



Global AIDS Alliance Comments ***Implementation of the Global Health Initiative:*** ***Consultation Document***

22 February 2010

The Global AIDS Alliance (GAA) welcomes the principles of the Global Health Initiative as outlined in *Implementation of the Global Health Initiative: Consultation Document*. The need for improved coordination, integration, and leveraging of other global health partners and donors has long been clear, and is essential for ensuring that the US government is adequately contributing to improved health outcomes for real people. A commitment to country ownership and leadership and to building health systems is fundamental to long-term sustainability and the appropriateness, relevance and efficiency of the global health programs supported by the GHI and other US health programs. The women- and girl-centered approach reflects the health-seeking behavior of families and communities, and the impact that women can have on breaking the cycle of poverty.

However, despite the strong principles of the GHI, GAA has serious concerns, and recommendations, in response to the *Implementation of the Global Health Initiative: Consultation Document*. For example, the issue of violence against women and girls (VAWG) and pediatric HIV/AIDS, two top priorities for successfully addressing HIV/AIDS and for promoting a women- and girl-centered approach is missing entirely from the Consultation Document.

Global AIDS Alliance – PRIORITY RECOMMENDATIONS

Our top five priority recommendations are:

- **Provide \$7.25 billion in funding for PEPFAR in FY11 and ensure that future budget requests are on track to maintain the growth mandated by Lantos-Hyde and to meet the need and ambitious targets set by the US government, this commitment must include at least \$1.75 billion to the Global Fund in FY11. [Although, evidence based needs estimates are considerably higher and the contribution should be no less than \$2 billion]**
- **Ensure that all HIV/AIDS targets included in the GHI are ambitious six-year targets, that include an additional year to remain consistent with those targets outlined in five year Lantos-Hyde or OGAC's five-year strategy to align with internationally agreed upon universal access targets by 2015.**
- **Deploy existing US government technical assistance and country presence to support demand creation and technical assistance for the development of Global Fund proposals that integrate MDG 4, 5 and 6, and encourage other partners to collaborate on this approach. This would enable a move toward the development of a Global Fund for Health MDGs.**

- **As an example of promoting a women and girls centered approach to HIV/AIDS services, OGAC should ensure PEPFAR COP Guidelines promote use of a comprehensive family-centered care approach for prevention, treatment and care of HIV/AIDS. This effort should be duplicated across diseases and integrated into the over all GHI approach.**
- **Utilize the strategic approach addressed in the International Violence against Women Act (S 2982 and HR 4594) to ensure the holistic and women-centered approach proposed by the GHI.**

Funding

The *Consultation Document* indicates the intention to provide “substantial new resources and unprecedented funding levels,” yet the proposed \$63 billion represents neither significant increases concomitant with the US fair share of the global need, nor is it consistent with authorized funding levels for PEPFAR. In addition, while the proposed GHI Strategic Reserve Fund attempts to solve the problem of siloed budgets leading to siloed programs, the GHI Fund is not sufficiently large to counteract the fact that “the integrity of the funding sources [from across USAID and State Department global health programs] will be maintained for reporting and accounting purposes.” Instead, it appears the GHI Fund will actually duplicate existing multilateral efforts (see below).

Recommendations:

- **Provide \$7.25 billion in funding for PEPFAR in FY11 and ensure that future budget requests are on track to maintain the growth mandated by Lantos-Hyde and to meet the need and ambitious targets set by the US government.**
- **Provide at least \$1.75 billion to the Global Fund in FY11. [Although, evidence based needs estimates are considerably higher and the contribution should be no less than \$2 billion]**
- **Address the role of siloed budgets in perpetuating siloed programs by changing reporting requirements and conditionalities for future funding.**

Coordination, Collaboration, Integration and Leveraging Other Partners

The *Consultation Document* indicates an intent to strengthen the US government’s relationship with the Global Fund to Fight AIDS, Tuberculosis and Malaria, yet the President’s FY11 budget cuts the US contribution to the Global Fund, contradicting the intent to strengthen the relationship and undermining the Global Fund’s ability to scale-up its support for ever-increasing high-quality demand. Similarly, the *Consultation Document* highlights increased support for leveraging the three health Millennium Development Goals (MDGs 4, 5, and 6); the Global Fund is one of few funding mechanisms that supports all three health MDGs and support must increase if the GHI is to accomplish this goal.

The GHI Fund’s purpose of catalyzing systemic changes, technical assistance, and baseline evaluations is duplicative of other international efforts to support national health plans and systems. Rather than leveraging other partners, this approach threatens to waste valuable

resources on parallel systems and diverts essential funding away from programs by prioritizing technical assistance.

The differences between linkages (upstream—policies and strategies that enable integration and coordination), integration (downstream—co-location of services or referrals from one service type to another), and coordination (both upstream and downstream—intentional joint programming, sharing of training and commodities costs, reduction of transaction costs through streamlined reporting, etc) are ill defined in the *Consultation Document*. Clarity in terminology and intent is needed to effectively coordinate at all levels and have the strongest positive impact on individuals and communities.

Recommendations:

- **Deploy existing US government technical assistance and country presence to support demand creation and technical assistance for the development of Global Fund proposals that integrate MDG 4, 5 and 6, and encourage other partners to collaborate on this approach.**
- **Ensure particularly strong cross-donor coordination for the training of health care workers, who will require new expertise to ensure efficient and results-oriented integration of services, and for technical assistance to support linkages at the policy and strategy levels.**
- **Utilize the funding intended for the GHI Fund to support the Global Fund's National Strategy Applications window rather than creating another parallel structure.**
- **Explicitly define "linkages," "integration," and "coordination" to hold the GHI accountable for improving its way of working, reducing transaction costs, and improving outcomes for women and their families at country level.**
- **The US government should support efforts to evolve the mandate of the Global Fund to Fight AIDS, TB and Malaria to support the priorities of the Global Health Initiative, such as a Global Fund for the Health MDGs.**

Pediatric AIDS

The GHI's focus to help partner countries improve health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns and children through programs including infectious disease, nutrition, maternal and child health is very encouraging. For newborn care, particular emphasis has been placed on appropriate feeding of infants and children; prevention and treatment of neonatal infections; and early diagnosis of HIV/AIDS. Child health also covers an array of essential services such as supporting expanded immunization that includes pneumococcal and rotavirus vaccines; and linkages to HIV diagnosis and treatment. However, the *Consultation Document* does not provide clear targets for the scale up of early infant diagnosis and pediatric treatment for HIV. In addition, the maternal and child health targets appear aligned with PEPFAR's five-year strategy rather than the six-year timeframe of the GHI, and have not been adjusted to reflect the new WHO Guidelines on ART, PMTCT, & Infant Feeding.

Recommendations

- **Include targets for the scale-up of early infant diagnosis and pediatric treatment for HIV.**
- **OGAC should ensure that PEPFAR guidelines and targets are revised and aligned with new WHO guidelines on ART, PMTCT, and infant feeding**
- **OGAC should ensure PEPFAR COP Guidelines promote use of a comprehensive family-centered care approach for prevention, treatment and care of HIV/AIDS.**
- **Ensure that new health care workers are trained in clinical management of pediatric HIV/AIDS, including treatment and care.**
- **PEPFAR COP Guidelines prioritize and encourage the expansion of EID/T infrastructure to improve efficiency of PCR testing results**

Targets and Specific Interventions:

CONSISTENCY WITH LANTOS-HYDE- The HIV/AIDS targets appear aligned with PEPFAR's five-year strategy rather than the six-year timeframe of the GHI, and have not been adjusted to reflect the new WHO treatment guidelines.

Recommendations:

- **Adjust HIV/AIDS treatment targets to reflect the increased need defined in WHO's new treatment guidelines.**
- **Ensure that all HIV/AIDS targets included in the GHI are ambitious six-year targets, that include an additional year to remain consistent with those targets outlined in five year Lantos-Hyde or OGAC's five-year strategy.**

Health Systems Strengthening

HIV/AIDS is the only disease area that includes a concrete target for health care workers, yet an ambitious health systems reform effort such as is outlined in the *Consultation Document* will require investment in health care workers across the health outcomes identified as priorities for the GHI.

Recommendations:

- **Ensure that health systems and health care worker targets are included for all disease components so that HIV/AIDS is neither bearing the entire burden nor disproportionately impacting the approach of such efforts.**

Women- and Girl-Centered Approach

The gender analysis undertaken to provide the example of the real-world experiences of women seeking health care is welcome. However, this analysis—and the interventions identified in the *Consultation Document*—ignore economic opportunities, and preventing and responding to violence against women and girls (VAWG), two issues that must be considered in a truly women-centered approach. The discussion does not clarify what will be done to

dramatically change business as usual. It is unclear what is meant by building off of PEPFAR's success to ensure a women-centered approach, when PEPFAR itself has not yet sufficiently addressed the needs of women in its own programming. Stating that it is "essential that PEPFAR and other programs ensure that services for women are linked to, and expand access for, their primary health care needs" does not respond to the need for co-location of services to address difficulties in accessing comprehensive services along the continuum of care.

Recommendations:

- **Prioritize linking relevant policies and strategies at the national level, while focusing on co-location of services (integration) and coordination with other donors to ensure additionality rather than duplication, with the ultimate goal of providing a single site of service delivery for women and their families.**
- **Utilize family-centered care as a primary lens for viewing programmatic design.**
- **Ensure that programs outside the health sector are included in the overall strategy to best address socio-economic challenges women face to health-seeking behavior.**
- **Include economic independence, cost of accessing health services and transportation, and the impact of VAWG on health outcomes and health-seeking behavior in all analysis and programs undertaken by the GHI.**

Violence Against Women and Girls

Violence against women and girls is both a cause and a consequence of HIV/AIDS and other ill-health outcomes. VAWG can impact a woman's willingness or ability to seek health care, to use money for transportation or health user fees, or to acknowledge HIV status and other health challenges. In addition, VAWG is a major factor in a woman's ability to negotiate safer sex. As a cross-cutting issue and as an issue highlighted by OGAC as a major PEPFAR contribution to the GHI, VAWG must be considered in detail in all implementation plans for the GHI and must be included in GHI Plus country plans.

Recommendations:

- **OGAC should expand on its commitment to support VAWG programming as part of its contribution to the GHI by holding civil society consultations and defining steps for taking VAWG programming to scale.**
- **Add explicit targets for VAWG, per OGAC's stated contribution to the GHI.**
- **Utilize the strategic approach addressed in the International Violence against Women Act (S 2982 and HR 4594) to ensure the holistic and women-centered approach proposed by the GHI.**

Tuberculosis, TB/HIV, MDR-TB

The Lantos-Hyde reauthorization bill which authorized \$4 billion dollars over five years used the WHO STOP Tuberculosis Strategy as one of the main drivers. Due to global investment in

the strategy to date, the tuberculosis DOTS/Stop TB Strategy has cured 32 million people and saved up to 8 million lives. However, one-third of the world's population is estimated to be infected with tuberculosis, and TB is the number one killer of people living with HIV/AIDS and kills over half a million women each year. The deadly synergy between HIV/AIDS and TB and the explosion of multi-drug resistant and extensively drug-resistant tuberculosis (XDR-TB) are undermining progress made and billions invested in the fight against both HIV/AIDS and TB in southern Africa. While basic TB control – DOTS strategy – costs approximately \$20 per full treatment cycle, multi-drug resistant TB is much more costly at a range of \$4,000 - \$7,000 per patient. Progress is undermined by inadequate tools including a TB drug that has not been further developed in 40 years, standard diagnostic tests that have changed little in over a century and lack of an effective vaccine. The Global Plan to Stop TB 2006-2015 still faces large annual funding gaps related to MDR-TB management scale-up and research and development of diagnostics, drugs and vaccines so critical to TB control and elimination, and research and development of new TB tools. The GHI calls for cost-efficient programming for TB treatment, however with additional resources being put into building lab capacity, development of new tools and scaling up capacity to address drug-resistant strains of tuberculosis, we must also ensure that funding commensurate to these efforts is supported. In the President's FY11 budget request, he called for a mere \$5 million dollar increase over the amount passed by Congress in FY10. The Administration is falling far behind the commitment made in Lantos-Hyde.

Recommendations:

- **Adjust TB treatment and prevention targets to reflect the increased need defined by the WHO's STOP TB Strategy and the authorized levels outlined in the Lantos-Hyde reauthorization legislation including building an additional year as reflected in the six year strategy.**
- **Ensure that funding levels to treat multi-drug resistant tuberculosis are commensurate with the level of MDR TB diagnoses and that the US provides its fair share to address drug resistant strains of tuberculosis, including fulfilling the 90,000 MDR treatments over five years and then cost and account for an additional year as it is framed in the GHI.**
- **The GHI must ensure that basic TB control funding is supported through USAID, that PEPFAR is also funded for its TB/HIV program, and that other agencies receive funding for their core TB/HIV, TB activities.**
- **Funding for global tuberculosis for FY11 should be raised to \$650 million.**

Stigma and Discrimination

The *Consultation Document* fails to address the role that stigma and discrimination play in accessing health services. The stigma and discrimination surrounding HIV/AIDS is associated with lower adoption of preventive behaviors, reduced participation in prevention programs such as those to prevent mother-to-child transmission, and often keeps people from getting tested. This is particularly true among women and marginalized populations, including injecting drug users, men who have sex with men, sex workers, incarcerated populations, indigenous populations, and people with disabilities. As a barrier to accessing and receiving

health services, stigma and discrimination must be addressed by the Administration in all pieces of GHI implementation.

Recommendations:

- **Ensure the training of health care workers on stigma and discrimination.**
- **Ensure the confidentiality of all people who have been counseled regarding prevention, who have been tested, and who are in treatment and care.**
- **Encourage recipient countries to include stigma and discrimination reduction strategies in their national health plans.**

Country Ownership and Civil Society Participation:

The GHI *Consultation Document* outlines four main components of its Operational Plan of which one focuses on the promotion of country ownership. While we support the GHI's emphasis on country ownership, it remains unclear to what extent the GHI will embrace soliciting input from civil society as an equal and mandatory partner to assess what is happening on the ground, and what barriers prevent populations from accessing services and information. The GHI consultation document shows no detail regarding whether the GHI will advocate for meaningful civil society participation in the development of country Memorandums of Understandings or national health plans. All too often, governments and donors seek input from civil society, as a token gesture, at the final stages of developing a plan, when it is difficult to make changes to that plan. When input is sought from civil society, it is primarily from international NGOs, as opposed to grassroots, indigenous or community-based organizations, which are closest to hard-to-reach populations, including stigmatized and marginalized populations (e.g., women living with HIV, people who inject drugs, sex workers, men who have sex with men and the incarcerated). The end product therefore becomes a government-led and owned plan, not a truly country-led and owned plan.

Recommendations:

- **Define explicit measures for assuring that civil society participation in the development of national plans and strategies, Global Fund proposals, GHI programs, and other such processes is meaningful and consistent.**
- **Make meaningful participation of civil society and marginalized populations—in the context of human rights—a contingency of country selection and ongoing support from the GHI.**
- **Ensure that consideration of human rights in all strategies and programs is a condition for the GHI to build off of existing agreements between the US government and host countries; if existing USG agreements with a GHI Plus country were not demonstrably created with meaningful civil society participation and/or do not address human rights and gender inequality, make**

production of new agreements or strategies a condition of participation in GHI Plus.

- **The GHI should adopt, at minimum, requirements similar to those established for civil society and community participation and involvement in the Country Coordinating Mechanisms (CCMs) of the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund guidelines stipulate that "The membership of the CCM comprise a minimum of 40% representation of the nongovernment sectors such as NGOs/community based organizations, people living with the diseases, key affected populations, religious/faith-based organizations, private sector, academic institutions". The full CCM guidelines can be found at - http://www.theglobalfund.org/documents/ccm/Guidelines_CCMPurposeStructureComposition_en.pdf.**

Implementing the Global Health Initiative:

While the GHI *Consultation Document* provides a framework for the GHI vision and approach, the Operational Plan section lacks clarity about the coordination and management of the GHI at the agency headquarters, as well as a specific plan for implementation of the GHI in focus countries. For example, which agency will take the lead in coordinating the GHI? How will the GHI be coordinated on the ground? How will the GHI Memorandum of Understandings align or coordinate with existing PEPFAR Partnership Frameworks, Country Operational Plans and the Five-Year Strategy, Millennium Challenge Corporation country compacts and other US bilateral development and health strategies?

Recommendations:

- **Provide explicit details on the GHI's operational plan - including information about specific interventions that will be implemented to achieve the stated goals with a consultative time from for input.**
- **Given that we are already in the third year of the GHI six-year initiative, provide clarification on the timeframe for the GHI.**

Scale May Not Be Sufficient for Impact and Input Targets are Missing:

Studies show that few donor-funded international health projects —as few as 5% — are of a scale to have a significant impact on health and the health delivery system in recipient countries. An essential shift occurred when US global AIDS and Malaria programs, with the advent of PEPFAR and the PMI, moved from a model in which most funding went to TA or pilot programs to directly support major scale up of treatment, prevention, and care programs. This must continue, with sufficient funding, and be extended to the other GHI areas.

The focus on outcomes and success is welcome. However, many pledges to save lives have been made previously without sufficient attention to the specific inputs needed from donors

to reach them. While narrow focus on targets has been a problem, they nonetheless are needed for accountability and ensuring efforts are truly new and additional.

We worry about discussions of strengthening health systems that are not linked to specific inputs such as the purchase of drugs for specific numbers of people, the hiring and paying of health workers, etc. Examples such as the failure of World Bank-led SWAPS programs over a decade illustrate the problems with this approach to donor funding.

It is impossible to tell, without these input goals, whether the goals of the GHI are reachable within the budget discussed. We have reason to worry however.

Our analysis of the Maternal Health Goal of Saving 300,000 lives suggests it would require:

Recommendations:

- **Explicitly shift to projects aimed at reaching universal coverage of key interventions.**
- **Set specific targets for US-inputs aligned with national strategies to act as guideposts, and create transparent mechanisms for reporting progress on these.**
- **Ensure key inputs are fully funded so that the US is truly financing the achievement of the stated goals.**

Focus on Direct Services and Commodities over Consultants: Technical Assistance is important; however it should not overshadow the greatest needs of people living in poverty. Director support to ensure services and commodities are available is a priority. According to estimates upwards of 40% of all health aid comes in the form of technical assistance, which is too often ineffective and overpriced. Information is unavailable for most programs but upon examination by Congress, some US health aid programs have been found to be made up largely or exclusively of Technical Assistance programs. Reliable and frequent anecdotes of clinics built without staff, or the medicines and Technical Assistance necessary to build strong supply chains without money to buy drugs make clear the problem with this approach.

In the consultation document the lack of concrete input targets in most areas (such as health workers trained and paid) along with significant discussion of technical or system-strengthening activities leads to concerns that the majority of funding will not go to direct services. This is especially worrisome outside of AIDS and Malaria programs, where questions remain but some of this shift has occurred. The GHI must focus on the most urgent needs to address the identified problems: sufficient health workforce and the medicines and supplies to provide care.

Recommendations:

- **Place explicit limits on the portion of funding that can go to consultants—ensuring that the clear majority goes to direct service.**

- **Ensure that technical assistance agencies, particularly those in the United Nations theme groups such as WHO, UNICEF, UNAIDS, and UNFPA are supported with U.S. funding to do their core work.**

Indigenous Populations

Globally, there are more than 300 million indigenous peoples spanning over 70 countries. Historically, these populations have not been recognized in meaningful ways by their national governments; therefore they may not be included in national health, nutrition, and poverty alleviation strategies. Many of these peoples live in rural areas; have high rates of poverty and high mortality and morbidity rate due to health indices. All areas of health are major concerns for these populations and issues of access are pervasive. Due to political, social, and economic factors, many of these communities do not have access to health, nutrition and education services. As a part of the GHI's strategy to provide quality health care, as a part of poverty alleviation efforts, it is important that indigenous populations are included as priority target populations in order to meet Millennium Development Goals 4, 5 and 6.

Recommendations:

- **Develop concrete strategies which focus on reaching indigenous populations for health, nutrition, and development assistance.**
- **Create a mechanism that ensures that indigenous peoples have a voice in the strategies that are developed to reach them under the GHI.**
- **Provide a reporting mechanism that is transparent which demonstrates progress in service provision to indigenous populations.**
- **Encourage recipient governments to prioritize indigenous populations in their national health program strategies, including funding health interventions in communities.**

Research and Development- New Global Health Tools and Technologies:

Implementation and operations research, as outlined in the *GHI Consultation Document*, are critical components of any global health response, and we congratulate the Administration for elevating these activities. However, in the context of the GHI, and in support of the NIH Director, Francis Collins' priority on global health as one of the five main pillars, the Administration should develop an inter-agency research agenda in a coordinated way that provides a full picture of US agency initiatives on global research and development. This should include a plan for implementing an expanded bold agenda from basic science to the development and introduction of new global health tools and technologies. This agenda should receive additional resources for its implementation. Providing existing prevention and treatment tools is only one part of the battle against pneumonia, diarrheal diseases, HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases.

Recommendations:

- **To ensure that we are winning the fight against these global diseases, the US must also continue to invest robustly in development of new global health technologies such as vaccines, drugs, microbicides, diagnostics, and devices aimed at diseases disproportionately affecting the developing world , including through product development partnerships (PDPs).**
- **The Administration must also ensure a more coordinated approach in order to gain a full picture of existing and future US agency initiatives and investments in global health R&D. These activities must be funded with new money not taken from the commitments made in the GHI.**