



FRENCH CONTRIBUTIONS TO THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

SYNTHESIS

EVALUATION REPORT



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Directorate-General of Global Affairs, Development and Partnerships

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AN EVALUATION OF FRENCH CONTRIBUTIONS TO THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Synthesis of the final report presented in August 2013

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Foreword

The Global Fund to fight AIDS, Tuberculosis and Malaria, founded in 2002, was an innovation in the domain of development aid, representing a new model of multilateral financing for the three pandemics.

Since its creation, the Global Fund to fight AIDS, Tuberculosis and Malaria has played a major role in the fight against the three diseases and has indisputably contributed to important advances, spectacularly increasing access to treatment and prevention measures in the countries in which the Fund operates.

France, which is a founder-member, is the Fund's second largest contributor worldwide and, since the Fund's inception, has enjoyed a firm political commitment at the highest level of the State. This position was renewed recently in July 2013 by the President of the French Republic who has decided to renew France's contribution in the amount of €360 million per year for the next three years.

The Global Fund to fight AIDS, Tuberculosis and Malaria is currently in a transitional phase following an in-depth examination of the sustainability of the model and the new funding mechanisms. So this assessment is taking place during a particularly pertinent period: it will afford the possibility of both learning from the past and allowing France to better specify its stance for the purpose of contributing to an improved functioning of the Global Fund to fight AIDS, Tuberculosis and Malaria. This report must not go unheeded; a certain number of recommendations can be operational in the coming months.

I would like to thank the numerous people who have participated in this assessment, both in France and in the field, and in particular the members of the steering committee whose involvement and commitment have been fundamental in guaranteeing the complete success of this assessment.

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Objectives and scope of the evaluation

Commissioned by the Directorate-General of Global Affairs, Development and Partnerships (DGM) at the French Ministry of Foreign Affairs (MAE), this evaluation covers France's participation in the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), a multilateral institution in which France plays a fundamental role as one of the founding members and second biggest contributor after the United States.

This has a dual dimension, both retrospective and prospective, responding to the public's need for information as channelled by Parliament and the French Court of Accounts, on the use of public funds and at the same time informing on France's international development strategy in a priority sector, health.

The Consultant has endeavoured to respond to each of the five defined objectives:

- analysis of the outcomes achieved by the GFATM programmes and the quality of the system put in place for measurement of those outcomes in priority countries for French Official Development Assistance (ODA);
- analysis of the action of the GFATM in those same countries;
- analysis of the consistency of the GFATM action with France's thematic priorities;
- establishment of a forward-looking analysis of the challenges arising from the change in the Fund's finance allocation model;
- evaluation of France's input to GFATM policy focuses and the effectiveness of its monitoring system.

The geographical scope comprises essentially the 16 poor countries defined as having priority for French ODA¹ in addition to five others in Sub-Saharan Africa (Cameroon, Congo, Côte d'Ivoire, Gabon and Rwanda). The analysis thus covers a total of 21 countries, to which may be added a regional "Abidjan-Lagos Corridor" programme involving five countries (Côte d'Ivoire, Benin, Ghana, Togo and Nigeria) for which the Principal Recipient (PR) is based in Cotonou.

The evaluation process is structured in four phases: framing, documentary examination and interviews, field missions and the drafting of the evaluation report. Two visits were arranged to the GFATM Secretariat in Geneva. The field missions were conducted over the period May to June 2013 in four countries: Democratic Republic of the Congo (DRC), Burkina Faso, Benin and Uganda (the latter being chosen for comparative reasons).

The GFATM rating system and its consequences for levels of disbursement

A1	Above 100%
A2	90% to 100%
B1	60% to 89%
B2	30% to 59%
C	Below 30%

1. Sixteen poor countries with priority for French ODA: Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Ghana, Guinea, Madagascar, Mali, Mauritania, Niger, Senegal, Togo. International Cooperation and Development Committee (CICID) 31 July 2013.

Preamble

The HIV/AIDS pandemic acted as a catalyst for the rapid transformation of global health governance. Following their appearance a dozen or so years ago (2000), vertical funds are now among the new instruments for development assistance.

The GFATM was set up in 2002 to meet an urgent need and to provide a comprehensive global response to the AIDS epidemic. As one of the founder members, France played a major role in its creation, notably by forming its precursor, the International Therapeutic Solidarity Fund.

The goal was the establishment of a partnership between governments, civil society, the private sector and development agencies. The basic concept was to design a new tool commensurate with the challenge and differing from the traditional approach adopted by United Nations bodies, these being judged to be insufficiently reactive and operationally ineffective. In the early 2000s the GFATM heralded – along with GAVI, the Global Alliance for Vaccines and Immunisation set up in 2000 – a new trend in favour of vertical programmes.

In 2006, UNITAID, the International Drug Purchase Facility, was formed at the instigation of France and Brazil. Its aim is to bring down prices and speed up the development of suitable, high-quality medical drugs to combat the three pandemics. Mainly funded by a solidarity levy on airline tickets, UNITAID has also contributed to the creation of the patent pool, which facilitates rapid arrival of the latest antiretrovirals in generic form in the poorest countries. UNITAID led to a reduction of nearly 50% in the prices of drugs used in programmes financed by the GFATM. Collaboration between UNITAID and the GFATM also covers the introduction of new tools and systems for the diagnosis and treatment of all three diseases. In this way, the GFATM also benefits directly from the programmes developed by UNITAID.

The Joint United Nations Programme on HIV/AIDS (UNAIDS), the GFATM, UNITAID and GAVI have changed the global governance of health substantially, notably by encouraging the participation of recipient countries, non-governmental organi-

sations (NGOs), civil society and representatives of patients in their management bodies. All these organisations and vertical funds work on a converging and mutually complementary basis, seeking rapprochement and synergy.

The specific character of the GFATM relates not only to its mode of governance, but also to its capacity to mobilise unprecedented financial flows against the three diseases, in addition to the scale of its scope of action. In the space of ten years it has become the world's main multilateral organisation for the raising of finance for health. It provides 82% of international funding against tuberculosis, 50% of that devoted to combating malaria and 21% of that dedicated to fighting AIDS. It also supports the strengthening of health systems, given that the inadequacies of the latter constitute one of the main obstacles to the intensification of intervention to improve the sanitary situation of populations affected by the three diseases².

On 15 July 2013, the President of the French Republic announced that despite budget constraints the French contribution to the GFATM would remain at at least the same level over the next three years (2014-2016), i.e. €1.08 billion. Maintenance of this level of funding has been made possible by the levy on air-tickets. Another contribution will also come from part of the proceeds of the financial transactions tax in place since August 2012.

Having contributed over €2.6 billion since the organisation was set up, France is the second biggest donor to the GFATM after the United States. It is also the leading contributor to the UNITAID initiative: French contributions from the proceeds of the air-ticket levy represented over 60% of that organisation's resources. The cumulative total of French contributions since the creation of GAVI in 2000 stands at \$254 million (ranking in 5th place among contributing countries). In conclusion, France has also continued to support UNAIDS by providing €600,000 in 2013 along with the assignment of experts (two experts at its headquarters and two at regional level) financed from funds available to the Ministry of Foreign Affairs.

2. Source : FMLSTP, June 2013.



France provides funding of €30 million to the World Health Organisation (WHO) every year, including €10 million in voluntary contributions, primarily focused on maternal and infant health (€4.5 million), sanitary security (€2.3 million) and public health protection (an annual average of €500,000 from 2009 to 2012). France also contributes to the funding of expertise at headquarters level (9 experts) and out in the regions (4 experts). Added to these contributions is finance for more specific projects by the Ministry of Social Affairs and Health and its agencies (health-environment, non-communicable diseases, etc.).

France is therefore one of the foremost donors where global health is concerned³. This high level of commitment is also one of its specific features. It has chosen to support vertical funds and organisations acting in pursuit of Millennium Development Goals (MDGs) 4, 5 and 6, aiming in this way to ensure consistency in its choice of programmes and partners, as well as generating greater leverage for its funding. The forms of financial support provided by France to the GFATM, UNITAID and GAVI are mutually complementary and allow the results achieved by each of these institutions to be “pooled” (for example, UNITAID has obtained a substantial reduction in the price of inputs used by the GFATM). France’s presence in the governance bodies of these three vertical funds also helps it to ensure the coherence of the action taken and to promote collaboration and efforts to ensure synergy.

However, France’s discretion in its outreach policy and the lack of visibility given to this major contribution are to be regretted.

3. Source: France at the UN, Website of the France’s Permanent Mission to the United Nations, July 2013.

Chapter 1

THE GFATM'S STRONG COMMITMENT TO PRIORITY COUNTRIES FOR FRENCH ODA

1.1. Remarkable progress achieved in Sub-Saharan Africa

A reduction in the burden of morbidity and mortality linked to AIDS, tuberculosis and malaria has been recorded in all countries where the GFATM is active. This trend is also true of the 16 priority poor countries as defined by the International Cooperation and Development Committee (CICID) and across Sub-Saharan Africa in general. The Fund has made possible a rapid increase in available finance to address the three diseases and to extend sanitary coverage and access to treatment and medical drugs for the general population.

It is nevertheless important to emphasise that this progress is the result of joint efforts by the various bilateral and multilateral international partners⁴, with the GFATM acting to supplement the financial efforts made by those partners.

In spite of this undeniable progress, the results fail to match the targets of the Millennium Development Goals for a 50% reduction in AIDS mortality and its incidence, a 75% cut in incidence of malaria and tuberculosis, and zero mortality from malaria by 2015.

However, it is the view of all observers, actors in the field and representatives of public authorities that the withdrawal of the GFATM from the countries of Sub-Saharan Africa would constitute a "sanitary disaster".

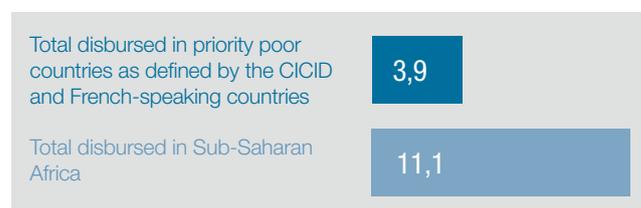
France's support for the GFATM is therefore relevant with respect to the burden that the three diseases continue to represent in Sub-Saharan Africa. Furthermore, the GFATM provides an effective channel for funding to combat all three diseases.

1.2. Investment of major levels of finance in priority countries for French ODA

By the end of July 2013, the GFATM had approved grants totalling \$25.6 billion for over one thousand programmes in 150 countries (775 active grants in July 2013). At that same date, the Fund had disbursed \$20.2 billion, 55% of which went to Sub-Saharan Africa.

At the end of July 2013, the total amount of finance approved for the 21 countries within the scope of this evaluation, and for the regional programme, stood at \$5.2 billion and 225 grants, 177 active, or 20.3% of the total funding approved and 22.8% of all active grants. The 21 target countries also account for 35% of total disbursements in Sub-Saharan Africa (\$3.9 billion) and 36.9% of amounts approved for the region.

Disbursements in Sub-Saharan Africa (billion dollars – July 2013)



Source : FMLSTP, July 2013.

4. US President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative, World Bank, Stop TB, GIP ESTHER, etc.

In those 21 countries, almost 48% of the total volume of finance related to HIV/AIDS (\$2.5 billion), 41.4% to anti-malaria programmes, while support for programmes against tuberculosis accounted for no more than 8.4% of the total. Finally, 2.3% of approved finance related to grants specifically dedicated to health system strengthening. This percentage is not representative however of the financial effort devoted to this component, the vast majority being included in grants linked to one or other of the three diseases.

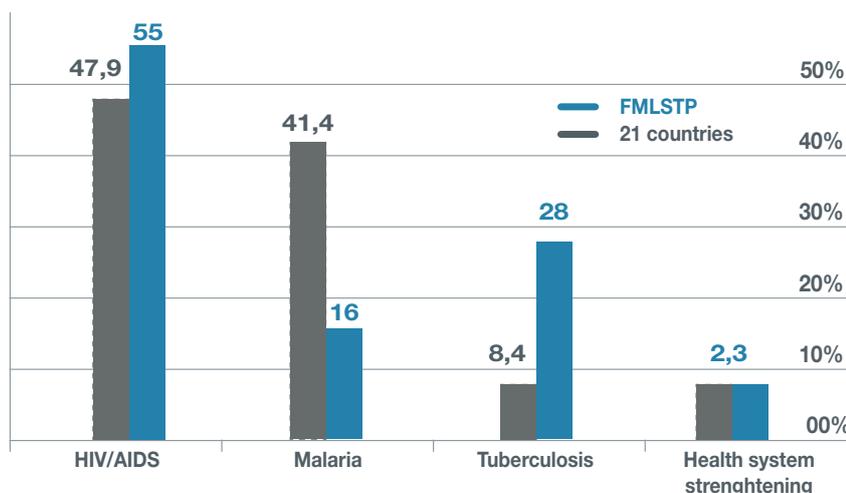
In the 21 countries under consideration, the share devoted to HIV/AIDS is comparatively smaller than the overall trend observed for the GFATM portfolio as a whole (47.9% as compared with 55%), while the share for malaria is noticeably greater (41.4% against 18%). The proportion dedicated to tuberculosis is on the other hand very substantially smaller (8.4% against 28%).

The following table provides an overview for the 21 target countries and for the regional programme of funding volumes approved and committed and the levels of disbursement as recorded in July 2013.

The levels of disbursement as compared with the amounts approved by the Board stand at between 73.9% and 76.6% for the three diseases, while the figure is no more than 49.4% for components linked to health system strengthening, which goes some way to explaining the difficulties encountered by operators in conducting the activities concerned.

The table on the following page provides an overview for the 21 target countries and for the regional programme of funding volumes approved and committed and the levels of disbursement as recorded in July 2013.

Comparison of the respective shares of funding devoted to each disease : overall trend for the GFATM and the situation in the 21 target countries



Source : Figures consolidated by the consultant from GFATM data, July 2013.

Total funding formally approved and committed in the 21 countries covered by the study
(in millions of dollars)

Country and category	Population	HIV prevalence in adults 2011 ⁵	Total of fundings signed, million dollars	Amounts committed (approved), million dollars	Percentage of amounts signed towards committed	Total disbursed	Percentage of amounts disbursed towards signed	Percentage of amounts disbursed towards committed
Benin (LIC)	8 850 000	1,2%	221,87	170,68	76,9%	138,69	62,5%	81,2%
Burkina Faso (LIC)	16 469 000	1,1%	311,24	292,19	93,9%	252,18	81%	86,3%
Burundi (LIC)	8 383 000	1,3%	260,85	191,47	73,4%	171,64	65,8%	89,6%
CAR (LIC)	4 401 000	4,6%	96,35	96,35	100%	76,22	79,1%	79%
Chad (LIC)	11 227 000	3,1%	126,07	87,16	69,1%	84,61	67,1%	97%
Comoros (LIC)	735 000	0,1%	17,72	14,881	84%	13,64	77%	91,7%
Djibouti (LMIC)	889 000	1,4%	28,85	24,35	84,4%	23,80	82,5%	97,7%
DRC (LIC)	65 966 000	ND	881,29	769,39	87,3%	630,70	71,6%	82%
Ghana (LMIC)	24 392 000	1,5%	481,12	418,65	87%	390,56	81,2%	93,3%
Guinea (LIC)	9 982 000	1,4%	116,04	106,04	91,4%	71	61,2%	67%
Madagascar (LIC)	20 714 000	0,3%	294,16	277,82	94,4%	243,18	82,7%	87,5%
Mali (PRF)	15 370 000	1,1%	255,32	160,58	62,9%	116,14	45,5%	72,3%
Mauritania (LIC)	3 460 000	1,1%	16,79	16,79	100%	15,33	91,3%	91,3%
Niger (LIC)	15 512 000	0,8%	123,70	112,12	90,6%	104,85	84,8%	93,5%
Senegal (LMIC)	12 434 000	0,7%	223,61	197,90	88,5%	161	72%	81,3%
Togo (LIC)	6 028 000	3,4%	189,029	167,11	88,4%	144,66	76,5%	86,6%
PPC subtotal	224 812 000	-	3 644,08	3 103,6	85,2%	2 638,3	72,4%	85%
Cameroon (LMIC)	19 599 000	4,6%	290,13	267,62	92,2 %	226,99	78,2%	84,8%
Côte d'Ivoire (LMIC)	19 738 000	3%	285,13	231,63	81,2%	192,36	67,5%	83%
Congo (LMIC)	4 043 000	3,3%	86,55	85,30	98,6%	50,75	58,6%	59,5%
Gabon (UMIC)	1 505 000	5%	31,35	29,60	105,9%	29,27	93,4%	98,9%
Rwanda (LIC)	10 624 000	2,9%	846,19	832,66	98,4%	758,89	89,7%	91,1%
Subtotal other French-speaking countries	55 509 000	-	1 539,4	1446,8	94%	1258,3	81,7%	87%
Abidjan-Lagos corridor	-		35,41	26,14	74%	26,14	74%	100%
TOTAL	280 321 000	-	5 218,87	4 576,54	88%	3 896,56	74,66%	85,4%

NB: Low income countries (LIC) ; low middle income countries (LMIC) ; priority poor countries as defined by the CICID (PPC); upper middle income countries (UMIC).
Source: GFATM, July 2013.

5. Source: UNAIDS, 2011 Report.

Chapter 2

OVER-COMPLICATED, TOO-FREQUENTLY MODIFIED GRANT MANAGEMENT PROCEDURES

The procedures for the management of finance granted by the GFATM are generally perceived by operators as complicated, requiring a great deal of time and in some cases as not always ideally suited to the circumstances in priority poor countries and Sub-Saharan Africa.

In addition, in high-risk countries, the procedures have undergone frequent changes and adjustments in the last two or three years, which makes ownership of the mechanisms, procedures and timeframes even more difficult for the principal and sub-recipients, requiring them to adapt constantly to new GFATM rules and requirements.

Lastly, all contractual documents are in English despite the fact that the negotiations, interim documents and management letters are in French. A number of information notes and reports are not in fact translated into French, and this is a problem for French-speaking African countries. The scale of the contribution made by France to the GFATM, and the extent to which French-speaking countries in Sub-Saharan Africa form part of the grant portfolio, argue for greater use of the French language in dealings between the GFATM and the countries concerned.

2.1. Procedures differentiated by groups of countries with an excessive focus on financial risk

The GFATM has moved from a uniform approach to financing to one differentiated by groups of countries based on a categorisation of risks and the principle of zero tolerance for risk of embezzlement and fraud. In accordance with this risk management framework, the procedures for the management and control of funds granted by the GFATM are also in turn “graded” depending on the country and the beneficiary. On the basis of the applied classification, 88% of French-speaking countries in Sub-Saharan Africa present an extreme or high risk and are therefore subject to more stringent levels of control and supervision than other countries⁶.

In the four countries visited, all of which are classified as high-risk, the financial risk and embezzlement prevention aspect plays a central role in the procedures for monitoring the funding granted by the GFATM. The other risks, most notably those linked to beneficiaries’ ability to manage and absorb the funds, receive less sustained attention.

The emphasis placed on the prevention of financial risk may be explained as a response to the crisis of confidence triggered at the end of 2010 by press reporting of the information contained in the public report issued by the Office of the Inspector General revealing the misuse of GFATM grants in Mali, Mauritania, Zambia and Djibouti. However, the principle of zero tolerance of financial risk should not blind us to the other operational risks (governance, availability of personnel, supervisory capacity, etc.), these being just as important for the effectiveness, efficiency and impact of the grants provided.

2.2. A limited role is accorded to local NGOs

While the breakdown of funding between public and private recipients is fair in the countries visited, only a limited role is accorded to local NGOs. In the four Sub-Saharan countries visited, there is a fair breakdown of funding between public and private sector recipients. With the exception of Uganda, private-sector recipients are usually international, often American, NGOs. In those countries, local NGOs express regret that they have only a limited part to play in the programmes financed by the GFATM. These claims are made against the backdrop of a reduction in the number of sub-recipients and the role allocated to local NGOs may therefore become even more limited, despite the fact that their involvement contributes to ownership by the country, skill transfer and promotion of local civil society. The possibility of fostering partnerships between international and local NGOs should for this reason be considered and encouraged by Country Coordinating Mechanisms (CCMs). French NGOs have an important part to play in advocacy in favour of their counterparts in the South.

6. Source : GFATM.

2.3. A step towards a necessary strengthening of the CCM entities

It seems necessary to reinforce the management and supervisory capacities of Country Coordinating Mechanisms to make them more operationally effective and responsive. In a large number of countries greater attention has been paid to the setting up of the “CCM entity” in accordance with the rules defined for its composition and the representative character of its stakeholders, than to any genuinely effective support for the “CCM function” in terms of responsibilities, preparation, submission and supervision of programmes at national level⁷. This was found to be the case in three of the four countries visited where there are problems with the Country Coordinating Mechanisms (Benin, Burkina Faso and DRC).

Another tendency that was generally observed in CICID and French-speaking Sub-Saharan countries relates to the absence of representation of medical practitioners and healthcare personnel in these bodies. This lack deprives the Country Coordinating Mechanisms of core expertise when choosing the activities most appropriate to reach target groups, discussing treatment protocols and, lastly, determining which approaches are to be prioritised.

CCM consolidation and the adoption of clear and transparent operating rules are a prerequisite for the implementation of the new funding model on the basis of satisfactory consultation. Reinforcement of their management capacity, particularly where their permanent secretariats are concerned, is also a priority. The role of the CCM will need to develop further in the context of the iterative process of dialogue gradually established between the Global Fund Secretariat and these countries, with greater responsibility for the coordination of discussions and procedures with the main stakeholders. At the same time, in 2012 support for CCM operations represented no more than 1.5% of the operating costs of the GFATM, for a total of \$4.480 million, including approximately \$1.2 million in priority poor countries as defined by the CICID and Sub-Saharan African countries⁸. This financial support needs to be increased if these bodies are to function satisfactorily.

In order to make them more operationally effective and responsive, CCMs should be organised along the lines of corporate management boards, whereas in their present configuration they operate more like general meetings. A trend towards reductions in the number of members sitting in these bodies is envisaged, or has already begun, in several priority poor countries and French-speaking Sub-Saharan countries. If CCMs become smaller, this will entail the downsizing of the representation of each component group, including the Technical and Financial Partners (TFP).

It is important for France to prepare for these changes in advance and to formulate recommendations for its diplomatic posts in order to implement the required strategy to ensure its presence in the CCMs of priority countries for French assistance. The position adopted by France should be differentiated according to the country concerned and its zones of influence

2.4. Lead-times to grant disbursement and the obtaining of “no objection” letters need to be improved

These lead-times continue to be excessively long in most priority countries for French assistance. In all four countries visited, principal recipients report lead-times of four to six months for the disbursement of their grants, or even longer where difficulties arise. Such timeframes can be put down to the series of stages and actors involved in the verification and validation of action plans. In part, it can also be explained by the difficulties encountered by certain principal recipients in satisfying the conditions, most notably those of structural character, laid down for the payment of the various fund tranches⁹.

At the same time, the GFATM will not agree to allow operators to prefinance activities other than in exceptional cases at times when grants are being reprogrammed, while advances paid out to operators do not exceed tide-over periods of three months (for half-yearly grant disbursements).

7. Source: *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Synthesis of Study Areas, 2 and 3*, March 2009.

8. Source: GFATM, Annual Report of the Global Fund to Fight AIDS, Tuberculosis and Malaria, 2012 and CCM-2012 Funding Disbursements.

9. The consultant defines structural conditionalities as those not directly related to the routine activities of projects (definition of a PSM plan, detailed definition of training plans, etc.), but more particularly to governance structure and grant management at the level of the beneficiary country.

This context is a source of difficulty and contradictory situations for operators. The rating system used by the GFATM is based on a framework of programmatic and financial performance. It is however difficult for operators to achieve the target levels set when the funding is not available. Such disbursement timeframes sometimes lead principal recipients to assure their organisational overheads alone, suspending the majority of their activities, which would appear to be in contradiction to the defined objective of cost effectiveness, the primary goal of the GFATM being to fund activities on the ground.

Aware of these difficulties, early in 2013 the GFATM switched the majority of its grants over to an annual disbursement cycle, offering principal recipients greater flexibility in how they operate and more peace of mind in managing their grants and their dealings with the GFATM. The Fund is also ready to authorise six-month tide-over payments if requested by a principal recipient.

The only grants still subject to a half-yearly cycle are those for which major levels of risk have been identified. Numerous grants of this kind relate to priority poor countries and French-speaking Sub-Saharan countries. This observation calls for support for the principal recipients concerned in order to allow them also to benefit from the advantages offered by an annual disbursement cycle.

The lead-times for obtaining “no objection” letters constitute a further problematic aspect for principal recipients and sub-recipients. The GFATM applies these procedures on an exceptional basis and in response to an identified risk. A large number of principal recipients in priority poor countries and French-speaking Sub-Saharan countries are however subject to such measures (these being high-risk countries).

2.5. Procurement and Supply Management: a major bottleneck in project implementation

The procurement of health products takes up 39% of all finance provided by the GFATM. For many principal recipients, the drawing up of a Procurement and Supply Management plan for medical

drugs and other health products (PSM Plan), including forecasts of consumption two or three years ahead, has been or continues to be a major difficulty. This is particularly the case for HIV/AIDS grant components.

This situation can be put down to an inadequate grasp of actual numbers of active patients and problems in planning and quantifying requirements, leading to bottlenecks in procurement and stock management processes.

Stock outages of antiretrovirals (ARV) and screening reagents have occurred in certain countries, although it is difficult to assess the precise extent of such shortages (the statements of those involved are contradictory). This state of affairs creates problems of treatment observance, possible resistance to the line of treatment adopted and ethical issues with regard to those living with HIV/AIDS.

A Voluntary Pooled Procurement mechanism (VPP) has been put in place for a transitional period in 12 countries in West and Central Africa (involving 23 grants). In 2010 and 2011 VPP led to cumulative savings of \$57.7 million, representing 16% of the total volume of finance initially provided for in PSM plans¹⁰. This system offers a solution for some of the difficulties encountered: the procedure for awarding contracts and direct payment of suppliers by the GFATM. On the other hand, it does not resolve the issues arising from the quantification of requirements in relation to correct management of a body of active patients, shorter procurement times (nearly 9 months from order to delivery) and inventory management. The use of this mechanism also appears to be incompatible with the objective of ownership by the countries concerned and the strengthening of their health systems and institutional capacities since they are no longer masters of their own procurement and contract award processes. On the other hand, it does offer greater security for the GFATM with regard to financial risks and helps put an end to cumbersome, slow “no objection” procedures.

The relevance of this mechanism varies greatly according to the circumstances in the country concerned. It is for that reason impossible to adopt any one fixed position on the matter.

10. Source: VPP evaluation report – GFATM – March 2012.



2.6. Difficulties for the implementation of components relating to health system strengthening

The lessons learned from previous grant series show that this component has all too often come up against difficulties in its implementation. A barrier exists at the levels of both the GFATM Secretariat and the beneficiary countries themselves to arriving at an effective grasp, quantification, including in financial terms, and measurement of the outcomes of the activities conducted, due to a lack of financial and operational traceability. Responsibilities have been entrusted in the area of health system strengthening to principal recipients, NGOs for example, for which, firstly, they were not prepared, and secondly, they do not have the necessary political support and technical legitimacy. The definition of the scope and extent of such programmes has often been lacking in holistic and systemic reflection aimed at greater coherence and integration into the health systems of countries that it is hoped to strengthen. And lastly, most of the actions funded under this heading in priority poor countries and French-speaking Sub-Saharan countries have obtained low ratings (B2 or C), which has a direct impact on the authorisation of disbursement for the programmes involved. These activities thus show relatively low levels of disbursement of around 49.4%.

Health system strengthening is a fundamental condition to be met if good performance is to be guaranteed for programmes financed by the GFATM in low-income and low middle income countries. The new funding model places greater emphasis than in the past on this component and allows countries to submit comprehensive proposals where the relevant activities also serve programmes against all three diseases. Greater scope than before is thus provided to beneficiary countries in this respect.

Given the weaknesses currently observed, this funding component should be a key element in improving the context for the implementation of the new funding model.

2.7. The operational research budget needs to be mobilised to a greater extent

Principal recipients have the option of including operational and programmatic research in grants from the GFATM up to a maximum of 5% of the overall budget. This option is not however used to maximum effect by the countries concerned.

In addition, only approaches validated by WHO can be financed by the Fund; the content and scope of proposed research programmes should therefore take this imperative into account.

Chapter 3

THE OPPORTUNITIES AND RISKS LINKED TO THE IMPLEMENTATION OF THE NEW FUNDING MODEL

The new funding model entails a major change in the manner in which project managers can access finance, transforming a request for finance into a deployment-ready grant.

3.1. A simplified procedure, a more flexible timetable, two possible funding channels

The new model provides countries with access to two sources of funding. The first, the most extensive and predictable, is indicative country finance based on the country's morbidity burden and the ability of the beneficiary country to ensure the "Counterparty Funding" now required by the GFATM to enhance the long-term viability of programmes¹¹. Each country will be informed of the indicative funding range in which it is placed, which will allow it to start the process of consultation of its partners and the preparation of its application. The second source, with an emphasis on competition, is incentive financing aimed at rewarding high-impact projects that produce good results.

Priority will be given to the countries with the greatest morbidity burdens and limited financial resources, while at the same time preserving the international diversity of the portfolio.

Based on these two funding channels, the new model is aimed at ensuring greater flexibility for the submission of applications for finance and greater visibility of the funds available to each country.

3.2. A tighter alignment with national strategies and a new concept note template

Concept notes, based on national strategies, are the "vehicles" countries use to submit their applications for grants to the GFATM for the three diseases and/or horizontal community and/or health system strengthening programmes. Therefore, the new concept note template will affect the content of grant applications.

For the concept note presentation template for use by first-phase applicants¹², the GFATM includes specific sections devoted to description of the following:

- The process whereby applications are drawn up and principal recipients selected, including the criteria to be applied in handling any conflicts of interest. Any CCM that does not submit a "dual-track" funding application¹³, i.e. an application that does not involve principal recipients from the public and private sectors, should give the reasons for this (indirectly encouraging CCMs to favour this type of partnership).
- Factors that may lead to inequality in access to treatment and prevention services such as gender-related norms, legal and political barriers, stigmatisation or discrimination.

By including these "questions" in its concept note template, the GFATM is adopting a more directive posture than in the past in order to lead countries firstly to prepare their applications on the basis of clear rules for transparency and consultation and, secondly, to include specific activities under key headings: public-private partnership, combating discrimination and access to healthcare for marginalised population groups. Systemic barriers to reduction of the disease burden should also be described, which is likely to improve the correlation between health system strengthening activities and activities directed at combating the three diseases. This approach is aligned with the values and priorities promoted by France.

11. Minimum thresholds for counterparty funding depend on the country's income category: low income: 5%; lower middle income – bottom of the range: 20%; lower middle income – top of the range: 40%; upper middle income: 60%.

12. Six countries and three regional programmes have been invited to take part in the process as a whole as first-phase candidates: DRC, El Salvador, Kazakhstan, Myanmar, the Philippines and Zimbabwe. The funding agreements with these countries are likely to be signed in the autumn of 2013. Implementation of the new funding model will begin at the end of 2013 once the amount of funding available for 2014-2016 is known.

13. This is the terminology used by the GFATM in its framing documents.

In addition, it is clear that the concept note template to be defined by the GFATM will guide applications from beneficiary countries and influence some of their priorities.

3.3. Priority countries for French assistance are as yet unprepared for implementation

Generally speaking, leaving aside the DRC, which is one of the pilot countries, the other countries of Sub-Saharan Africa have all been informed that a new funding model will shortly be put in place and all are aware, with varying levels of interpretation, of its general objectives. Conversely, few have any precise idea of the stages in the application process, the expected content for the concept note, the methodologies and consultations required for the definition of proposals or the consequences in terms of choices of funding allocation between the three diseases. They are as yet unprepared for the implementation of the new model despite the fact that it will involve fundamental changes in the process whereby grants are prepared and negotiated.

It is important for beneficiary countries and their technical and financial partners to have available to them as soon as possible the information and conceptual tools to allow them to prepare as best they can for this new stage in their relations with the GFATM. France and its operators such as AFD, ESTHER and the “5% Initiative” scheme can make a major contribution to assisting priority poor countries and French-speaking Sub-Saharan countries in drawing up their proposals and in providing the forms of support that may possibly be necessary at the various stages of implementation.

3.4. The new funding model, a step towards an improved functioning?

An analysis of the framing documents and the information notes currently available makes it possible to anticipate consequences and potential risks that may arise from this new model.

3.4.1 Expected positive consequences

3.4.1.1 Limitation to exceptional cases of funding subject to conditionalities of structural type¹⁴

A fundamental change brought in by the new model relates to the fact that unlike the model currently used the country team at the Fund Secretariat is involved in giving a favourable opinion ahead of Board approval of the grant. The main aspects relating to the management of operational and financial risk are addressed in advance. Activities can therefore start immediately after the Board gives its approval. The aim of this new approach is also to limit conditionalities of structural character to exceptional cases, or even eliminate them altogether. Such an approach also makes it possible to give more consideration to beneficiary countries' management and absorption capacities and to improve upstream analysis of the conditions for feasibility of the proposed activities (principle of realism).

3.4.1.2 Greater flexibility for the preparation of funding applications

The alignment of funding applications with national budget cycles and specific national constraints will give individual countries the time they need to prepare their applications and to conduct their national consultation process.

3.4.1.3 Enhanced participation by the Fund Secretariat

The new funding model involves the Fund Secretariat in more proactive participation in ongoing dialogue at country level. Portfolio managers will also spend more time in the field. This enhanced participation, which has in fact already begun, can genuinely contribute to greater fluidity in dealings between principal

14. The consultant defines structural conditionalities as those not directly related to the routine activities of projects (definition of a PSM plan, detailed definition of training plans, etc.), but more particularly to governance structure and grant management at the level of the beneficiary country.

recipients and GFATM representatives, improve understanding of constraints and imperatives by all concerned and promote better cooperation in the search for solutions in the event of difficulties, abiding by the GFATM's non-interference policy.

More involvement by local fund agents in the preparation process for the “new generation” grants should be encouraged in order to capitalise on their extensive experience of local circumstances and their knowledge of the management and absorption capacities of likely principal recipients.

3.4.2 Main identified risks and points on which vigilance is needed

3.4.2.1 The need to ensure a fair balance in the finance allocated to the three diseases in accordance with the individual country's disease burden

The new funding model transforms a system of “competition” between countries for finance from the GFATM into a system for internal national competition between the three diseases. However, efforts to counter these three diseases are not promoted identically either in civil society in general or in CCMs in particular. Due to their history and their major advocacy role, organisations representing individuals living with HIV/AIDS are far more structured and active than their counterparts, where the latter even exist, for the other two diseases.

In some priority poor countries there is a risk that a disproportionate share of the indicative country envelope will be devoted to HIV/AIDS, to the detriment of the other two diseases. Avoidance of this risk presupposes national strategic reflection to define the major balances to be preserved in the efforts devoted to the respective national plans against the three diseases, taking account of the morbidity burden.

This is an important point on which vigilance is particularly required from national authorities, CCMs, GFATM portfolio managers, representatives of civil society and technical and financial partners.

3.4.2.2 Expected consequences of the breakdown in indicative and incentive envelopes for priority countries for French assistance

The effect of the definition of percentage allocations of resources for “country indicative envelope” funding channels and “competitive finance” will not be insignificant for priority countries for French assistance.

Priority poor countries and French-speaking Sub-Saharan countries in Africa are all low-income or lower middle income countries characterised by inadequate institutional capacities. In many cases, they have difficulty in employing the grants allocated to them by the GFATM within the allotted timeframes because their levels of programmatic and financial performance are far from ideal. As an illustration of this, the scores obtained for French-speaking Sub-Saharan countries and those of English- and Portuguese-speaking countries are compared below (see table on the following page).

The number of grants rated A1 is much higher in English- and Portuguese-speaking countries (9.28%) than in those that are French-speaking (3.11%). This gap also applies, although it is less marked, to grants rated A2 (8.07% against 12.9%), B1 (30.4% against 34.5%) and B2 (24.2% against 18.6%). Lastly, only 4.12% of grants going to English- and Portuguese-speaking Africa are rated C, whereas this category accounts for 11.8% of grants in French-speaking countries.

Certain countries in French-speaking Sub-Saharan Africa are therefore at risk of being less effective than their neighbours in this “competition” or they may even, if the percentage allocation of the incentive envelope is set too high, see an overall cut in the finance granted to them.

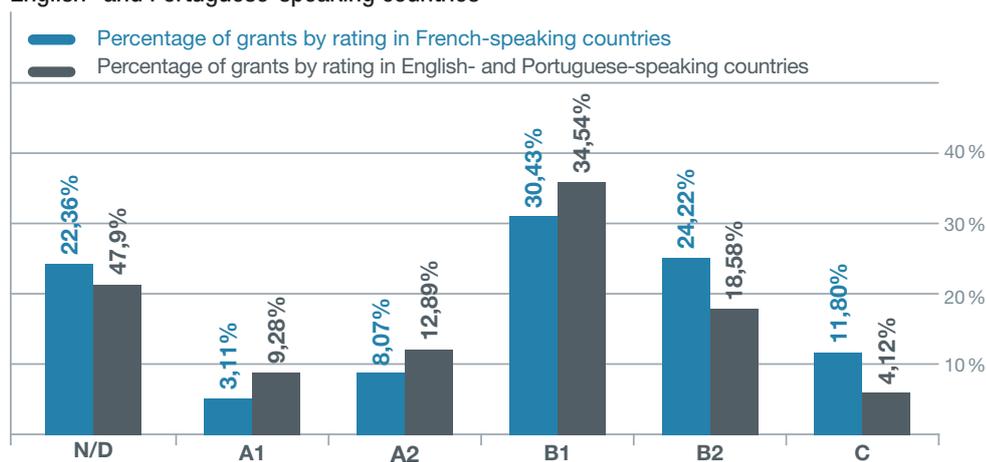
It is therefore possible to conclude that at percentages greater than 10% of total finance this choice would be detrimental to some French-speaking countries at greater risk than their neighbours of encountering difficulties in obtaining supplementary funding.

3.4.2.3 More information on the selection criteria that will be applied by the GFATM in order to support priority countries for French assistance more effectively

The presentation and framing documents published by the GFATM stress the priority that will be given to high-impact investment. A number of strategic information notes intended to guide beneficiary countries in drawing up their proposals are already available.

In addition to such information notes, it is also important that the GFATM should set out in more detail the criteria it will itself be using to determine which investments have high impact and to select applications presented for the two funding channels, “country indicative” and “incentive”. Information on these criteria will enable more effective support to be given to priority countries for French assistance in drawing up their proposals.

Breakdown by grant rating between African French-, English- and Portuguese-speaking countries



Source : Data compiled by the consultant based on the GFATM website, July 2013.

Chapter 4

French input on GFATM policy focuses and the effectiveness of its monitoring system

4.1. Priorities and values very similar to those of France

As a founding member of the GFATM, France has brought to it its values, principles and priorities, both thematic and geographical. Since its creation in 2002, the finance provided by the GFATM has supported a number of those priorities.

While there is a high level of convergence between France's vision and that embodied in the founding principles of the GFATM, they diverge on occasion with regard to the programmes actually implemented for certain target populations.

Remarkable progress has been made on Prevention of Mother-To-Child Transmission (PMTCT), especially since 2009. Conversely, the results for marginalised populations are patchier, and until recently programmes directed at such groups were relatively limited, while nevertheless making progress. This situation can be explained to some extent by the lack of spontaneous enthusiasm on the part of recipient countries for

action in favour of such minorities, especially those subject to social opprobrium, or even judicial action, such as men conducting sexual relations with other men in the case of numerous African countries. In some countries, international partners or international NGOs deal with these programme components: for example, Médecins du Monde does extensive work on the reduction of sanitary risk linked to injectable drugs and ESTHER is a sub-recipient in Côte d'Ivoire for the support of activities for HIV prevention, screening and treatment in prisons.

The GFATM defines a number of measures and actions in its 2012-2016 strategy to improve the observed inadequacies. The strategy is also aimed at enhancing the mobilisation of civil society, a sharper policy focus on possibilities for funding operational research programmes, although incentive tools would benefit from development, the adoption of a more directive attitude to encouraging countries to include in their proposals activities to counter discrimination and inequality of access for marginalised population groups.

Principles, values and priorities common to France and the GFATM*

Principles and values

Solidarity: The sharing by all of medical progress and improvements in access to healthcare and treatment.

Human rights: Rejection of all forms of discrimination, respect for minorities, promotion of gender equality.

Aid effectiveness: Ownership by countries, alignment with national strategies and systems, coordination of donors, harmonisation of procedures, mutual accountability and performance-focused management (in compliance with the commitments embodied in the Paris Declaration).

Involvement of civil society: Participatory decision-making, partnerships with governments, NGOs, faith organisations, the private sector and associations of patients.

Thematic priorities

- Speedier access to treatment.
- Strengthening of the most vulnerable health systems.

- Mother and infant health (MDGs 4 and 5).
- Combating HIV/AIDS (MDG 6).
- Promotion of actions combining MDGs 4, 5 and 6, such as Prevention of Mother-To-Child Transmission (PMTCT).
- Combating other communicable diseases (malaria, tuberculosis, neglected tropical diseases).
- Scientific and academic cooperation (treatment research and innovation for HIV, malaria and tuberculosis).

Priority geographical zones

France's priority solidarity zone: French-speaking African countries and priority poor countries as defined by the CIGID. At the close of 2011, 55% of all finance disbursed went to the countries of Sub-Saharan Africa. CIGID and French-speaking Sub-Saharan countries accounted for over 36.9% of all funding approved and 35% of disbursements in Sub-Saharan Africa.

* Source : Directorate-General of Global Affairs, Development and Partnerships, Ministry of Foreign Affairs, *France's strategy for international cooperation in health*, 2012.

4.2. France's capacity to exercise influence

4.2.1 An inadequate system to follow the relevant activities in Paris

Compared to the workload involved in following the relevant activities and in light of the high level of France's financial contributions, the system of monitoring in Paris appears inadequate. In Paris, France has an Ambassador for the fight against HIV/AIDS and communicable diseases (who sits on the Board of the GFATM) and a full-time GFATM "focal point". Monitoring also involves the head of the Health, Food Security and Human Development Department and a special assistant to the Ambassador. This means that in July 2013 only one person was monitoring this area on a full time basis.

The ministries of health and research are involved in this monitoring work, which notably includes attendance at GFATM Board preparatory meetings. The input from these ministries needs nevertheless to be enhanced and in fact the Ministry of Social Affairs and Health has indicated its desire for greater participation. Representatives of those ministries could be included in the French delegation to the GFATM Board.

The high level of French contributions to the GFATM logically entails attentive monitoring and close involvement for the exercise of influence in the decision-making of that institution. This is a necessary *quid pro quo* to guarantee consistency between its values and priorities and the programmes funded by the institution. It is also a condition to be met for the consolidation of France's influence and visibility in beneficiary countries. The human resources assigned by the DGM to the monitoring of the GFATM and other vertical funds in the health domain are at present markedly inadequate to meet the imperative requirements of such monitoring. This weakness is made even more apparent by comparison with the arrangements put in place by the UK and Germany.

A minimum of three additional posts is necessary to strengthen French monitoring in Paris. As is the case for the GFATM, closer monitoring will also give France more effective representation in the governance bodies of UNITAID and GAVI, oversight of the coherence of the programmes funded by all three institutions and, lastly, the ability to promote to an even greater extent collaboration and efforts to ensure synergy between those programmes.

3.2.2 A genuine influence; a presence that needs to be consolidated

France has its own constituency on the Board of the GFATM. The Vice-Chair of the Board is Mireille Guigaz, formerly France's Ambassador for the fight against HIV/AIDS and communicable diseases.

In addition to monitoring arrangements in Paris, it is just as important to follow closely the main organisational bodies constantly working alongside the Board to prepare its decisions. These are the Strategy, Investment and Impact Committee (SIIC), the Finance and Operational Performance Committee (FOPC) and the Audit and Ethics Committee (AEC). Each Board constituency has the option to sit on a maximum of two of the above standing committees.

Lastly, there is a Coordinating Group with eight members, these being the respective Chairs and Vice-Chairs of the Board and each of the three aforementioned committees. Its task is to assist the Board on all issues of governance, risk assessment and general administrative operation, which means that between sessions of the Board (which meets no more than three times a year) the Group is the *de facto* supervisory body for the Fund. France is not a member of this coordinating body.

Since the appointment of Mireille Guigaz as Vice-Chair, France has a presence in only one committee (Strategy, Investment and Impact)¹⁵.

15. Prior to this appointment, Mireille Guigaz was a private member of the Audit and Ethics Committee.

The high level of presence of US nationals in the posts of Chair and Vice-Chair of Board standing committees also means that of the six members who sit on the Coordinating Group (not including the Chair and Vice-Chair of the GFATM Board), two are American.

France needs to consolidate its presence on the Fund's standing committees by sitting on two of the committees and aiming to hold the office of Chair or Vice-Chair on at least one, which will also allow it to ensure its presence in the Coordinating Group. The membership of the AEC is to be renewed in the near future and this should permit France to position itself in this regard. Similarly, renewal of SIIC membership is scheduled for end 2013/early 2014.

Despite the need for a stronger presence in the leadership of standing committees, France does enjoy genuine influence on the Board of the GFATM, this being notably justified by the high level of its financial input. For example, in 2012, confronted with major divergence in opinion on the GFATM's policy focuses and governance rules, France resolved to make payment of the tranches of its financial contribution conditional on a number of steps to meet its concerns. The action taken by the GFATM in response to these demands permitted a gradual resumption of the process of disbursement of the various tranches of its contribution.

Recourse to such an approach should however remain exceptional; otherwise the very operation of the GFATM and the quality of its programmes could suffer.

In order to avoid such tensions, France's influence should come from within the institution itself, which will allow France to weigh directly on the strategic policy focuses that are defined, as well as the tools developed and the decisions reached.

4.2.3 The necessity of strengthening France's visibility and position on the ground

In the beneficiary countries day-to-day monitoring of activities and the highlighting of the value of French participation are largely the responsibility of France's embassies.¹⁶

The positioning and visibility of France is reflected in its participation in Country Coordinating Mechanisms.

While France is present in 23 Country Coordinating Mechanisms in Sub-Saharan Africa¹⁶, it could nevertheless participate in more such bodies. A lack of duly mandated personnel required to report at regular intervals, as well as inadequate preparation of CCM election processes means that diplomatic posts have no presence in, and monitor no more than cursorily bodies in which essential matters relating to projects and their implementation are discussed. For example, France has no part in three CCMs in the 16 priority poor countries: Burkina Faso, Ghana and Guinea.

In addition, the participation of France's representatives in CCMs is inadequately prepared ahead of meetings either internally (i.e. with the diplomatic post and where applicable with the DGM) or in conjunction with France's operators and experts in the field. Another problem relates to the absence of clear messages to be expressed in these bodies on behalf of France regarding its strategy, priorities and close ties with priority countries for its ODA.

Enhanced visibility for France and its input into reflection and strategic choices in these bodies requires:

- A stronger role for French Ambassadors in monitoring and highlighting the value of French participation in the GFATM.
- The designation in each priority country of an individual responsible for representing France and reporting to the Ambassador and the DGM.
- Greater involvement and empowerment of such representatives (mission statement) in the technical preparation of CCM meetings, using on each occasion where necessary and feasible the feedback and information channels provided by France's operators and experts present on the ground.

16. The countries in which France has a presence in the CCM: Benin, Burundi, Central African Republic, Comoros, Democratic Republic of the Congo, Djibouti, Gabon, Madagascar, Mali, Mauritania, Niger, Senegal, Togo, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Guinea Bissau, Kenya, Sao Tome and Principe, Sierra Leone, Sudan and Zimbabwe.

4.3. The place of French operators and stakeholders in the context of projects financed by the GFATM

4.3.1 The AFD: A major role in promoting sectoral policies, health system strengthening and support for civil society in beneficiary countries

A greater place and role is needed for the Agence française de développement (AFD – French development agency) as the pivotal operator/financial source in the French system of official development assistance given its extensive presence on the ground as well as its technical expertise. Stronger engagement most notably with civil society in priority countries for France's official development assistance should be promoted using the network of French NGOs with which the AFD is already very familiar. And lastly, it is necessary to foster the role that the AFD could play in promoting sectoral policies and health system strengthening in beneficiary countries, most notably in the context of the demands of the new funding model.

4.3.2 5% Initiative: an initial favourable assessment of its activities; strategic positioning to be strengthened with a priority focus on the values promoted by France

Created in 2010, the 5% Initiative is France's response to the conclusion shared by a number of actors in French-speaking countries that the latter were encountering recurrent problems in accessing GFATM resources, or in implementing the funding received. The Initiative was implemented in the form of an indirect contribution by France to the GFATM equivalent to 5% of the overall French contribution each year, amounting to €18 million annually for the years 2011 to 2013.

Two distinct categories of funding have been put in place: Channel 1 relates to one-off requests for expertise. Channel 2 is aimed at financing 2- to 3-year projects to meet programmatic requirements or structural problems in beneficiary countries. Channel 2 takes up approximately 65% of the Initiative's annual budget. Grants are allocated by means of competitive calls for projects. Two thematic calls for projects are defined each year following a logic aimed at capacity-building in the countries involved. The four thematic headings chosen for 2012 and 2013 are: health system strengthening, operational research, procurement and supply management and governance.

For both Channel 1 and Channel 2, the priority areas for action chosen for the 5% Initiative appear to be relevant to the difficulties and bottlenecks identified in beneficiary countries.

Among the specific features of the 5% Initiative compared with similar programmes implemented by other countries (the German Backup initiative and the American GMS) is the distinction between two funding channels. It reflects the deliberate choice made under the Initiative to adopt a positioning on longer-term support for the provision of more sustained assistance and the dissemination of best practices. Channel 2 is more focused on supplementing grants from the GFATM rather than providing support for their implementation as and when necessary, although it does also contribute to this.

Given its recent creation, the 5% Initiative needs to raise awareness of it in French ODA priority countries and to develop its supervisory and evaluation tools.

4.3.3 ESTHER: a public sector operator with close involvement in national programmes against AIDS, a flagship for France's values

ESTHER is a sub-beneficiary of the GFATM in Benin and Chad and provides support for certain countries in formulating their applications to the GFATM: Burkina Faso's first applications for funding were prepared with its assistance for example. Additionally, in October 2012 ESTHER became a GFATM sub-recipient (9th Series) for the implementation of prevention and care programmes in eight prisons in Côte d'Ivoire.

ESTHER's key capacity for promoting France's values, notably with regard to the provision of care for the most vulnerable or marginalised population groups, and in promoting French expertise, should continue to be highlighted, at least in the poorest countries with continuing priority for action.

4.3.4 Few French NGOs are operating in the front line in programmes financed by the GFATM

There are few French NGOs operating in the front line in programmes financed by the GFATM. The situation is very different where their Anglo-Saxon colleagues are concerned, these being in many cases large organisations based in Africa for decades.

This context can be put down to a difference in the philosophy underpinning action in countries with limited resources: French NGOs seek to foster the emergence of local NGOs with national scope and with the required skills to conduct programmes to combat the pandemics.

In countries in French-speaking Sub-Saharan Africa the place of civil society and local NGOs in the grant portfolio financed by the GFATM continues to be very limited. Greater involvement by them should be advocated in connection with the new funding model. The French NGOs present on the ground have in this regard a major role to play in supporting and assisting their opposite numbers at local level.

4.3.5 French research institutions: positions that vary from organisation to organisation

The Institut Pasteur, backed by their long history, conduct their own research activities in local facilities based mainly in Asia and Africa (including four in West Africa and one in Madagascar). They represent the grand tradition of French specialists in infectious diseases and they are not alone if the list is widened to include organisations dedicated to infectious diseases other than those addressed by the GFATM (Institut Pierre Richet in Bouake, Côte d'Ivoire, for research into malaria and human trypanosomiasis; Niamey meningitis and schistosomiasis research centre in Niger; the Bamako tropical ophthalmology institute in Mali, as well as the Fondation Follereau, which combats leprosy).

In the area of clinical and public health research, the IRD in Marseilles, EHESP in Rennes and, to a lesser extent, ESP in Nancy and ISPED in Bordeaux, are carrying on a long-established tradition. However, their presence on the ground in the health domain in French-speaking Africa appears still to be limited.

The situation is different for the ANRS (Agence nationale de recherche sur le sida et les hépatites virales – French national agency for research into AIDS and viral hepatitis), which has a particularly active presence in the countries of the South.

In addition, France is part of the European and Developing Countries Clinical Trials Partnership (EDCTP) established in 2003 under the European Commission's 6th Framework Programme for Research. The EDCTP focuses on phase II and III clinical testing in Sub-Saharan Africa in order to speed the development of medical drugs, vaccines, microbicides and diagnostic methods for AIDS, tuberculosis and malaria. It supports projects that cover a number of centres and combines clinical tests, capacity-building and network formation. The EDCTP is a good example of North/South cooperation fostering the integration of health research into sanitary policy and practice in the countries of the South, thus supplementing – or even “de-verticalising” – programmes financed by the GFATM.

The GFATM currently supports very little operational research activity, despite the fact that possibilities for their finance do exist (up to 5 % of the overall budget). It is recommended that there should be more involvement by French research institutions in supporting priority poor countries and CCMs to increase the operational and programmatic research in the portfolio of grants financed by the GFATM. Those institutions should also take part in the process of dialogue and consultation with WHO, GAVI and UNITAID regarding the new treatment protocols, this being an imperative condition for their approval by the GFATM.



4.3.6 Very limited interest of French companies in projects financed by the GFATM

Private-sector contributions to GFATM financing come essentially from support provided by major US corporations. French firms do not contribute but some have shown interest in supporting the activities of the GFATM (Total Foundation, Sanofi, Net-À-Porter) which indicates that partnerships may be possible in years to come. On the other hand, few French companies are interested in projects financed by the GFATM with a view to benefiting from the economic opportunities they offer. This type of activity and encouragement should be promoted by diplomatic posts and especially by economic missions in high-potential countries.

Recommendations

Recommendation n°1

Fair weighting for the different categories of risk

France's message in GFATM bodies: an effort should be made to ensure fair relative weighting of risk categories (financial, operational and technical risks, absorption and disbursement capacities) in grant management and monitoring procedures.

Recommendation n°2

Reinforcement of the operating rules and management capacities of Country Coordinating Mechanisms

France will apply all the influence at its disposal with regard both to GFATM bodies and the countries themselves, working most notably through its national representation in Country Coordinating Mechanisms (CCM), in order to encourage and involve those bodies in strengthening and restructuring themselves ahead of the implementation process for the new funding model. The principles of such restructuring are:

- A slimming down of membership in order to allow these bodies to operate effectively like corporate management boards.
- An effort to ensure enhanced representation for healthcare professionals.
- A strengthening of their management and supervisory capacities and of their permanent secretariats in particular.

France should argue for an increase in the operating budgets allocated to CCMs by the GFATM in order to permit them to function optimally.

Recommendation n°3

French presence in the Country Coordinating Mechanisms of priority countries for its official development assistance

France should make every possible effort to ensure its presence in the Country Coordinating Mechanisms (CCM) of countries that enjoy priority for its official development assistance. In view of the probable reduction in CCM size, it is important for France to anticipate these changes and to formulate recommendations for its diplomatic posts in order to adopt the right strategy to ensure that a French representative has a seat in those bodies and can therefore be elected. It is also strongly recommended that such French representatives should be members of the strategic monitoring committees set up by those bodies.

Recommendation n°4

Thematic areas for support to be prioritised by French bilateral operators in priority countries for French assistance

French operators, who possess acknowledged competence in the health domain, should seek first and foremost to provide support for countries enjoying priority for French assistance under the following thematic headings:

- Governance and technical support requirements of Country Coordinating Mechanisms.
- Procurement and stock management.
- Funding preparation, management and monitoring/evaluation (notably with a view to allowing a maximum number of principal recipients to switch to annual disbursement cycles).
- Support for local NGOs and civil society to allow them to increase their participation in activities financed by the GFATM.
- Support for the development of grant components relating to high-risk, marginalised, stigmatised and vulnerable population groups.
- Health system strengthening (working most notably through the AFD and ESTHER, which are already active on this type of programme): provision of assistance to countries in preparing and implementing this grant component.

Recommendation n°5

Development of operational and programmatic research

France's message in GFATM bodies: the need to encourage beneficiary countries to make more use of the envelope available for research activities: for example, by adding a specific section on "operational and programmatic research" to the template for the concept note to be used under the new funding model.

France should encourage its research institutions to:

- support priority countries for French ODA and principal recipients in including more operational and programmatic research in the portfolio of grants financed by the GFATM,
- develop dialogue and consultation with WHO, GAVI and UNITAID on aspects relating to new treatment protocols.

Recommendation n°6

Preparation for the implementation of the new funding model

France and its operators in the health sphere should provide technical support for priority countries for French assistance to assist them in preparing for the consequences and requirements flowing from the application of the new funding model.

That support should relate to the upstream phases in grant applications, including:

- The definition and updating of national strategies for each of the three diseases.
- Reflection at global level on the burden due to each of the diseases and the respective need for funding in each case (based on epidemiological data and input from TFPs).
- Assistance in drafting the concept note and defining programme targets.
- The strengthening of information systems: the quality and reliability of epidemiological data.
- Preparation of the future components relating to health system strengthening.
- Assistance for these countries in accessing incentive financing more easily.

Recommendation n°7

Limitation of the incentive envelope percentage

France's message in GFATM bodies: the incentive envelope should represent a limited percentage possibly set at around 10%.

Recommendation n°8

Maintenance of the level of priority allocated by France to the GFATM under its development assistance policy

France should continue to show its strong commitment to multilateral aid as the most appropriate means of achieving its priorities for development assistance in the health sphere. This policy should be thought through, coordinated and, as often as possible, implemented with an eye on synergy with its European Union partners, preferably with those countries expressing similarly ambitious goals in terms of financial and operational commitment. Such a choice is possible if the financial contribution to the GFATM is set at a high level. It is on that basis that France will be best able to support the GFATM while at the same time exercising a degree of influence over the Fund when choosing its geographical and thematic priorities.

Recommendation n°9

Reinforcement of French monitoring arrangements and a tighter focus for geographical and thematic priorities

- Reinforcement of the DGM team responsible for monitoring vertical funds and the GFATM by funding three additional posts.
- Tighter links and closer consultation between the Ambassador for the fight against HIV/AIDS and communicable diseases, now based in Paris, and the representatives of the ministries concerned: Health, Research, Industry. Encouragement of the participation of those ministries in the French delegation to the GFATM Board.

- Reinforcement of France's position on the standing committees of the Fund with seats on two of such bodies and aiming at occupation of the office of Chair or Vice-Chair on at least one. This approach will also give France a presence in the Coordinating Group. Encouragement and promotion of the candidacies of French experts sitting on other committees and working groups, most notably the committee responsible for the technical evaluation of proposals.
- The ranking of French priorities in the health domain: high-priority countries and target populations.
- These policy focuses should be communicated to diplomatic posts to form the strategy for France's posture with regard to the activities financed by the GFATM.
- A stronger role for French embassies, which should be mandated by the Health, Food Security and Human Development Department of the French Ministry of Foreign Affairs (DGM/DBM/SAH) to monitor and highlight the value of French participation in the GFATM at local level. The Ambassador will designate the individual or institution to represent him or her in the Country Coordinating Mechanism (depending on the circumstances in the country).
- Definition of terms of reference (or a mission statement) setting out in detail the powers and duties assigned to such representatives in order to ensure greater effectiveness for their presence in Country Coordinating Mechanisms plus genuinely effective preparation ahead of meetings (including aspects involving coordination with other actors and partners).
- An intensification of the arrangements for communication and mutual provision of information between the DGM and diplomatic posts.
- Support for French representatives in CCMs, ensuring that they are supplied with the technical information (strategy included) required to enable them to play their role to the full.
- A stronger policy on alliances and efforts to find synergy with other European countries and the EU Delegation in beneficiary countries in order to foster a sharing of tasks and possible roles, mutual complementarity between programmes, and common positions on joint priorities and problems. This action should be conducted in coherence with the activities of the Ambassador for the fight against HIV/AIDS and communicable diseases, who will seek the same synergy of action and joint positioning with his European opposite numbers.

Recommendation n°10

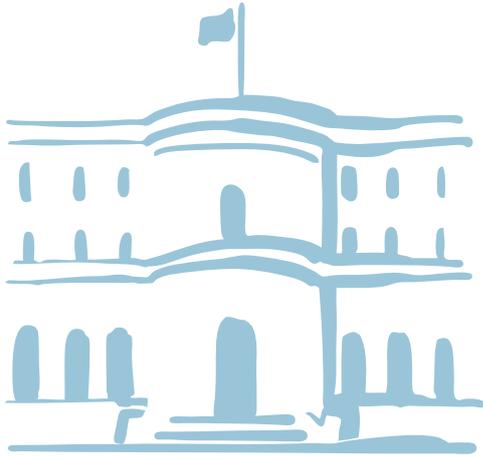
Optimisation and promotion of the 5% Initiative

Ranking of the priority axes for action through Channel 1 and Channel 2

- For Channel 2:
 - prioritisation of geographical zones and specific groups of partners to enable action to be focused on high-impact projects and financial resources to be concentrated for implementation of "high structural impact projects", avoiding a scattergun approach to resource employment.
- For Channel 1 (and possibly Channel 2 in the future), aim as a priority to provide support in thematic with greatest importance for France such as:
 - Promotion of local civil society and greater involvement of the latter in GFATM grants against discrimination and for access to healthcare for the most exposed and marginalised key populations.
 - Development of innovative tools and working methods, including remote support and the dissemination of best practices.
 - Strong commitment to assisting French-speaking countries in Sub-Saharan Africa in implementing the new funding model and preparation of the phases leading to that implementation.
 - Development of a genuinely effective outreach strategy in order to enhance France's presence and profile in beneficiary countries and with respect to civil society and non-profit associations.
 - Consolidation of tools for the evaluation of programmes financed by the Initiative (the systems developed by the German and US initiatives should provide food for thought on this).

List of abbreviations

AEC	Audit and Ethics Committee
ACT	Artemisinin-based combination therapy
AFD	<i>Agence française de développement</i> / French development agency
ANRS	<i>Agence nationale de recherche sur le sida et les hépatites virales</i> / National agency for research into AIDS and viral hepatitis
ARV	Antiretrovirals
CCM	Country Coordinating Mechanism
CICID	<i>Comité interministériel de la coopération internationale et du développement</i> / Interministerial International Cooperation and Development Committee
CRCS	<i>Conseiller régional de coopération en santé</i> / Regional health cooperation counsellor
DFID	Department for International Development (United Kingdom)
DGM	<i>Direction générale de la mondialisation, du développement et des partenariats</i> / Directorate-General of Global Affairs, Development and Partnerships
DG Trésor	<i>Direction générale du Trésor</i> / Treasury Directorate-General – French Ministry for the Economy and Finance
DN	Data not available
EDCTP	European and Developing Countries Clinical Trial Partnership
EHESP	<i>École des hautes études en santé publique</i> / French National Public Health School of Rennes
ESP	<i>Écoles de santé publique</i> / Others French Public Health Schools
ESTHER	<i>Ensemble pour une solidarité thérapeutique hospitalière en réseau</i> / Network for Therapeutic Solidarity in Hospitals
FOPC	Finance and Operational Performance Committee
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	<i>Deutsche Gesellschaft für Internationale Zusammenarbeit</i> / German Society for International Cooperation (Germany)
GMS	Grant Management Support – US equivalent to the 5% Initiative
HIV/AIDS	Human immunodeficiency virus infection / Acquired immunodeficiency syndrome
ISPED	<i>Institut de santé publique, d'épidémiologie et de développement</i> / Institute of Public Health, epidemiology and Development
LIC	Low Income Country
LMIC	Lower Middle Income Country
MAE	<i>Ministère des Affaires étrangères</i> / French Ministry of Foreign Affairs
MDG	Millennium Development Goals
MR	Multiresistant (tuberculosis)
NA	Non available
NGO	Non-governmental organisation
ODA	Official Development Assistance
OIF	<i>Organisation internationale de la Francophonie</i>
PEPFAR	President's Emergency Plan for AIDS
PMTCT	Prevention of Mother-to-Child HIV Transmission
PPC	Priority Poor Countries – list defined by the CICID, for French ODA
PSM	Procurement and Supply Management
PwC	PricewaterhouseCoopers
SAH	<i>Sous-direction de la santé, de la sécurité alimentaire et du développement humain</i> / Health, Food Security and Human Development Department, within the Directorate-General of Global Affairs, Development and Partnerships, French Ministry of Foreign Affairs
SCAC	<i>Service de coopération et d'action culturelle</i> / French Cooperation and Cultural Action Section
SHS	Health System Strengthening
SIIC	Strategy, Investment and Impact Committee
TFM	Transitional Funding Mechanism
TFP	Technical and Financial Partners
UMIC	Upper middle income countries
UN	United Nations Organisation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNITAID	International Drug Purchase Facility
USAID	United States Agency for International Development
VPP	Voluntary Pooled Procurement
WHO	World Health Organisation



AN EVALUATION OF FRENCH CONTRIBUTIONS TO THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The significant commitment of France towards global health is a distinctive feature of our involvement on the international scene. Health is at the heart of our foreign policy and is historically an important vehicle of the French renown. The Interministerial Committee for International Cooperation and Development decided on July 31st, 2013 that France would remain among the world's leading contributors in the field.

Nearly a billion euros per year is spent by our country in the field of global health. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) receives an annual contribution of 360 million euros from France. The ambition that our country places in the fight against communicable diseases is echoed by the French requirements vis-à-vis the GFATM regarding adaptability, efficiency and transparency.

This evaluation highlights the fact that the GFATM is a particularly relevant and effective tool with regards to the objectives and priorities that France has set itself in the field of global health and through its development aid policy. It also issues important recommendations aiming at improving the French synergies and influence within and in support of GFATM programs.

Philippe Meunier,
Ambassador for the fight against
HIV/AIDS and communicable diseases.