Global Fund to Fight AIDS, Tuberculosis and Malaria

KEY FINDINGS

- In current Global Fund TB and HIV/AIDS grant application forms, the only guidance recommending TB-HIV integration is included as a footnote, resulting in limited attention paid to TB-HIV in grant proposals.
- An analysis of Global Fund TB and HIV/AIDS proposals from funding Rounds 5 through 7 for nine countries, together accounting for more than half all new estimated TB-HIV cases in 2006, shows that most lacked the basic set of TB-HIV services as recommended in the WHO interim policy.
- In these nine countries only an estimated $6.8 million was budgeted for TB-HIV activities in 2008, and in some cases TB-HIV activities had no associated budget line.
- Global Fund programs have not effectively monitored the implementation of key TB-HIV activities. TB-HIV indicators are recommended, though not required. Variability in the use of indicators across projects has hampered capacity to monitor and evaluate TB-HIV activities in the aggregate.
- In 2008 the Global Fund board adopted a decision point that, if implemented effectively, could lead to significantly improved TB-HIV integration within proposals in future funding rounds.

BACKGROUND

The Global Fund was established in 2002 to mobilize new resources to combat HIV/AIDS, TB, and malaria in regions most in need of support. It has since become the largest external funder of TB programs, providing roughly one quarter of international funding for HIV/AIDS (GFATM 2005a). Funded through voluntary contributions from donor countries, foundations, and the private sector, the Global Fund is a financing agency only, granting funds in response to proposals submitted by stakeholders in low- and middle-income countries. The Global Fund has approved over $15.1 billion in grant funding, with over $7.29 billion disbursed and more than $10.4 billion[1] committed. Its innovative model of country-owned, transparent, results-driven funding has met with considerable success, establishing a new method for financing development and saving an estimated 3.5 million lives to date.

Applicants for Global Fund grants have considerable freedom to structure their proposals as they see fit, provided they are technically sound and adhere to the Global Fund's core operational principles.[2] The Global Fund Secretariat reviews all proposals for funding eligibility, forwarding qualifying submissions to the Global Fund's

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1. All funding amounts are based on a detailed grant report run on February 19, 2009, available at http://www.theglobalfund.org/en/commitmentsdisbursements.

2. Funding requested from the Global Fund must supplement, not replace, existing resources. Programs must also pursue tangible time-bound goals, reflect broad-based country ownership, align with national strategic plans for disease control, and move toward achieving the sustainability of interventions.

Technical Review Panel (TRP). The TRP reviews them for "technical merit" based on soundness, feasibility, and sustainability (GFATM 2008e). Proposals failing to meet these criteria may be recommended for rejection or re-submission pending substantive revision.

Available information suggests that the Global Fund has supported comparatively few TB-HIV activities, and even fewer at the scale needed, as part of its $15.1 billion in approved grant funding. An analysis of Global Fund grant proposals for nine sub-Saharan African countries, together home to more than half of all new TB cases in PLWHA in 2006, shows that only an estimated $36.9 million was budgeted for collaborative TB-HIV activities in these countries during Rounds 5 through 7. Only an estimated $6.8 million in Global Fund support was budgeted for the implementation of TB-HIV activities in 2008.

At its most recent meeting, the Global Fund Board adopted a decision point that calls on funding applicants to address TB-HIV in their grant proposals. In addition, the Global Fund reports that it will soon complete and widely disseminate a TB-HIV fact sheet, so that applicants are better informed of the need to include TB-HIV activities in Round 9 proposal submissions (GFATM, personal communication 2009). Both of these measures represent progress. However, further action is necessary to ensure that the Global Fund Secretariat, TRP, and Board encourage expanded and comprehensive TB-HIV programming so that TB-HIV services are actually taken to scale.

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POLICIES

As a "country driven" funding mechanism, the Global Fund recognizes that "in-country settings have a significant impact on what is appropriate to particular country contexts…there is no 'one list' of what should be included in proposals" (GFATM 2008b). The principle of country ownership lies at the core of the Global Fund's model, and as such it allows grantees considerable flexibility in the design of programs.

While applicants are responsible for developing the core elements of grant proposals, grantees often seek guidance from international technical agencies during proposal development, and this guidance can play a significant role in shaping program content. In addition, the Global Fund mandates that proposed health programs meet certain minimum requirements around quality and process.

All Global Fund-supported programs must procure second-line TB drugs through the Green Light Committee, for example, and recipients must draw pharmaceutical products from either national or international standard treatment guidelines or the WHO's essential medicines lists. If proposal applicants are from middle-income countries, proposed health programs must focus interventions primarily on key affected populations and those living in poor regions. As part of every grant proposal, applicants must answer specific questions regarding each of these issues, describing if and how each prerequisite will be met, or otherwise justify their request for an exemption.

The Global Fund has not placed comparable weight on the importance of integrating TB and HIV/AIDS services. Since Round 5, the Global Fund has encouraged grantees to implement

TB-HIV activities, but only by including the following text as a footnote on the Global Fund's grant application form:

> In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB-HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

This language is merely advisory and serves as the single substantive mention[3] of TB-HIV in either the proposal application or the accompanying instructions. Applicants for TB or HIV/AIDS funding are not required to include TB-HIV activities in proposed health programs, nor are they required to integrate HIV/AIDS services with those for TB or vice-versa.

Recognizing the urgent need to scale up TB-HIV efforts within its programming, the Global Fund recently took steps to strengthen its TB-HIV guidance. At its November 2008 meeting, the Board adopted a decision point that "emphasizes that all applicants should include and implement significant, robust tuberculosis interventions in their HIV/AIDS proposals and HIV/AIDS interventions in their tuberculosis proposals" (GFATM 2008a). This decision point also instructed the Secretariat to amend guidelines for TB and HIV programs that have successfully completed an initial two-year phase and are requesting funds to continue (i.e., Phase 2 funding requests), requiring that "CCMs[4] explain their plans for scale up to universal TB-HIV collaborative services and explicitly articulate what TB-HIV activities, funding, and indicators will be included in each proposal" (GFATM 2008a). In adopting this decision point, the Board took an important step toward strengthening TB and HIV/AIDS programs as they enter Phase 2. To further its impact, the Board should extend this requirement to all new grant applications.

Given that preventing and treating TB-HIV is critical to meeting the needs of both TB patients and PLWHA, the Global Fund should ensure, to the greatest extent possible, that its TB and HIV/AIDS programs provide for the integration of TB and HIV/AIDS services. Toward this end, the Global Fund should require that every TB and HIV/AIDS proposal provides for some measure of TB-HIV integration, and it should include a section in the grant application form in which applicants must describe how they will ensure all people in supported HIV/AID programs receive TB screening and follow-up services and vice versa. The form should clearly identify WHO's TB-HIV policy as the internationally recognized standard of care for TB-HIV co-infection. Because the policy recommends interventions appropriate for a range of epidemiological contexts, requiring applicants to adhere to it would not force them to include unnecessary activities or follow a cookie-cutter approach.

PROGRAMMING

The ACTION project relied on two measures to assess the Global Fund's support for TB-HIV programming. The first was an analysis of all approved TB and HIV/AIDS proposals to determine which included at least one

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3. The Guidelines for Proposals for Round 8 refer to TB-HIV co-infection in two places. On page 8, the guidelines state that collaborative TB-HIV activities can be included as part of both TB and HIV proposals. On page 41, the guidelines state that the portion of the application that deals with multi-drug resistant TB should be completed for TB and HIV proposals if collaborative TB-HIV activities are included. On page 59, applicants are informed that the TRP will evaluate proposals based, in part, on whether proposal rely on interventions that are consistent with international best practices, citing WHO and UNAIDS guidance but with no specific reference to WHO's policy on collaborative TB-HIV activities.

4. Grant proposals are submitted by a partnership of government, civil society, the private sector, and affected communities, operating as a collaborative body known as a Country Coordinating Mechanism (CCM). After grant approval, it is the CCM's responsibility to oversee progress during program implementation and report to the Global Fund on this progress.

TB-HIV activity recommended by the interim policy — a relatively low threshold. This analysis showed that, over time, an increasing number of TB proposals have included at least one TB-HIV activity, increasing from 33 percent of proposals in Round 1 to 79 percent of proposals in Round 7 (Box 1). HIV/AIDS proposals have not shown any discernable progress — hovering around 40 percent of proposals from Round 1 to Round 7.

The ACTION project also analyzed grant proposals, grant agreements, performance reviews, and other publicly available information on TB and HIV/AIDS programs to discern how and to what extent TB-HIV components were included. An in-depth review of Global Fund-supported activities, budgets, and indicators from Round 5 through 7 for nine sub-Saharan African countries, together representing 54 percent[5] (Table 5) of all new estimated cases of TB-HIV co-infection in 2006, shows that Global Fund-supported programs have considerable ground to cover before they comprehensively address TB-HIV.[6]

Table 5. Estimated 2006 TB Incident Cases

Country	2006 TB Incident Cases	2006 HIV-positive TB Incident Cases	HIV Prevalence in TB Incident Cases (%)
Malawi	51,172	35,781	70%
Swaziland	13,097	7,060	54%
Botswana	10,230	5,504	54%
Kenya	140,548	73,122	52%
Lesotho	12,670	6,137	48%
South Africa	453,929	200,693	44%
Rwanda	37,563	15,270	41%
Tanzania	123,140	21,653	18%
Ethiopia	306,330	19,220	6.3%
Total	1,148,679	384,440	33%
	% of all 2006 HIV-positive TB Incident Cases (709,000)		**54%**

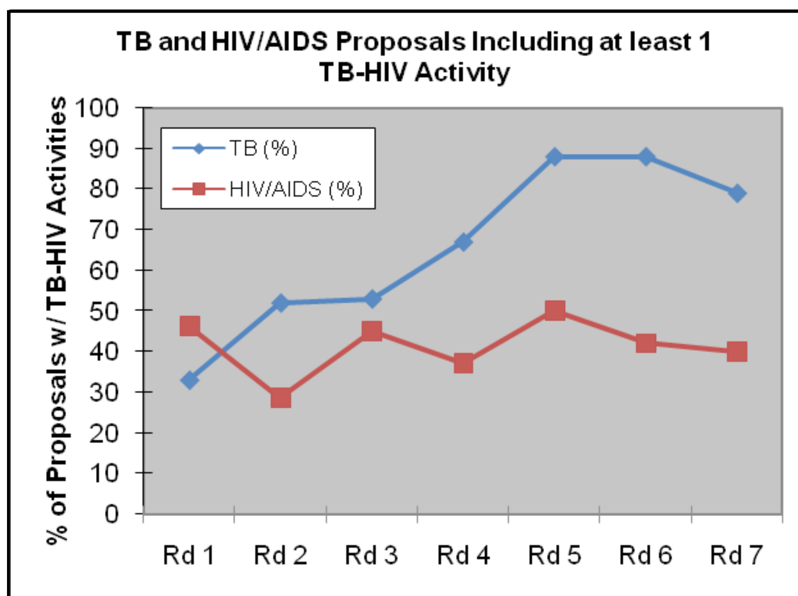
Source: Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2008. Geneva: WHO. WHO/HTM/TB/2008/393

During Rounds 5 through 7, Global Fund resources have supported few effective TB-HIV activities in the nine countries analyzed, and rarely at a scale needed to make progress toward universal access to quality TB-HIV services. In proposals that identify TB-HIV as a major problem, proposed TB-HIV activities tend to be limited in scope and scale. In some cases, no TB-HIV activities are proposed at all, even in countries with a significant and growing burden of TB-HIV co-infection. Kenya's Round 7 HIV/AIDS proposal, for example, aims to significantly scale up ART, but makes no provisions for integrating TB-HIV services, including screening those on ART for TB. Swaziland had the highest TB-HIV co-infection rate in the world in 2006, yet its HIV/AIDS grant proposal from Round 7 does not include a single TB-HIV activity.

5. This analysis is based on global TB surveillance data from 2006, the latest available at the time this report was written.
6. Where specific activities could not be clearly identified in grant agreements or performance reviews, this analysis relied on the program descriptions found in grant proposals.

Box 1. Global Fund Grant Proposals with TB-HIV Activities, Rounds 1 - 7

In Round 1[7], only 33 percent of TB proposals included at least one TB-HIV activity, increasing to 88 percent by Round 5 before dropping to 79 percent in Round 7. HIV/AIDS proposals have not performed as well. The percentage of HIV/AIDS proposals that included at least one TB-HIV activity has hovered around 40 percent for all funding rounds, reaching as low as 29 percent in Round 2 and peaking at 50 percent in Round 5.



Source: Data for Rounds 1-6 for TB proposals and Rounds 4-6 for HIV/AIDS proposals were taken from a presentation by Haileyesus Getahun at the Global Fund and Scientific Policy Seminar in Geneva, Switzerland on October 5, 2007. The remaining proposals were analyzed by ACTION using the same methodology.

Notes:

1 Each data point is marked with the total number of TB or HIV/AIDS proposals approved during that round.

2 One Round 1 HIV/AIDS proposal is available on the Global Fund website only in French; the Round 1 percentage for HIV/AIDS is calculated out of 26 HIV proposals instead of the 27 that were approved.

3 One Round 2 HIV/AIDS proposal is available on the Global Fund website only in French; the Round 2 percentage for HIV/AIDS is calculated out of 42 HIV/AIDS proposals instead of the 43 that were approved.

4 Two Round 3 HIV/AIDS proposal are available on the Global Fund website only in French; the Round 3 percentage for HIV/AIDS is calculated out of 30 HIV proposals instead of the 32 that were approved.

5 One Round 6 TB proposal is missing; the Round 6 percentage for TB is calculated out of 34 TB proposals instead of the 35 that were approved.

6 Two Round 6 HIV/AIDS proposals are missing; the Round 6 percentage for HIV/AIDS is calculated out of 31 HIV/AIDS proposals instead of the 33 that were approved.

7 Two Round 7 TB proposals were not available on the Global Fund website; the Round 7 percentage for TB is calculated out of 19 TB proposals instead of the 21 that were approved.

8 One Round 7 HIV/AIDS proposal was not available on the Global Fund website; the Round 7 percentage for HIV/AIDS is calculated out of 25 HIV/AIDS proposals instead of the 26 that were approved.

7. For Rounds 1 through 4, proposals could be submitted under a separate TB-HIV category, but the category was eliminated due to the limited number and poor success rate of TB-HIV proposals. The board also concluded that "having a separate HIV/TB component seems to suggest to applicants that programming between the two diseases should be handled as a separate endeavor" (GFATM 2005).

As part of its policy on TB-HIV collaboration, the WHO has identified three key interventions — branded the "Three I's" — to decrease the impact of TB on PLWHA: intensified case finding, isoniazid preventive therapy (IPT), and TB infection control (WHO 2008b). Among TB and HIV/AIDS grants approved during Rounds 5 through 7 for the nine countries reviewed, only one program explicitly provided for all of the Three I's (Table 6). Four out of the nine countries' proposals included no explicit provisions to carry out any of these activities. Fewer than half included systematic TB case-finding in HIV settings, a critical entry point for identifying PLWHA with TB disease as well as for offering IPT.

Table 6. Country requests for Global Fund support for the Three I's, Rounds 5-7

Country	Intensified Case Finding	Isoniazid Preventive Therapy	TB Infection Control
Malawi	X	X	X
Swaziland			
Botswana	X		
Kenya			
Lesotho			X
South Africa			
Rwanda	X	X	
Tanzania	X	X	
Ethiopia			

Of the countries reviewed, Tanzania and Rwanda were the only two countries to address TB-HIV in a substantial way. In Tanzania, the Round 6 TB grant provides $13.2 million to help integrate TB services into HIV settings and HIV services into TB settings and to build capacity for joint TB-HIV planning at the national, regional, and district levels. A Round 6 HIV grant contributes an additional $358,000 in support of TB-HIV activities in Zanzibar (Tanzania's semi-autonomous island territory), providing funding for TB-HIV policy development, strategic planning, health worker training, disease surveillance, and the establishment of a TB-HIV M&E system. In Rwanda, $10.1 million was requested as part of the country's Round 6 and Round 7 HIV/AIDS proposals to support the integration of HIV/AIDS treatment and care into TB centers and the expansion of TB care for PLWHA.

While Round 8 proposals were not made available in time to be included in this report's analysis, the TRP's Round 8 report states that in "both HIV and tuberculosis disease specific proposals, the TRP found that there were many missed opportunities for integration" (GFATM 2008d). As ACTION's analysis suggests, this conclusion just as accurately describes proposals from earlier funding rounds.

FUNDING

To supplement this programmatic analysis, ACTION assessed how much funding these proposals provided for TB-HIV activities.[8] Across countries and funding rounds, funding requests for TB-HIV were inconsistent and insufficient to drive progress toward universal access to TB-HIV services. From Rounds 5 through 7,[3] during which more than $797 million in funding was approved for TB and HIV/AIDS grants for the nine countries, country applicants budgeted only an estimated $36.9 million (4.6 percent of total funding) to support targeted TB-HIV activities (Table 7). Some portion of an additional $37.6 million in requested funding may go toward TB-HIV programming, but there is no objective way to determine how much, if any, will support TB-HIV activities (Table 8).

Table 7. TB-HIV Budgets in TB and HIV/AIDS grants, Round 5-7 (USD)[1]

Country	Round 5	Round 6	Round 7	Total
Botswana	411,695[a]	—	—	411,695
Kenya	0	9,171,789[b]	0	9,171,789
Malawi	0	—	1,385,425	1,385,425
South Africa	—	0	—	0
Swaziland	—	—	0	0
Lesotho	24,208	653,882	0	678,090
Rwanda	—	1,048,505	9,060,000	10,108,505
Ethiopia	—	1,608,200	0	1,608,200
Tanzania	—	13,557,288[c]	—	13,557,288
Total	**453,903**	**26,039,664**	**10,445,425**	**36,920,992**

[a] Only a confirmed $164,678 over two years was budgeted for TB-HIV collaborative activities. Based on average funding for these two years, and assuming consistent annual expenditures throughout the grant period, the five-year budget for TB-HIV would total an estimated $411,695.

[b] This grant does not focus on supporting delivery of TB-HIV services, but rather on expanding physical infrastructure, increasing human resources, and expanding health planning and management capacity in order to facilitate TB-HIV service delivery at the sub-national level.

[c] This amount includes $13.2 million as part of a TB grant and $360,000 as part of an HIV grant for Zanzibar.

Table 8. Budgeted Amounts Containing Unspecified TB-HIV Funding (USD)

Country	Round 5	Round 6	Round 7	Total
Kenya	6,822,059[a]	—	6,103,188[b]	12,925,247
Lesotho	21,823,175[c]	—	—	21,823,175
Tanzania	—	2,874,055[d]	—	2,874,055
Total	**28,645,234**	**2,874,055**	**6,103,188**	**37,622,477**

[a] No information is available on what portion of this $6.8 million, budgeted for behavioral change communication activities around TB and TB-HIV, will go toward TB-HIV messaging.

8. This analysis focuses on Rounds 5 through 7 because 1) these funding rounds occurred after the most recent TB-HIV guidance language was embedded in proposal cover sheets and 2) activity-specific budget information was not consistently available for all countries evaluated prior to Round 5.

[b] $6.1 million was budgeted for the provision of prophylaxis for OIs, but no explicit focus on TB or TB-HIV was identified. Other Kenyan Global Fund proposals distinguish between OIs generally and TB in particular, suggesting this $6.1 million will focus on OIs other than TB.

[c] In addition to the confirmed $24,208 that was budgeted for TB infection control activities, $21.8 million was budgeted for the integration of HIV/STI/OI services, some portion of which will go toward integrating TB services.

[d] An additional $2.87 million was budgeted in Zanzibar's HIV grant to support a number of HIV/AIDS activities. Some portion of this funding of which will support the integration of TB and HIV/AIDS services as well as public, private, and civil society outreach and mobilization around TB-HIV issues.

WHO has projected that it will cost an estimated $19 billion over eight years to reduce worldwide TB mortality among PLWHA by 80 percent by 2015. Of this total, a minimum of $536 million was needed in 2008 alone for the implementation of collaborative TB-HIV activities (ACTION 2008a). Despite this projected need, the Global Fund's estimated contribution for TB-HIV in 2008 for these nine countries (with 54 percent of the global TB-HIV burden in 2006) was only $6.8 million (Table 9). Furthermore, Tanzania, Rwanda, and Kenya account for approximately $5.9 million of this estimated $6.8 million. Combined, the other six countries budgeted less than $1 million for TB-HIV activities in 2008.

Table 9. Estimated Global Fund Grant Funding For TB-HIV Activities, 2008 (USD)[a]

Country	**Estimated 2008 Budgets**	**Assumptions[b]**
Botswana	82,339	2008 is Year Three of Round 5 TB grant.
Kenya	962,428	2008 is Year Two of Round 6 TB grant.
Malawi	345,167	2008 is Year One of Round 7 TB grant.
South Africa	0	N/A
Swaziland	0	N/A
Lesotho	212,417	2008 is Year Three of Round 5 HIV grant and Year Two of Round 6 TB grant.
Rwanda	2,270,700	2008 is Year Two of Round 6 HIV grant and Year One of Round 7 HIV grant.
Ethiopia	325,270	2008 is Year Two of Round 6 TB grant.
Tanzania	2,648,104	2008 is Year Two of Round 6 TB grant ($2.5 million) and Year Two of Round 6 HIV grant ($127,606).
Total	**6,846,425**	

[a] These calculations encompass all cost assumptions found in Table 7.

[b] If the annual breakdown of proposal budgets were broken down by the generic "Year One" through "Year Five," instead of by calendar years, estimated 2008 budgets were based on the annual breakdown listed under "Year Three" for Round 5 proposals, "Year Two" for Round 6 proposals, and "Year One" for Round 7 proposals.

The distribution of funding presented in Table 4 demonstrates that even in grant proposals for which TB-HIV activities were described, there was generally little funding budgeted to support them (Table 10). Botswana's Round 5 TB grant, for example, included TB case finding among PLWHA and HIV screening for TB patients, but

budgeted only an estimated $82,339 per year to support these activities. Ethiopia's Round 6 TB grant, with a focus on health worker training and drug and supply procurement, aimed to expand TB screening to 340 health facilities and to provide HIV testing at all the TB diagnostic centers — but it budgeted only $1.6 million to accomplish these tasks. Despite Malawi's having the highest estimated rate of TB-HIV co-infection in the world in 2006, less than $1.4 million was requested as part of Malawi's Round 7 TB grant to finance a broad set of proposed TB-HIV activities.

Table 10. Proposed TB-HIV Activity / Funding Requests in Selected Countries (USD)

Proposal	General Description of Proposed TB-HIV Activities	Total Funding Request (5 years)	Average Annual Expenditures (over 5 years)
Botswana Round 5 TB	TB case finding among PLWHA and HIV screening for TB patients.	$446,995	$89,399
Ethiopia Round 6 TB	TB case finding among PLWHA and HIV screening for TB patients.	$1,608,200	$321,640
Malawi Round 7 TB	Establish infection control procedures in health care settings, conduct screening for TB in HIV settings and vice versa, improve access to integrated TB treatment and ART, and develop and train health care workers on a policy around IPT.	$1,385,425	$277,085

The Global Fund Secretariat recently took steps to mobilize additional demand for TB-HIV resources. In November 2008, Global Fund staff participated in a WHO workshop with representatives from 14 sub-Saharan African countries, assisting in the development of action plans for TB-HIV scale-up that aimed to boost demand for TB-HIV funding. The Secretariat and technical partners should expand on this work and make demand-creation for TB-HIV resources a key priority moving forward.

MONITORING & EVALUATION

Though the Global Fund requires all grant proposals to include a comprehensive M&E strategy, it does not specify which indicators funding recipients must monitor. Rather, the Global Fund encourages applicants to select indicators based on local epidemiology, choosing "a balance of input, process, output and outcome indicators" that will "explain success and gaps in program implementation" (GFATM 2008c). The Global Fund recommends a standard set of TB-HIV indicators that should be monitored as part of any TB or HIV/AIDS program, but it is proposal applicants that decide whether or not to include them (Table 11). The Global Fund was revising its recommended indicator set at the time this report was written (with at least two indicators marked for revision), but the extent of potential changes was not yet clear.

Table 11. Global Fund Recommended TB-HIV Indicators (as of March 2008)

HIV/AIDS Programs
No. and % of PLWHA receiving HIV testing and counseling or HIV treatment and care services who were screened for TB symptoms*
No. and % of newly diagnosed HIV+ clients given treatment for latent TB infection*
No. and % of TB patients who had an HIV test result recorded in the TB register
No. and % of HIV+ TB patients who received CPT
No. and % of HIV+ TB patients referred to HIV care and support services during TB treatment
Estimated no. and % of HIV+ incident TB cases that received treatment for TB and HIV
TB Programs
No. and % of registered TB patients tested for HIV (during and before TB treatment)
No. and % of HIV+ TB patients who received at least one dose of CPT during their TB treatment

Source: Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria; Second Edition; January 2006; Addendum March 2008. Geneva: GFATM.

*Under revision

Global Fund TB and HIV/AIDS proposals often include some indicators for tracking TB-HIV activities. At times, however, proposed indicators appear to not allow the efficacy of TB-HIV activities to be adequately evaluated. Process indicators fail to capture program outputs, for example, while some outcome indicators fail to track TB-HIV project outcomes. Botswana's Round 5 TB proposal tracks only the number of HIV counseling and testing staff trained on intensified TB case finding, but not the actual number of people screened for TB. According to Rwanda's Round 7 HIV/AIDS proposal, efforts to provide ART in all TB clinics will be measured by tracking the number and percentage of HIV-positive TB patients receiving ART. However, no information will be captured on the number of the TB clinic staff or community health workers trained in the provision of ART, the activities to which Global Fund resources will contribute.

At an aggregate level, having such variation in indicators from program to program limits the Global Fund's ability to evaluate whether supported programs are meeting standards of care. For example, TB is the leading killer of PLWHA in developing countries, yet the Global Fund Secretariat does not know what portion of people served in supported HIV programs have been screened for TB (GFATM, personal communication 2008; WHO 2008a). Such examples and M&E outcomes call for increased technical assistance to ensure effective use of indicators to track progress and identify changes that are needed.

RECOMMENDATIONS

The Global Fund should amend its application process to promote greater resource flows to TB-HIV, ensure that programs meet international TB-HIV standards of care, and adequately track the implementation and outcomes of TB-HIV activities. Such action would save more lives and help to safeguard global investment in the fight against both diseases.

Toward these ends, the Global Fund should implement the following:

- For countries with moderate to high burdens of TB and HIV/AID, require all TB proposals to include robust, detailed, and costed HIV/AIDS components and HIV/AIDS proposals to include robust, detailed, and costed TB components, extending this requirement beyond Phase 2 funding requests.
- Amend the grant proposal form to require countries to articulate a plan to scale up to universal screening of PLWHA for TB, voluntary HIV testing and counseling to all TB patients, and comprehensive follow-up prevention and treatment as needed. If applicants do not include the activities, budget, and indicators to contribute to this plan, they should be required to justify the omission.
- Provide clear instructions on how to operationalize the November 2008 Board decision point on TB-HIV. This guidance and these instructions should be incorporated into the Guidelines for Proposals for Round 10 and for all subsequence funding rounds.
- Brief TRP members about the elements of TB-HIV services that must be included in TB or HIV/AIDS programs in order to meet recommended standards of care. Ensure a TRP process that allows applicants to re-write proposals that lack essential TB-HIV services.
- WHO, UNAIDS, and other technical agencies must prioritize and actively recommend the incorporation and rigorous monitoring of key TB-HIV indicators as part of Global Fund TB and HIV/AIDS programs.