded by skewed regional distribution as well as urban to rural distribution.

viii) Weal M&E system characterized by incomplete and inaccurate data

5. Sustainability strategies and approaches for the national HIV/AIDS, TB and Malaria response

The HIV AIDS Response

The sustainability strategies and approaches discusses in this section are those identified by the National AIDS Control Council as technically viable options. However some of options propose introduction of new taxes and will need goodwill and approval from the relevant authorities before they can be implemented. In this regard NACC is working with the Ministry of Public Health and Sanitation (MOPHS), Ministry of Medical Services (MOMS) and the Ministry of Finance to develop a Cabinet Memo for discussion and approval. The NACC has established a sustainability technical working group that is spearheading this initiative.

i) Government increase of funding for HIV and AIDS: The Government spending on health is about 5.2% of total government expenditure (NHA 2005/2006) much lower that the Abuja target of

15% of total government expenditure. Only 6.4% of the health sector budget is spent on HIV/AIDS even though HIV/AIDS now accounts for 15% of the under 5 child mortality rate and 20% of maternal mortality rate. A proposal to increase government budgetary allocation through the normal budgetary process has been made to fill the financing gap. This strategy would depend on the overall performance of the economy. The Kenya economy growth rate has on average been below 4%.

ii) Establish an AIDS trust Fund: An AIDS Trust Fund with a contribution of 1% of government revenue has been proposed. International experience with AIDS trust funds shows they improve the coordination and effective and efficient management of AIDS expenditure. Projections by the NACC technical working group show that a HIV/AIDS Trust Fund with a 1% allocation out of government revenue will cover 74% of the HIV financing gap up to 2019/20. Though this option looks technically feasible, its political feasibility may present challenges. This option was proposed in the Cabinet Memo developed by NACC.

iii) The National Hospital Insurance Fund: Several feasibility studies have indicated that the NHIF could expand its benefit package to include the cost of ARV and outpatient opportunistic infections. To finance the additional cost, the insurance premium would have to be increased, and the NHIF should be managed more efficiently, redirecting reductions in management costs to cover increased outlays for AIDS benefits. It is estimated that NHIF would generate substantial additional funding for AIDS of up to 58% of the financing gap in the period to 2019/2012[25]. Moreover NHIF would represent a stable, predictable and large scale financing stream for HIV and AIDS. The NHIF in Kenya is well established though in the past issues of probity in fiduciary management have been raised.

iv) Airline Levy: Introducing airline levy as a source of funding for HIV and AIDS is also being considered. Evidence from IATA, which represents the airline industry Worldwide, confirms that an additional tax of this kind is expected to have no effect on demand for air travel to Kenya. The airline levy is projected to fill 20% of the HIV financing gap to 2019/2020.

v) Improved efficiency and effectiveness: There are opportunities for filling the financing gap through efficiency gains on the current costs of services. Preliminary studies show that Kenya's HIV response is not fully efficient. Data from a cross-country review show that other countries achieve double the output in terms of people on ARV, PMTC and VCT, with the same amount of investment compared to Kenya. However there is need to investigate how and where efficiency gains.

vi) AIDS bond: An AIDS bond is another option on the table for discussion given Kenya's vibrant financial market. The bond could be issued by the government targeting large Kenyan businesses.

Discussions with the National Malaria Control Programme (NMTP) and Division of Leprosy, Tuberculosis, Lung Diseases (DLTLT) did not establish concrete sustainability initiatives though it was indicated that the Government had been approached to increase annual budget allocations to the 2 diseases and discussions were underway.

6. Sustainability of Global Fund Investments

The Global Fund investments in Kenya amount to US$ 479 million; US$ 235 million invested in HIV/AIDS, US$ 211 million in Malaria programme and US$ 32million in TB programme. Out of the 16 grants awarded 7 grants were under implementation. Three grants are in phase 2 of grant while the other 5 are in phase 1 of the grant. Table 19 shows the end dates of the specific grants. Kenya is classified as a lower income country by the Global Fund. The country is also a high impact country and therefore regarded as a strategic investment country. This means the country stands good chances of accessing future Global Fund support depending on performance of the existing grants and

[25] Sustainability Financing Review for AIDS in Kenya, July 2012

availability of funding. However Kenya like other countries is required to demonstrate increased counterpart funding[26]. At the same time the grants from the Global Fund are subject to the prioritization policy which may limit the level of funding the country may access in the coming years.

Table 19: Kenya grant portfolio end dates

Grant No	Principal recipient	Phase	End date
KEN-S11-G12-T	Ministry of Finance	1	30-6-2013
KEN -911-G11-T	AMREF	1	30-6-2013
KEN- H-MOF	Ministry of Finance	1	30-6-2014
KEN-H-KRC	Kenya Red Cross	1	30-6-2014
KEN-708-G10-H	CARE International	2	31-3-2014
KEN-011-G14-M	AMREF	1	31-01-2014
KEN-011-G13-M	Ministry of Finance	1	31-12-2013
KEN-405-G06-M	Ministry of Finance	NCE	31-12-2014
Source: The Global Fund Grant Management System			

Based on the high HIV prevalence in the country, NACC is of the view that Global Fund support should at the minimum be sustained at current levels. This is in line with the Cabinet Memo NACC has submitted requesting the Cabinet to approve more funding to the national HIV response. This scenario is the same for the Malaria and TB programmes.

Estimates of the level of funding required to sustain the national HIV/AIDS, TB and Malaria responses for the next 5 years are shown in the Table 20 below. The financing requirements were obtained from the National AIDS Strategic Plan 2009/10-2012/13, the National Malaria Strategic Plan 2009-2017and the DLTLD Strategic Plan 2011-2015. As the National AIDS Strategic Plan ends in 2013, financing requirements up to 2016/17 have been estimated to increase at 5% per annum in line with the trend observed in the current strategic plan. The country requires US$ 1.4 billion for the 3 disease in 2012/2013. This increases to US$ 1.5 billion in 2016/2017.

Kenya is a recipient of external support from various bilateral and multilateral partners including the Global Fund, PEPFAR, DFID, JICA, PMI, among others. It is projected that the country will receive same level of funding received in 2011/2012 amounting US$660 million. If maintained there will be a financing gap of US$ 748 million in 2012/2013 increasing to US$ 848 million in 206/2017. According the NACC, NMCP and DLTLD managers, there are on-going discussions on how the gap could be funded. These discussions are at initial stages and no indication on the source and level of funding is available at this time.

[26] Global Fund policy on counterpart financing

Table 20: Overall Financing gaps in US$ '000					
Financing requirements	**2012/13**	**2013/14**	**2014/2015**	**2015/16**	**2016/17**
HIV and AIDS	1,054,000	1,106,000	1,162,000	1,220,000	1,281,000
TB	58,317	57,572	59,275	59,275	59,275
Malaria	296,223	158,514	151,851	319,484	168,202
Total financing requirements	**1,408,540**	**1,322, 086**	**1, 373, 126**	**1,598, 759**	**1,508, 477**
Sources					
HIV and AIDS	590,000	590,000	590,000	590,000	590,000
TB	18,000	18,000	18,000	18,000	18,000
Malaria	52,000	52,000	52,000	52,000	52,000
Total resources	**660,000**	**660,000**	**660,000**	**660,000**	**660,000**
Financing gap	**748,540**	**662,086**	**713,126**	**938,759**	**848,477**
Source: Projections based on the HIV/AIDS 2009/10-2012/13 NSP, NMCP Strategic plan 2009/17 and DLTLD Strategic Plan 2011/2015					

7. Sustainability plan

A sustainability plan for the Global Fund supported programmes has not been prepared. The NACC has however initiated mechanisms towards addressing the issue of sustainable financing of the national HIV response. As mentioned earlier, NACC has submitted a Cabinet Memo seeking approval for increased funding through annual budgetary allocations by the Ministry of Finance, as well establishment of an AIDS Trust Fund. The Cabinet sought modifications to the memo and consultations between NACC, Ministry of Public Health and Sanitation (MOPHS), Ministry of Medical Services (MOMS) and the Ministry of Finance (MOF) are in progress.

Annex 4: Sustainability plan for HIV and TB response in South Africa

1. Background

South Africa, with a total population of 49.9 million people in 2010, has maintained a moderate population growth rate of between 1.0% and 1.35% over the last 10 years. The country's economy grew on average by 3.6% between 2002 and 20011. During the same period per capita income (constant 2,000 US$) grew from US$ 3,108 in 2002 to US$ 3,825 in 2010. Using the standard World Bank Atlas method that adjusts for exchange rates and the difference between a country's inflation and that of the worldwide inflation, GNI (Gross National Income) per capita (Atlas method) grew from US$ 2,620 in 2002 to US$ 6,960 in 2010. South Africa was classified by the World Bank as Upper Middle Income Country (UMIC), in 2004. The country's health spending averaged 8.3% of GDP over the last 10 years, 2002 to 2011, and is ranked 3rd among the countries' selected for this review. However with an expenditure on health as a percentage of total Government expenditure of less than 11.0% over the last 10 years, South Africa ranked 6th among the countries selected for the review. Though the country is UMIC, it is eligible for Global Fund grants because of extreme HIV and TB disease burden.

2. HIV and TB epidemic Profile

South Africa had an estimated HIV prevalence rate of 17.8% among the adult population aged 15-49 in 2009. The country has the largest HIV epidemic in the world with approximately 5.7 million people living with HIV and its related opportunistic infections contribute significantly to maternal mortality (50%) and mortality of under 5 years of age (35%).

According to a report on "Know Your Epidemic" survey of 2010 conducted by the South African AIDS Council (SANAC) new HIV infections were estimated at 343,249 annually. Among the 9 provinces of South Africa, Kwazulu-Natal led with 100,787 new infections followed by Gauteng with 68,618 new infections. It is estimated that in the next two decades, 5 million more South Africans will be infected. The HIV epidemic in South Africa is driven by biological (mother to child transmission, male circumcision), behavioural and social (early sexual debut, multiple sexual partners, use of condoms) and structural (mobility and immigration, gender roles and norms and sexual violence) factors. The South African HIV epidemic is heterogeneous within provinces, districts and sub-districts.

According to the World Health Organization (WHO) estimates, South Africa ranks third in the world after India and China in terms of TB burden. The Country had an incidence of 948 new infections per 100,000 population in 2010. The number of cases detected for all forms of TB has steadily increased from 148,164 in 2004 to 401,048 in 2010.

3. The National HIV Response

The Government of the Republic of South Africa has expanded HIV prevention, care, and treatment programmes since 2008. Key success of this expansion include the national HIV counseling and testing campaign with 20 million tests conducted since the start of the campaign in April 2010; the launch of the accelerated PMTC plan that has led to universal access to PMTCT services across the country and a decrease to 2.7% of early transmissions; significant scale up of voluntary medical male circumcision with 500,000 circumcisions conducted in 2011; a rapid increase in access to antiretroviral treatment (ART) with an estimated 1.7 million people on treatment in 2012 making it the world's largest ART program; and improvement of TB cure rate to 73%.

The National Strategic plan 2012-2016 has set the following goals over the next 5 years:

i) Reduce new HIV infections by at-least 50%, using combination prevention approaches;

ii) Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation

iii) Reduce the number of new TB infections, as well as the number of TB deaths, by 50%;

iv) Ensure an enabling and accessible legal framework that protects and promoted human rights in order to support implementation of the NSP

v) Reduce the self- reported stigma and discrimination related to HIV and TB by 50%.

The South Africa AIDS Council (SANAC) working in collaboration with other key stakeholders will coordinate the implementation of the NSP. To ensure appropriate governance and accountability the government appointed a review team to make recommendations on future governance and institutional framework for implementation of the NSP 2012-2016.

South Africa spent close to US$ 1.0 billion on HIV and TB in 2007/8 increasing by 39% to US$ 1.4 billion in 2008/9 and to US$1.6 billion in 2009/2010. Over this period the Government was the main source of funds contributing on average 75% while external resources contributed 16% and the private sector 9%[27].

4. Global Fund Support

The Global Fund is a major partner to South Africa's national HIV and TB response. According to the NASA report of 2012, The Global Fund contributed 65% of total multilateral funding, 12.3% of external funding and 2.1% of total funding. Global Fund has supported 8 grants amounting to US$ 243 million since 2002 when the country received the 1st grant. Three grants have since ended and currently there are 5 grants in progress amounting to US$ 150 million. All the 5 grants are in phase 1 with two grants ending date of November 2012 and 3 grants ending date of March 2013. The Global Fund at the request of the country has approved a cost extension of all the 5 grants phase 1 to end in July 2013. The country is in the process of preparing phase 2 renewal applications to be submitted in April 2013.

5. Financial Sustainability of the national HIV and TB Response

The NSP 2012-2016 estimates the total resource requirement of US $2.2 billion (ZAR 18.7 billion) in 2012/13 increasing to US$ 3.8 billion (ZAR 32.3) in 2016/17 to support the national HIV and TB response in South Africa. The rise in costs will obviously require the government to mobilize more funding further straining the already constrained public budget.

Table 21 shows the projected financing gap of the national HIV and TB response. The estimated financial requirements have been extracted from the NSP 2012-2016. Government of South Africa contribution from the domestic resources represent government commitment to the HIV response of 80%. Though South Africa receives support from several development partners the review has included contributions from PEPFAR and the Global Fund where figures are available for the period. The estimate builds in Phase 2 Global Fund support of US$ 312 million which is anticipated from the on-going renewal application to and negotiations with the Global Fund. The US$ 12.5 million available from the Global Fund to UMICs with extreme disease burden has also been factored in 2015/16 and 2016/17. With regards to the PEPFAR the PIF shows commitment to 2016/17 used in this estimates.

Given this scenario sustainability of the Global Fund programmes will have an overall financing gap shown in Table 21 below. In the first year there will be a gap of US$ 193 million growing to US$ 1.6 billion in 2016/2017. The gap is mainly because of the increasing financing requirements over the period and declining external resources without corresponding increase in domestic funding sources. Alternative sources of funding for prevention, care and support, HSS and supportive environment programmes currently supported by the Global Fund and PEFAR grants have not been identified. Secondly, the government has committed to funding 80% of the ARV treatment leaving 20% unfunded.

[27] National AIDS Spending Assessment, 2012

Table 21: Global Fund Financing Gaps for South Africa					
	2012/2013	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Financing needs	2,203,294	2,756,706	3,132,706	3,373,529	3,793,882
Financing sources: SAG	1,422,000	1,641,000	1,723,000	1,810,000	1,900,000
PEPFAR	484,000	459,000	413,000	350,000	250,000
Global Fund	104,000	104,000	104,000	12,500	12,500
Subtotal	**2,010,000**	**2,204,000**	**2,240,000**	**2, 172, 500**	**2,162,500**
Financing Gap	**193,294**	**552,706**	**892,706**	**1, 201,029**	**1,631,382**

Source: HIV/TB National Strategic Plan, 2012/16, Global Fund website and PEPFAR PIF

6. Key Challenges to the sustainability of the National HIV and TB Response

i) *High new infections*: In 2010 the estimated annual HIV incidence rate was 1.2% translating to 343,249 new annual HIV infections[28]. It is estimated that in the next decade about 5 million, approximately the same number of people currently infected, will be infected with HIV swelling the number of patients needing ARV treatment[29] . The increased number of infection present a financing challenge to an already constrained budget. The country needs to make more investments in prevention measures such as male circumcision, mother-to-child transmission and condom promotion that have demonstrated to have high impact in prevention of infections.

ii) *Low ART coverage*: Currently 1.8 million people (out of an estimated 3 million people in need) are under ARV treatment estimated to be 66% coverage of those in need. It is estimated that 5.6 million people are infected and will need ARV treatment in the coming years. The NSP goal is to ensure 80% of eligible clients are initiated on ART, and that 70% of those initiated on ART are alive and on treatment at the end of 5 years.

iii) Financing gap: It is estimated that the country's resource requirements for the national HIV/TB response will increase from US$ 2.1 billion in 2012/13 to US$ 4.4 billion in 2031. Though the government has allocated substantial resources to the HIV epidemic, even with the support of development partners, raising the required funds to support the interventions identified in the NSP plan will be a challenge given that external funding is declining and the government budget is already constrained. Exploring other new areas for funding HIV and the TB response such as a national insurance fund, AIDS trust fund, the private sector is necessary.

iv) Declining Government allocation to prevention interventions: The country's GDP growth rate in 2012 was 1.2% down from projected growth of 3%. Consequently in the 3 year budget for 2012/13, 2013/14 and 2014/15 the government has introduced reductions in public expenditure of 1%, 2% and 3% respectively. In the 3 year budgets, 2012/13 to 2014/15 the government has not allocated funds for HIV prevention interventions.

v) *High cost of ARV drugs*: The cost of ARVs in South Africa is one of the highest in the region. The annual cost of an ARV patient is approximately US$ 692 compared to an average of US$ 200 in the region[30]. There is need for reliable information for determining unit costs, service coverage and cost effectiveness for evidence based decision making.

vi) *Declining external Resources:* Though the country receives external support from multiple bilateral and multilateral sources, the government of United States, through PEPFAR has been

[28] Know Your Epidemic survey 2010

[29] Long Run Costs and Financing of HIV in South Africa

[30] Clinton Foundation study report, 2011

the highest source of external funding contributing 46% of the external aid in 2009/2010. According to PEPFAR this support will decline over the next 5 years to 2016/17 when it ends.

The above scenario requires clear financial sustainability strategies and approaches. The Government and all other stakeholders have initiated discussions aimed at identifying sustainability strategies.

7. National HIV and TB Response sustainability strategies and approaches

The country recognizes that in the long term it will have to rely on domestic resources to sustain the national HIV response. A review of the NSP, other national documents as well as discussions with key informants identified several measures that are being pursued to enhance sustainability of the national HIV response. Some progress had been made in implementing some of the measures while other are yet to be initiated.

Measure for broadening and enhancing domestic resource mobilization

i) Government funding of the cost of ARVs:

The government has significantly increased its spending on national HIV response since 2004. In 2009/0 government spending accounted for 75% of total expenditure. The government recognizes that sustainability of the national HIV responses relies on increased domestic spending and has committed to fund 80% of the cost of ARV needs in the country with effect from 2013/2014.

ii) Integrating HIV into the National Health Insurance

HIV treatment will be included in the package of chronic disease to be covered under the NHI fund. The government is piloting the use of NHI in 9 districts (one in each of the 9 provinces) in the country. It is expected that for planning purposes the pilot will be able to better estimate funding needs in the country based on the revised package and data collected during the pilot.

iii) Integrating care and support services into the poverty reduction programmes

The Government of South Africa funds several programmes aimed at supporting the poor people. The child care grants, disability grants and the foster grants include some of the grants currently offered by government. The integrated anti-poverty strategy brings several sectors together to develop sustainable interventions to reduce poverty and is funded by the government. This strategy provides an avenue to address the care and support services such as home-based care and OVC programmes. SANAC is exploring this as one of the strategies for sustaining the national HIV programme.

iv) Introducing innovative financing mechanisms

The NSP identifies excise taxes on tobacco, alcohol, and unhealthy foods as possible sources to fund the national HIV/TB response. AIDS levies on personal income tax and interest on savings or bank deposit are also proposed in the NSP. However progress has not been made in this area according to SANAC.

Measures to improving cost efficiency and effectiveness

(i) Integrating of HIV prevention, care and support services into the primary health care system and school education curriculum

Integrating prevention services into the primary health care systems and the school education curriculum is on-going. In this approach the national government is working closely with the provincial governments. Integration is expected to benefit from synergies that should improve costs and efficiency

(ii) Cost efficiencies and cost effectiveness

It is recognized that there are opportunities to enhance sustainability of the national response through cost efficiency and effectiveness. The government is therefore working with other partners in reducing the cost of inputs as well as streamlining the coordination and management of the HIV

programmes. In this regard the low price of ARV negotiated in the last tender issued by the government will see the cost of the ARVs reduced significantly.

8. Recommendations

According to SANAC, Global Fund support is seen as long term collaboration with South Africa for another 20-30 years. For this reason the country has no intention of assuming financial responsibility for Global Fund supported programmes at least in the near future. The Global Fund could however influence this position. Likely strategic options available include:

Measures to broadening and enhance resource mobilization

(i) Domestic Funding for the prevention component

SANAC sees opportunities to convince the government to commit itself to match public funding with the funding from development partners. The Global Fund would work with other partners and SANAC to lobby for this commitment.

(ii) Domestic funding for the care and support component

The Government currently funds several programmes targeting the poor and vulnerable groups. This could be tapped into to enhance domestic funding for care and support services currently required for OVC, PLHIV, and home based care.

(iii) Support to CSOs and MARPs

Interventions targeting MARPs and funding of CSOs involved in Global Fund programs face sustainability challenges given that the government has no specific support programmes for these groups. The Global Fund could strategically continue support to these activities while lobbying the government and privates sector to gradually assume financial responsibilities. South Africa support CSO with funds from the National Treasury as well as the provincial governments.

Measures to improve efficiency and effectiveness

Opportunities to improve cost of service delivery through efficiency and effectiveness exist. For instance, the October 2012, ARV tender by government realised significant reduction in unit cost demonstrated that there are enormous opportunities for enhancing sustainability through cost efficiency and effectiveness measures. The Global Fund would support efforts by the Ministry of Health and other development partners to further strengthen health and community systems for efficient and effective service delivery.

Annex 5: List of people interviewed

	Name	Designation	Organization and Location
1	Dr. Daniel Low-Beer	Head, Impact Results & Evaluation Department	Global Fund, Geneva
2	Dr. Ryuichi Komatsu	Senior Manager Impact Evaluation and TERG,	Global Fund, Geneva
3	Simon-Pierre Tegang	Specialist Impact and Evaluation	Global Fund, Geneva
4	Maria Kirova	Department Head; Asia, Europe, Latin America and the Caribbean	Global Fund, Geneva
5	Dr. Urban Weber	Department Head High Impact Asia 1	Global Fund, Geneva
6	Noemie Restrepo	Fund Portfolio Manager Latin America and the Caribbean	Global Fund, Geneva
7	Nicolas Cantau	Regional Manager, Eastern Europe and Asia Team	Global Fund, Geneva
8	Dr. Valery Chernyavsky	Fund Portfolio Manager Romania	Global Fund, Geneva
9	Phillippe Creac'H	Fund Portfolio Manager Thailand	Global Fund, Geneva
10	Debrework Zewdie	Deputy General Manager	Global Fund, Geneva
11	Sarah Churchill	Manager, Access to funding team	Global Fund, Geneva
12	Johannes Hunger,	Senior Manager Strategy and Policy Team	Global Fund, Geneva
13	Silvio Martinelli	Regional Manager Latin America and Caribbean	Global Fund, Geneva
14	Heike Allenndorf	Head, Fund Raising Strategy and Innovations;	Global Fund, Geneva
15	Makiko Takayama	Specialist, Fund Raising Strategy and Innovations	Global Fund, Geneva
16	Tarek Elshimi	Senior Advisor to the Deputy General Manager	Global Fund, Geneva
17	Dr. Mazuwa Banda	HIV Department	WHO, Geneva
18	Dr. Peter Olumese	Global Malaria Program STOP TB Department	WHO, Geneva
19	Edward Vela	Senior Advisor to the Executive Director	UNITAID, Geneva
20	Santiago Cornejo	Head of Immunisation Financing Country	GAVI Alliance, Geneva
21	Abdallah Bchir	Senior Specialist / Evaluation/Policy and Performance	GAVI Alliance, Geneva
22	Anja Nitzsche-Bell	Team Leader, Global Financial Mechanisms and Impact Team	UNAIDS, Geneva
23	Stephen Emblad	Head, Donor Relations Department	Global Fund, Geneva

	Name	**Designation**	**Organization and Location**
24	Dr. Victor Bampoe	Senior Fund Portfolio Manager, South Africa	Global Fund, Geneva
25	Dr. Shiva Murugasampillay	Global Malaria Programme	WHO
26	Perry Mwangara	FPM for Swaziland; Africa 2 High Impact	Global Fund, Geneva
27	John Ochero	FPM for Kenya; Africa 2 High Impact	Global Fund, Geneva
28	Ronald Tran Ba Huy	Regional Manager, Central Africa Team	Global Fund, Geneva
29	William Conn	PEPFAR Coordinator Caribbean	USG/USAID, Washington
30	Shiyan Chao	Senior Health Economist	World Bank, Washington
31	Michael Maragh	Principal Finance Officer	Ministry of Health,Jamaica
32	Dr. Pierre Somse	UNAIDS Country Coordinator for Jamaica, Belize, and The Bahamas	UNAIDS, Jamaica
33	Dr. Kevin Harvey	Director, Division of Chronic and Infectious Disease	NHP, MOH, Jamaica
34	Dr. Nicola Skyers	Directon, National HIV/STI Programme	NHP, MOH, Jamaica
35	Mrs. Sannia Sutherland	Head of Principal Recipient, Ministry of Health	NHP, MOH, Jamaica
36	Prof. K.C Househam	Head, Department of Health	Provincial Health Department Western Cape, SA
37	Teresa Gunthrie,	Executive Director	Centre for Economic Governance and AIDS in Africa (CEGEA), SA
38	Fareed Abdullah	Chief Executive Officer	CCM/SANAC Meeting,SA
39	Nevilene Slingers	Project Manager	SANAC,SA
40	Gert Van Der Mwere;	UGM/NGO Programme Manager	Right to Care(RTC),SA
41	Ian Ralph	Development Manager	Right to Care(RTC),SA
42	Marieta De Vos	Programme Director	Networking AIDS Community of South Africa(NACOSA),SA
43	Marc Myburg	Programme manager	National Religious Association of Social Development (NRASD), SA
44	Regina Ombam	Strategy Manager	National AIDS Control Council, Kenya
45	Dr. David Soti	Head, Division of Malaria Control	National Malaria Control programme, Kenya
46	Dr. J.K. Sitienei	Head, Division of Leprosy, TB and Lung Diseases	Division of Leprosy, TB and Lung Diseases, Kenya

Annex 6: References

1. The Global Fund Strategy 2012-2016- Investing for Impact; November 2011

2. Global Fund Consolidated transformation plan. November 2012

3. Global Fund Board Handbook

4. GlobalFund_SecretariatStructure_GrantManagement_April2012

5. Policy on eligibility criteria, counterpart financing requirements and prioritization of proposals for funding from the Global Fund, November 2011

6. New Global Fund funding model; Global Fund

7. Supplementary Guidance on the Transitional Funding Mechanism

8. National expenditure on health, 1995-2010; WHO

9. National Strategic Plan on HIV, STIs and TB, 2012-2016, Jamaica

10. Kenya National AIDS Strategic Plan 2009/10-2012/13

11. National Malaria Strategic Plan2011-2017; Kenya

12.End of Terms Review of the NSP 2007-2011, November 2011, Jamaica

13. Country health profile; WHO

14. Epidemiological fact sheet for HIV/AIDS, 2008; UNAIDS

15. Epidemiological profile for Malaria, 2010; WHO

16. Division of Leprosy, Tuberculosis and Lung Disease Strategic Plan, 2011-2015, Kenya

17. The Synthesis Report of the Kenya National AIDS Strategic Plan NSP 2009/10-2012/13, Mid-Term Review.

18.Lessons learnt from phase out of donor support in national family planning program, the case of Mexico, 2005

19. The long-run costs and sustainability financing report, South Africa, 2012

20. Guidelines for developing PEPFAR frameworks with emphasis on sustainability, 2011

21. Caribbean Regional HIV and AIDS Partnership Framework 2010-2014

22. Guidelines for preparing a national immunization programme financial sustainability plan, 2004

23. Financial Sustainability: The Gavi Experience, Kaddar, M and Levine, R.

24. Strategies for financial sustainability of immunisation programme: a review of the strategies from 50 national immunisation programme financial sustainability plans, Kamara et al. 2008

25. The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities

and Impact, UNAIDS, 2009

26. Kenya Malaria Indicator Survey 2010

27. Sustainability Financing Review for AIDS in Kenya, July 2012

28. National AIDS Spending Assessment, 2012

29.Know Your Epidemic survey 2010

30. Clinton Foundation study report, 2011

31. The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria. September 19, 2011

32. Technical Evaluation Reference Group, Report on the Assessment of Country Coordinating Mechanisms: Performance Baseline. October 2005

33. The Global Fund: Consolidated Transformation Plan, -Fifth Board Meeting GF/B25/4 Accra, Ghana, 21-22 November 2011 1/17