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39th Union World Conference on Lung Health
Plenary Session 1: Contribution of the Global Fund to Fight AIDS, TB and Malaria
International Union Against TB and Lung Disease
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ASMA EL SONY: Good afternoon, ladies and gentlemen, and we welcome you to this very important session. Professor Rifat Atun, our speaker today, joined in September the Executive Management Team of the Global Fund to Fight AIDS, Tuberculosis and Malaria as the Director of Strategy, Policy and Performance.

Prior to this he was Professor of the International Health Management and Funding Director of the Center of Health Management at the Empire College, London. He will be on extended leave from Imperial College during his tenure at the Global Fund.

Professor Rifat's research has used multi-method approaches to explore how contextual and health systems factors influence the adoption and diffusion of complex health innovations, especially for control of tuberculosis and HIV/AIDS, as well as mental health and primary healthcare. His cluster is currently involved in multicountry collaborative learning exercises with the World Health Organization and World Bank and Harvard University and a consortium of academic partners that explores interactions and synergies between global health initiatives and health systems.

Further areas of work explore introduction of public health technologies and the use of national health accounts framework for TB and HIV to explore applications of financial

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resources for disease control and effects of this on the efficacy and equity.

Professor Rifat has worked extensively with the World Health Organization, the World Bank and other international agencies. He was a member of the Strategic Technary Advisory Group of the World Health Organization, the Task Force of Health Systems and Develop Control.

Until recently, he was a member of the Advisory Committee for Douglas Shore's Health Center for Health Development in Japan. Health Systems and Human Resources contribution of the Global Home to Fight AIDS, TB, and Malaria is his talk for us today. You are welcome [applause].

RIFAT ATUN: Thank you, Asma, for your very kind words. I didn't realize I did so many things. It's a great honor and a privilege to be here and I thank the Union for inviting me to give this plenary presentation, which will focus on health systems and human resources contribution of the Global Fund.

It's been very interesting over the last few weeks. There has been an intense discussion around business programs and health systems and I'm seeing a very unhealthy force dichotomy emerging, health systems on the one side and business contract programs on the other side. As if these were working isolation and with different objectives.

What I want to do today is to try and demonstrate how investment in tuberculosis and HIV in particular, and malaria

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can strengthen health systems to help us achieve our objectives and our goals, which is to provide equitable access for health and to improve health outcomes for those who are in need.

So, my presentation will have four elements. I want to, first of all, introduce you to the guiding principles of the global fund so you understand our mandates and the way we operate. Then briefly look at the evolution to illustrate that we are a young organization, then look at the funding overview over the last five to six years. Then focus on the main topic, which is the global fund health system strengthening and human resources.

So, first of all, the guiding principles. We are an international public private partnership and I want to emphasize this, we are a partnership. We rely strongly on our partners, our technology enormity partners, such as the World Health Organization, development partners such as the World Bank, who co-invest with us, technical organizations and agencies such as Stop TB partnership, the Union, and most important of all the countries who actually implement the programs that are funded by the Global Fund.

We raise and disperse funds that are substantial and that are additional and we try to operate transparently and follow mutual accounting as a principle. And our objectives to that have sustained impact for HIV/AIDS, TB and malaria.

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So, we operate as a financing entity, providing additional financing, but for TB we fund around 70-percent of additional funds for globally for tuberculosis control. So, we are a big player in TB control. We have an independent review process through out technical review panel to assess applications, proposals from countries.

We emphasize counter ownerships and inclusiveness. And by inclusiveness I mean in addition to the governments or specific programs, we try and insure that effected communities are included in the proposals and the design and implementation, the civil society and the private sector, and most importantly, we try to be person-focused as our mission.

So, it's important that we don't forget the patients and their families in the process. And our model – I think we are distinguished from other programs in the sense that we follow the principle of performance-based funding, so funds are disbursed against achieving certain performance targets.

So, we try, as an entity, as a partnership, improve our operations performance through our grants to achieve system effects and to impact on HIV, TB and malaria. And as you can see in terms of the total impact, our role is very much dependent on the contribution of our partners. So, we have to have every stage work with partners.

We are committed to the Paris principles and the Anchorage for Action. Those of you who are not familiar with

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global talk, on aide architecture, that means trying to encourage harmonization and alignment in countries but also globally of the key agencies and countries, country ownership, mutual accountability, and managing for results.

So, as I said, we are a young organization. The idea for a global fund came in the, in 2000 at the G8 meeting in Okinawa. In 2001, this idea was endorsed by the African leaders, who committed to greater response in Abuja, then Congas endorsed the need for a global fund.

And, in July 1, over $0.5 billion were pledged towards establishment of the Global Fund. And by '02, we had created our board and we had created the Global Fund and had our first meeting and by April we offered first proposals. So, very rapid take-off.

Then by '05, we had the second phase of the grants approved and first replenishment was completed. And in September 2007, we completed our second replenishment with around $10 billion pledged. And now we've just launched our Round 9.

So, within six years we have had eight rounds of financing and the 9th is launched, so a very rapid scale-up. And in this period we have pledges of around 20 billion and we received 11 billion of this and we have approved 11.7 billion up to Round 7 and the Round 8 is going to the Board in

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November, the largest ever round. And we have so far disbursed around $6 billion.

And as you can see we operate in most countries around the world, around 136 to date. Now, I think this is a very interesting slide for the TB community. If we look at the investment by disease area, this is rounds 1 to 7, up to June 2008. Of the 10.8 billion dispersed, around 61-percent goes to HIV/AIDS, 25-percent invested in malaria, and 14-percent for tuberculosis.

If we look at the grant size by disease, this is also an interesting slide because if we look at HIV and malaria, the grant size tends to be larger than grants for tuberculosis control.

So, what are we doing in terms of health system strengthening and human resources, which is a critical component of health systems? If we look at estimated TB incidents and we focus on the areas of our doctoring where the estimated new TB cases actually is low. And look at where we are operating, we operate in all countries where TB is a problem.

So, today 107 countries have grants of $2.4 billion approved for TB control. This also includes HIV and TB grants. So, we've been working to strengthen health systems in a number of areas, for instance, laboratory strengthening. Around 6 or 7-percent of the grants include a laboratory-strengthening

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component. So, I am giving some examples here from this chart, newly equipped laboratories, in the Philippines training health work force in microscopy both in the public and private sector, and in Yemen establishing new laboratories for case detection.

If we look at the countries we have been strengthening you can see in most of the countries we operate in we have laboratory strengthening programs. And we are beginning to see the results of this investment. If we look at the amounts disbursed over time, this is up to 2007, and the new post of cases treated under dots, you can see a very rapid take-off.

Around 1.9 patients to date have been detected and treated through funds that we have contributed, obviously working with our partners and in countries.

A big problem, MDRTB. We are investing significantly but not enough to support MDR TB control. To date we have around 13,000 patients on treatment, and that's a very small number. Again, I'd like to emphasize our model of working. We rely, we specify country ownership, so the demand is generated and the proposals are generated by countries and these proposals are developed with support from technology partners.

I think there is a very important message here that MDR TB, XTR TB, MDR TB HIV construction is a big problem but, although, we have very rapid takeoff, the numbers are still small. And a lot of the MDR TB cases treated are actually in Russia and in China still and also in Latin America. We need

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to invest much more in Africa, specifically Sub-Sahara in Africa.

So, I think an important take home message for countries and also for technical partners who work with proposal development and implementation.

Next is TB/HIV. WE have increased support to TB/HIV control, both in terms of the number of cases screened which is the blue line, but also in terms of the numbers of people who are on treatment for TB/HIV, around 168,000. We are mostly investing in prisons, which is a big area for MDR TB as well as HIV.

If we look at TB and HIV screening and treatment by region, the installment numbers are actually in Sub-Sahara in Africa, but, again, the numbers need to be scaled up substantially.

Yes, I don't know if you can see it, but TB can be cured, so we are trying to do our best to achieve this objective. And we try and achieve this objective by encouraging the civil society and affected communities, patient groups and their families, too, to be part of the design and implementation process.

So, strengthening the civil society on partner groups is a priority for us. And for this we have established a Guild Track Financing, which enables funds to go to principle recipients both in the public sector but also to the civil

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society organizations directly into private sector organizations.

And we are trying to expand the scope of support by funding, providing funding for not just health systems but also community systems, strengthening. And funding to increase outrageous inequalities, to increase equities for gender and also for sexual minorities and vulnerable groups.

And if we look at the principal recipients and sub-recipients or implementing our grants, the grantment accounts for 50-percent. And the rest is implemented by NGO community-based organizations, faith based organizations, the private sector, academic partners and communities themselves. So, a good balance.

Right. This is a picture from Polis, Bolivia. And another important area we are investing this is public/private partnerships. And around 51-percent of the TB grants have a PPM component, and around 9-percent of the existing grants implemented by principle recipients are allocated to PPM activities.

And as I showed in the earlier slides, the private component is very broadly defined, is not just-for-profit organizations, these are non-state organizations that may be faith-based organizations, NGOs, municipalities or private medical practitioners, which have a very strong presence in many countries, for instance, in India. And as you can see, we

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have PPM programs in, or these are country programs funded by us in a large number of countries.

Human resources, critically important this is in a way the software within the system. It's no good just having the infrastructure of the laboratories, if you don't have the human resources we will not be able to design and implement programs in which patients – there is a training program in Jordan.

We work in the area of human resources in a number of ways. One is increasing the number of human resources by providing direct funding for salaries, but also providing salary top up to the top human resources within the health system.

We also invest in training to develop and enhance existing capacities and very interestingly, we also affect human resource capacity indirectly by saving lives of the health workers, specifically in countries that have very high incidence and prevalence of HIV by saving lives of workforce who are HIV-affected.

And also by affecting positively, by registering the burden for malaria, HIV and TB, we being to release capacity for HR to focus on other health system priorities.

So, let's try to implicate how we achieve this in turn. So for instance, in Malawi we have invested to upgrade the quality of training institutions. We have augmented the professional and technical stuff by providing service support

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and we also fund it in non-health system, non-traditional health workers, and community-based assistance to enhance health surveillance.

This part is a little bit complicated because the metric used is rather aggregate and rather composite and not very clean. So numbers actually are very large. This refers to the number of people trained in the number of different programs. So, a person may be trained in several programs.

So, if you multiply these we get an aggregate number of 770,000 community workers and health personnel trained in TB case detection and strengthening the collaboration between community-based institutions and hospital institutions in China.

In India, around 150,000, I should call this person-training episodes involved in some community mobilization and capacity building. In Ethiopia, around 63,000, and Zambia, around 100,000. Again, don't forget these are not individual people. But substantial investment in developing capacity.

And if we look at the numbers, not surprisingly, China is big because China is a lot of people and a lot of health workers and we have a lot of programs in China. Yes, health workers, critically important for implementing ARV programs, but also those programs and so more complex interventions.

So, by saving lives of the health workers, we are also providing additional capacity or retaining capacity within

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health systems. So, this slide shows this is the capacity needed, the healthcare worker input needed to deliver ARB program in Malawi and this is the healthcare worker person they've saved through the ARB programs that we've invested in.

In fact, we have saved more days that needed to implement the ARB program. So, as you can see, we can enhance the capacity of the workforce in more than one way.

And, finally, I showed this graph two days ago. This is malaria in Rwanda. If we look at the number of inpatient cases, this is when the interventions through our investments have begun. You can see a big decline in inpatient cases but also you can see a rapid decline in outpatient cases and this has released capacity to enable the health workforce to deal with more malaria cases.

So, by reducing the incident of crowding out within the health system by the three diseases, we give capacities to deal with other health system priorities that will change from country to country. So, if you look at, and again we invest over a period of time, so let's look a Cambodia as a case study to see how the investment in TB control program has strengthening the health sector and the disease program.

So, Cambodia started a program to integrate thoughts into health centers in 1999, and in about five years this was implemented in 490 health centers. Then, in 2003, round to grant started in Cambodia. Around 26,500 community of those

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supporters were trained, around 67,000 adults and 80,000 students received TB health education, around 2,000 health center staff were trained in TB control and around 24,000 cases were referred for TB-suspected cases.

And you can see within two years the number of health centers implementing those programs had increased from 492 to 853 as well as 40 health posts. And by '06, with around five grantors started, we began to invest in social mobilization, but also to join the private sector to deliver those programs.

And, again, we have mobilized NGOs for rural areas and in health centers for the urban poor, again emphasizing this principle of reducing inequalities.

And now Cambodia is well-placed to meet MDGs so by 2005 was 100-percent coverage at the health center level and 70-percent scenario positive case detection and over 80-percent treatment success rate. So, we can see how the investment over time brings positive results.

Looking forward, in terms of health systems strengthening, we will be encouraging countries to provide national strategy applications. These are national strategies for disease programs that can be used to strengthen health systems that can be funded over a period of time.

So, countries can present their national health strategy and within these disease-specific strategies that can be health sector or multisector interventions. And this will

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be in terms of the review process, we will use our existing processes but ask countries to provide in addition to their nationalist strategies some supplemental information that is specific to us as a funder. But this will be light, so we are not burdening the countries with excessive paperwork.

And we will, jointly with our partners, use a shared validation process picking some aggressive attributes. And this validated the strategy of the country can then be used to seek funding from diver sources. And the benefits of the national strategy approaches to ensure that there is greater country ownerships of all the programs or initiatives around health system strengthening, improve alignment of the accented fund to prioritize.

And the budgets be framework, so they start with the budget cycle and the reviews and reporting is aligned in this country processes. Again, the importance, to achieve greater harmonization of different funders to ensure that there is no duplication and we achieve synergies. Again, rather than having multiple funders funding multiple programs that do not talk to each other, we will try and fund one national strategy or one national program for a specific disease and this should in time rate transaction costs.

And also applying our performance-based funding principle, hopefully, this operation will encourage folks and results, outputs and outcomes, as well as mutual accountability

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by all parties concerned to achieve the objectives and goals that we have set to achieve.

So, this approach is very much in with the Paris Principles and the Action to which we are seeking to make. So, this is from an Arabic program in Namibia, and just finally we are seeing what they would see in Cape Canaveral. We have takeoff. If we look at ARV and those number of people on treatment, this is DOTS. We can see rapid increase because ARVs began an exponential curve and a big takeoff in insect-site treatment benefits for malaria. So, we are seeing increased access to interventions.

And, in terms of outcomes, again, as we said we are a young organization and it will take a few years to see the benefits, to see the outcomes of these investments, but we are seeing some early results and with some modeling we can see how the investments may be impacting on health outcomes.

This is malaria and infectious-treated bednets in Tanzania. As you can see over a period of time there was very little change in child mortality, but with interventions you can see a decline in child mortality and if we are able to continue along this trajectory, Tanzania will be able to reach MDG targets by 2015.

So, ladies and gentlemen, dear friends and colleagues, thank you for giving me this opportunity. I would like to finish by saying that I find this, as I said earlier on, this

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false dichotomy of health systems versus disease control programs rather unnecessary. I think through the strengthening disease programs we strengthen health systems and by strengthening health systems we strengthening these programs.

And our objective is to ensure that we achieve the outcomes we have set out to achieve. So, let's try to, instead of burying our patients, let's try to bury this unnecessary debate and this false dichotomy. Thank you for your attention [applause].

MICHAEL KIMERLING, M.D., M.P.H.: Thank you very much for a comprehensive review of where the Global Fund has been and where it hopes to go. So, I think we have time now and we would like to open the session to questions from the floor.

So, please, persons interested come to the microphone and state your name and with whom you work and then proceed with your question of short or of brief duration, not a side speech of any sort. Thank you. Any questions? Please come forward.

IAN HARPER: My name is Ian Harper from the University of Attenborough. I was just wondering why the double fund doesn't have in-country presence, and uses the LFA mechanism, if you could explain that for us. Thank you.

RIFAT ATUN: Thank you very much. The purpose of the Global Fund was to rapidly accelerate investment in countries, and one of our principles also to be lean. So, we don't want

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to, because we work through our partners, we don't want to create yet another agency with country presence. There are many of our partners are multilateral institutions that have country presence, bilateral agencies through countries that also have presence in countries.

So, rather than replicating that, we try and work through the CCM, the Country Coordinating Mechanism, that includes both the state factors as well as civil society, affected communities, patient groups and other parties who have a stake in designing and implementing our busiest program. So, more health dollars go to the country as opposed to infrastructure.

KEN CASTOR: Thank you for the presentation. I'm Ken Castor from CC United States. It is clear that Global Fund has been a lifesaver and it has provided us all with renewed optimism. The one thing that draws my attention is all the numbers that you thorough at us. If you could tell me more about data management systems because at the end of the day, the data are only as good as their accuracy and validity.

What systems do you have in place to independently validate that when you claim to have such rises in persons, place on DOT or antiretrovirals, it's not the result of duplicate counting or things like that. If you could please tell me more about what you do in that regard I would appreciate it.

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RIFAT ATUN: Thank you, that is a very important question. And the results, performance evaluation, as well as monthly evaluations actually within my cluster. As I said, we work through partners and the impact part is as a result of not just our investment but actually work with our partners.

So, the numbers I present is acutely much more collective than Global Fund alone. Data is an issue, I think, not just for us but for all partners working in countries where the three diseases presence.

There are a number of issues with data. One is the quality of the data, and secondly analyzing the data that' available. And I think the second one is probably more problematic than the first. There are huge amounts, vast amounts of data that are not analyzed appropriately.

So what we are trying to do searching at the Global Fund within my cluster is to put in, we have developed a number of tools working with our partners to undertake data quality audits, which we undertake on a regular basis. Gross investing substantially and monitoring an evaluation, so encouraging companies to look at their monitoring evaluation systems.

Undertaken assessment and we have joined with WH and other partners. We have develop the tool kit to enable countries to assess their MNI, the strength of their MNE systems, and to think about investing through the Global Fund grants to strengthen their MNE systems over time.

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Additionally, we work with partners to undertake surveillance to try to understand and different times what's happening, but I think this is a collective responsibility. I mean, it is not acceptable 25 years after HIV still in many countries we don't know what is happening. So I think this is not something for us, we are fully committed to getting appropriate data, timely data and segregate data.

I think averages can be very misleading, you need to get data on gender, we need to get that on vulnerable groups. We need to get data on the groups that we are targeting so we can understand how the epidemic affecting different communities.

So, using the statement Know Your Epidemic, yes, let's try to really know our epidemic, but let's also know how we are impacting on this epidemic so that we can continually define the way we are implementing our programs over a period of time. So, I think there is a need to call for action to really invest in many systems in countries, and we rely on our partners to take this initiative through.

TONY HARRIS: Tony Harris, Soviet Union. Thank you very much for a really great, great talk. I want to ask you about ARV therapy. Now, I think, in the last four years, remarkable scale-up in resource-limited settings, Global Fund support, FR support and others.

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But just thinking into the future, and I wonder if you would do this for us, if we are really good with universal access, it's possible in ten years' time we could have instead of three million people on ART we could have 30 million people on ART. And if we don't get a handle on prevention, that number could continue and of course these patients are on treatment for life.

Now that's a huge bill. I worked in Malawi for five years scaling up ART and the question that always came up during training sessions, will the money be there next year? Will it be there in four years' time, will it be there in five years' time?

I know it's difficult particularly with the current problem going on globally, but would you like to say something about how you think we'll have the funds in 10 years' time? Will we have the funds? What do you think about it?

RIFAT ATUN: Well, it's an excellent question and I'm not sure that I'm well-positioned to answer this because I'm not a donor country. We rely on our partners to provide the funding, so we think of ourselves as being, what my executive director, Michelle Kozechcan, would call an upstream swap or an upstream basket of the funds coming in, which would then channel into countries.

Interesting, your question is excellent because with one of my team members, McDaniel, today, we were talking about

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our comprehensive funding policy, i.e., we provide comprehensive funding to the programs that we invested in over the lifetime of the grant, but also those grants that have ended, we provide funding for continuing the services.

I wrote a paper recently, it's under review. Hopefully, it will get accepted, but looking at HIV as a chronic disease. And a 25-year old, I think the paper was from the Netherlands, diagnosed with HIV who started on ARB appropriately. Life expectance of this person is 33 years, on average.

Similar to life expectancy of somebody with type I Diabetes of the same age, I think this is a remarkable success for the HIV community, something that we need to celebrate. But this success also brings responsibilities, not just for us but also for all of the partners.

So any tenure that people put on ARBs are funded not just through the program but actually beyond, so we need to look at comprehensive policies for the lifetime of the patients. And, again, as I said, we are a young organization and alone will not be able to solve the global problems.

HIV has been around for 25 years, but I think we're are conquering our fight against HIV, TB and malaria, but we need to better understand how our investments are improving longevity, more long-term commitments so far, as a fund but

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also as a global community and think about financing appropriately for TB, HIV and malaria.

And, recently, a new task force was established by that's going to be chaired by Gordon Brown and Mr. Zelich, who is the President of the World Bank. This is the task force on innovative financing, which closely contributing from the Global Fund.

And I guess this task force will explore some of these issues to try and understand what our long-term commitments to the international funding is to continue scaling up, but also sustaining the investments of people who have these. So, no easy answer but we are acutely aware of this issue.

ASMA EL SONY: I think that we would like to see that Mr. Brown the G8 work on another issue and that is the foreign development investment, the FDI of the poor countries. We would like to see that that improves.

So, it is not sustaining you know, the funding and asking the development partners to put more funds along, but we would like to see that it is poverty alleviation and that the program for that and that the Foreign Development Index in poor, developing countries, as well, rises, because now the FDI is mainly among the three giants, and that is the United States, Europe and Japan.

RIFAT ATUN: Thank you, Asma, for this very challenging question. I wish I could speak on behalf of Prime Minister

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Gordon Brown but I'm afraid I don't have the prerogative for this. But FDI funding investment in countries is critically important, and especially given the financial crisis.

Approaching the management of these diseases, we are dealing with very complex problems and it is very important not just in the treatment but to look at the prevention activates but also going more upstream to look at the determinants.

But I think that requires the funding agencies in countries to look at development generally within this managing of particular disease specifically. A foreign direct investment in a country will enable countries to improve the economic and hence their GDP income and through that education, and through that invest in water, sanitation, public health intervention, et cetera. So we will see sort of positive benefits.

But this will take time, so I think we need to balance managing the problems now with long-term investment to strengthen the economic capacity within countries so that the upstream determinants can also be addressed to reach the same qualities.

So, the two need to work in tandem, and I guess these are the prerogatives of the World Trade Organization that are going to meet in December to discuss some of these issues. But I'm very interested to hear that at the Union Conference we are discussing global market economic issues, so we can see that

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health is an integral part of economic development, so investing in health would improve economies as well as improving health. I think that is a very important statement.

AMELIE VEVINSON: Can you hear me? My name is Amelie Vevinson. I am from Norab and I have just returned from Molave where I was on the Norwegian delegation in the health sector stop that was undertaken last week. And as you probably know, the Global Fund is also a partner in the health stop.

So, I was a bit intrigued or surprised when you were quoting this health surveillance assistance because you did - you have it to 6,000. New health surveillance assistance, but only 25-percent of them have been trained. And they were recruited and employed a year ago.

And it was said during the meeting and this goes back to what you were saying about alignment and harmonization, that it was one thing to training capacity but also the funds for the training have not come through because of some conditions from the fund. So, they are sitting there, 75-percent of those 6,000, not doing a thing because they haven't been trained and in addition to that they are being paid more than the health surveillance assistance that the government of Molave has employed themselves.

My intention was not to raise this but since you brought Malawi up I thought at least I should bring it to your attention.

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RIFAT ATUN: Thank you very much, the number I present does not refer to a specific number of people trained, this is a number of people in a number of courses, including short courses. It is not a very clear number and I presented numbers in a caveat.

In terms of disbursements, we disburse against performance is our model. So we don't include conditionalities. We have existent with countries, we agree on the performance indicators for countries such and before the funds can be dispersed.

If there are delays this may be due to a number of reasons, one that the performance targets have not been achieved and these performances are joint beset. Actually, the countries set them, we monitor them. And sometimes there may be delays in signing phase II grant or there may be delays in signing new grants that are coming through.

So, I don’t know, specifically, the details of Malawi but I can certainly find out and find out why these delays might be. But we have some portfolio managers who manage these funds, so I'm not positioned to know. We have over 500 or so grants in different countries. So, I don't know each fund, each program in detail. But we can certainly provide information to you offline as they say.

PETER HOMELY: Thank you, Michael. Peter Homely, first of all, thank you very much for a very good and also a very

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interesting overview. I also completely agree that the health funding that we sometimes see or that according to you is even showing a revival at this moment between the system and disease specific would be at then extremely damaging for the health of the people that we are responsible for.

So, in complete agreement and without trying to create a lot of the company that – I was very pleased with what you said about the interventions on the human resources, on the quantities and qualities. And you do realize the people that are working in the countries, that it is an extremely important issue.

But in the countries we also see that what you are also now saying is not always in line what other financial institutions like World Bank and IMF are advising to the countries. It is creating problems, not only for the disease programs, but also for the Minister of Health because the Minister of Finance is at the end, is the one who is deciding.

So what are you doing to streamline or to your strategic interventions with those huge financial institutions?

RIFAT ATUN: Thank you. This question always comes up in many, many fora and many meetings. And it is an important question. I think maybe just to articulate what the question refers to, in some countries where IMF or some agencies have presence, there is an agreement, there is a seating on what the

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public sector can spend in a given year as part of managing the medium-term expenditure in countries.

And sometimes if there is additional investment, for instance, in human resources, let's say, in the public sector, this ceiling in theory may prevent this investment because we are breaching the seating order that limit is set.

And there are a number of instances where this has apparently has been a problem. Now, we don't set conditions as the Global Fund, and I cannot speak on behalf of other agencies. I think we should have an IMF for a World Bank of Central to answer this question directly.

But clearly we need to find innovative ways of addressing this issue and there a number of models one can use. I can quote from - I have dual citizenship, British and Cypress, so with my British, in Britain, we are also bound by the Master Treaty, which meant that as a country we could only have in terms of our annual budget we could not exceed certain limits and also in terms of our long-term debt we should not exceed certain limits.

So, in Britain they came up with something called the Private Planning, which essentially allows the country to have off-balance sheet investments. So you can invest through the private sector or through the non-public sector entities to add additional capacity to the country without disbursing the budgetary principles that you have set.

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So I think what we need to look at are ways of enabling scaling up in terms of investment, while ensuring that there are some appropriate frameworks to adhere to.

But I'm not an economist and this is a question not just for us, but I think it's a question for all the agencies to work through to see what models can be used to ensure that investments are not or scale-up is not prevented due to the framework set.

Again, having a national strategy may help address this issue to a great extent, because the national strategy will have to look at the budgets that is contributed by the public sector as well as by other agencies and look at medium-term expenditure framework set for the country and try and look at ways of scaling up while meeting the mockery kind of objects of the country.

Which may be set by external agencies in collaboration with the country but often in some cases this is also set by the country themselves to ensure that they have economic growth without inflation.

JOSEN DEMIA: Josen Demia, H Foundation East-West, working in Eastern Europe and Central Asia. Thank you for your presentation. It showed a very impressive progress through the involvement of the Global Fund. You've showed you are active in many countries; you highlighted the increasing importance that the Global Fund attaches to involvement of civil society.

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Now, what you didn't show is that soon the metric of the coverage may soon be much wider because the eligibility criteria you are pulling out of quite a bit of countries. And that poses a problem, perhaps, also particularly for civil society in some of those countries.

And I wonder whether you could comment a little bit on that, especially since that might actually delay or hamper the progress that you so impressively highlighted in this presentation.

RIFAT ATUN: Which aspects of the eligibility criteria are you referring to?

JOSEM DEMIA: Well, the macroeconomic criteria, basically. That's what so-called rich countries are falling off the list, which in a way is understandable and on the other hand some of these countries like Russia, civil society has made enormous progress and it will be down the drain soon, I'm feeling.

RIFAT ATUN: In a progress way, the economic crisis may help address this issue, because the GDP per capita in many countries will probably decline going forward, so it may be less of an issues going forward than – again this is something we were discussing this morning.

Clearly this is something we need to look at much as from the Global Fund but as the partnership to see what happens in countries that have passed this threshold. And there will

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be a fluctuation in some countries, some will be eligible and depending on their economic performance they will not be eligible. But, again, this is why the harmonization at the global level is so critical, so we don't just start investing in the country then the programs are not followed.

We need to find a way of investing continuously, but also the mutual accountability. We need to ensure that the countries where the GDP has arisen, they are also contributing to the well-being of their citizens.

And we always encourage and try and invest through civil society. But I think this mutual accountability is critically important. We cannot solve all the problems ourselves as the Global Fund. We are one of the actors. But we have certain principles that we try and emphasize, but this is a partnership effort. Thank you.

MALE SPEAKER: Thank you, sir. We can see in your presentation the work against the tuberculosis, HIV and malaria. And this activity is widely possible in the developing countries due to the Global Fund. So the Global Fund constant flow of grant is necessary, inventing this help, especially in the developing countries.

I am one of the developing countries like Bangladesh and we have got much in that of tuberculosis and malaria. We have thought that this would be one of the great examples in s

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the subcontinent. So, to maintain this program, funding is really necessary.

But sometimes we get fund delayed, so our assistance is not achieved in time and delay is partially from that Global Fund, partially from my government side and also from my inplementary side. There are some disasters, due to the disasters, the implementation is hampered.

So, the fund is not arrived in time. The maintenance of this quality or this achievement is very difficult. The day before yesterday or we saw the Age of Depression from HIV. The one to leave, so for this reason funds are essential.

So in any problem, fund is delayed, achievement of our target and our continuation with this is not possible. So this is my worry.

RIFAT ATUN: Thank you, and you raise a very, very important point that we are very aware of and in a way this also relates to Malawi example and I want to give a more generic answer. We are acutely aware of this issue of sort of scheduled-based funding.

But we are a young organization; we have only been around for five, six years. But we are a learning organization, we're always trying to learn from our experience and trying to innovate, to enhance the way we invest and to work with countries to find solutions.

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To the issues that you have raised, we are currently undertaking a substantive review of our what we call our architecture that will enable more sustained investment over time in countries. So rather than having this scheduled investments sort of phase one and phase two, we invest over a period of time and to try and release investments against the performance that are aggrafied by the agents.

So, rather than having, sort of, short-term grants, think about longer-term investments. I cannot give you the details because we have just actually begun this work and on Monday we have our kick-off meeting to discuss with the working group how we are going to operationalize this by '09.

So we are aware, we are looking at ways of addressing this. We have already introduced some innovations such as rolling continuation channels, but we are not thinking about investment over a longer period of time rather than a project based, or programmatic interventions over five or six years as the case is now.

So, maybe in the next Union meeting after my presentation I'll be able to answer your question with more confidence.

MICHAEL KIMERLING, M.D., M.P.H: Okay, we have the final question here, thank you.

MEGAN ELLIOT: Thank you for your presentation. My name is Megan Elliot. I'm from Population Services

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International, PSI. I have a question for you concerning national strategy applications and if you could elaborate a little bit more on those, specifically will this be some more guiding Principles on how countries can complete section 4B of the proposal format?

And how will this work with other funding mechanisms like swaps, like IHP that we have heard about? It is a little confusing and I'm hoping you can clarify that.

RIFAT ATUN: Thank you. Very important question. I wish I could clarify this. We have just - NSA is the second major piece of work within my cluster that we are going to present to the Board, so in principle this has been agreed and we are working with our partners that are involved with the International Health Partnership, so called IHP+.

To think how the NSA will align itself with IHP+ borrows a swaps, but I can tell you some general principles. General principles are that there is the country is working with partners develop their own national strategies and then these are jointly reviewed and validated against a set of commonly-agreed attributes to ensure that they are targeting population groups. They are investing appropriately in key areas.

Then these national strategies generally or specific disease components in our case can be used to submit as a proposal, with some additional documentation that will meet the

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needs of different funding agencies, maybe PEPFAR, maybe I don't know if PEP is going to be involved but in our case it's the Global Fund.

And, then, in terms of funding, so we are actually going to roll this out in a number of countries in 2009. We are in the process of developing the eligibility criteria for the first wave counties, but also the criteria through which we'll review the proposals for their validation and the mechanisms through which the funding is going to be channeled into a country if there is an existing swap or if there isn't one how this is going to work.

So this is a substantive piece of work that is just started. And, again, I'm hoping at the next meeting, Michael I hope you're taking notes, I will be able to answer this question in more detail.

MICHAEL KIMERLING, M.D., M.P.H: Thank you. The next Union Meeting is in Mexico, December 2009. Anyway, with that I would like to thank our speaker, Professor Atun and also would like to encourage everyone to visit the poster sessions that will now be displayed and the presenters should be present so it is a good time.

Also, to interact with people from countries who are trying to present their information, it is a good opportunity and I wish you a nice continuation for the conference. Thank you [applause].

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