The “fair share” of shared responsibility

A case study analysis by Aidspan of how The Global Fund’s willingness-to-pay policy leveraged additional government resources in the new funding model

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List of acronyms

ART	Antiretroviral therapy
CCM	Country coordinating mechanism
EECA	Eastern Europe and Central Asia
FPM	Fund portfolio manager
HIV	Human immunodeficiency virus
HR	Human resources
LIC	Low-income country
LMI	Lower-middle income
LMIC	Lower-middle-income country
NFM	New funding model
SMT	Substitution maintenance therapy
WTP	Willingness-to-pay
UMI	Upper-middle income
UMIC	Upper-middle-income country

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Key messages in brief

How much money did countries commit as part of willingness-to-pay?

- ✓ All thirteen countries in our sample exceeded their minimum WTP requirements.
- ✓ Countries sampled have committed a total of $1.66 billion *more* during the NFM phase (2015-2017) than they did in the previous phase (2012-2014).
- ✓ Iran and Thailand committed the greatest WTP (as a proportion of their minimum requirement), while Jamaica and Fiji committed the least.

What are countries spending their willingness-to-pay commitments on?

- ✓ The two most common areas in this sample were treatment (TB and HIV) and key populations. Both of these areas were included in the WTP commitments of nine out of the 13 countries. People who inject drugs and prisoners were the most commonly prioritized key populations for WTP.
- ✓ Only one country in this sample (Ukraine) has specific conditions in their grant agreements which specify where WTP commitments must be spent.

Introduction

With the roll-out of the new funding model (NFM) there has been a 56% increase ($3.5 billion) in government contributions to Global Fund-supported programs.[1] This increase has been most apparent among lower-middle-income countries, which have increased their contribution by 81%.

This shift is ground in mounting evidence that many countries can and should be spending more government resources on health (and perhaps receiving less in international assistance). One study found that Botswana, Namibia, South Africa, Mexico, and the Dominican Republic all receive more than five times the expected level of development health assistance (DHA), given their income levels and disease burdens.[2] Botswana, Namibia, and South Africa's DHA "surplus" was mostly driven by donor spending on AIDS. Further research shows that these three African countries should in fact be able to fully fund their own AIDS programs with government resources by 2018.[3]

The inclination of affected countries to contribute more government resources to their AIDS, TB, and malaria programs is especially relevant for upper-middle-income countries being faced with transition out of Global Fund eligibility. If transition occurs before a country is willing or able to cover the necessary costs of its response, there are potentially dire consequences. In Romania, for example, there has been a large spike in HIV infections among people who use drugs since

[1] Oberth, G. (2015, February 26). The "fair share" of shared responsibility: domestic financing and the sustainability of Global Fund-supported programs. *Global Fund Observer, Issue 261.* Aidspan, online at http://www.aidspan.org/gfo_article/%E2%80%9Cfair-share%E2%80%9D-shared-responsibility-domestic-financing-and-sustainability-global-fund

[2] Dieleman, J. L., Graves, C. M., Templin, T., Johnson, E., Baral, R. et al. (2014). Global health development assistance remained steady in 2013 but did not align with recipients' disease burden. *Health Affairs*, *33*(5), 878-886.

[3] Resch, S., Ryckman, T., & Hecht, R. (2015). Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries. *The Lancet Global Health*, *3*(1), e52-e61.

The Global Fund departed in 2010. In 2013, about 30% of new HIV cases were linked to injection drug use compared with 3% in 2010.[4] The specific HIV outbreak among drug users in Romania in 2011 has been directly linked to a significant decline in harm reduction services as The Global Fund left[5]; the country had not absorbed these costs, making for a very unstable transition. As such, while acknowledging that there has been progress on increasing government spending levels, it is not clear that this government investment is rising high enough or fast enough to cover program gaps in transitioning countries. It is also important to assess *where* government spending is being directed, as increases in spending do not necessarily indicate that essential programs are being absorbed by government when The Global Fund departs.

Contents of this report

This report begins by describing the history of The Global Fund's willingness-to-pay (WTP) policy, followed by sections on how WTP is calculated and the ways in which it will be monitored and enforced. Following these background sections, the paper outlines the purpose of the study as well as the methodological process followed to achieve its stated aims and objectives. Next, a series of 13 country case studies is presented as the main body of this report. Case studies highlight the specific amounts and priority areas to which each country has committed government spending over the next few years. This paper then closes with a discussion section, summarizing and analyzing WTP commitments from the 13 countries. The discussion focuses on WTP commitments made towards key populations, as well as how WTP is related to transition processes in many of the countries sampled. The discussion section of this report is also forward looking, emphasizing the importance of monitoring WTP commitments and ensuring that civil society and key populations are empowered to be at the forefront of watchdogging these commitments. The report closes by calling for a follow-up analysis which tracks whether countries actually followed through on the WTP commitments detailed in this study.

Overview of counterpart financing and willingness-to-pay

The Global Fund has always had some form of counterpart financing policy as part of its grants. In the early rounds of funding, countries needed to fill in a table which reflected their request to The Global Fund (by year) and the counterpart financing they were committing (by year), and they needed to calculate their counterpart financing as a percentage of total financing.[6] In Round 8, counterpart financing was replaced with a "cost-sharing" formula for the first time, as the Fund sought to establish maximum levels of funding it would contribute for each disease.[7] Cost-

[4] Open Society Foundations (OSF) (2014). Undermining the Global Fight: The Disconnect Between The Global Fund's Strategy and the Real-life Implications of the New Funding Model.
[5] Bridge, J., Hunter, B. M., Albers, E., Cook, et al. (2015). The Global Fund to Fight AIDS, Tuberculosis and Malaria's investments in harm reduction through the rounds-based funding model (2002–2014). *International Journal of Drug Policy*.
[6] See Round 6 Call for Proposals http://www.theglobalfund.org/ProgramDocuments/TJK/Proposals/TAJ-R06-HA_Proposal_0_en/
[7] Rivers, B. (2008, March 14). Global Fund Launches Round 8, With Focus on "Dual-Track" Financing. Global Fund Observer, Issue 86. Aidspan, online at http://www.aidspan.org/gfo_article/global-fund-launches-round-8-focus-dual-track-financing

sharing in Round 8 meant that The Global Fund would pay for up to 100% of the national program for lower-income countries, up to 65% of the national program for lower-middle-income countries, and up to 35% of the national program for upper-middle-income countries.[8] This change was the result of the Fund's decision to use national needs instead of national contributions as the basis for calculation.

In May 2011, The Global Fund Board again adopted new counterpart financing requirements for applicants, including minimum thresholds for domestic contributions, increasing contributions, and improving expenditure data.[9] The term for the policy was also changed from "cost-sharing" back to "counterpart financing." The first change – a minimum threshold for domestic contributions – meant that governments had to contribute a percentage of their requested funding: 5% for lower income countries, 20% for lower LMICs, 40% for upper LMICs and 6% for UMICs. This split between lower LMICs and upper LMICs was introduced specifically for the new counterpart financing requirements. Second, the new counterpart financing policy for the first time included an increasing contributions element, whereby countries had to demonstrate that government contributions to the national disease program and overall health spending were increasing annually. This is the first time the general concept of "willingness-to-pay" was included as part of counterpart financing, though it was not so named and not yet fully defined. Third, the revised policy included a provision on improving expenditure data, where countries were required to report annually on financing information (by source) for the national disease programs.

In November 2012, The Global Fund Board approved a design for the NFM, which contained several further changes to the counterpart financing policy.[10] One of these was an additional component called "willingness-to-pay" (Box 1). Willingness-to-pay essentially tied 15% of a country's total funding allocation to the condition that the country commit to additional levels of government spending – i.e. over and above what countries had to meet in terms of their minimum threshold for counterpart financing (5% for LICs, 20% for LMICs, etc.).

How is willingness-to-pay calculated?

The Global Fund has been relatively ambiguous about what the minimum WTP requirements are for countries and how they are calculated, opting for vague descriptions, such as: "The amount of additional commitment required is linked to a country's ability to pay"[11]; and "The Global Fund Secretariat will work with CCMs and national governments to determine the specific additional amounts required for each national government."[12]

[8] Report of the Portfolio Committee to The Global Fund Board at the 16th Board Meeting 12-13 November 2007.
[9] Garmaise, D. (2011, May 13). Global Fund Board Adopts New Criteria for Eligibility, Counterpart Financing and Prioritisation. Global Fund Observer, Issue 146. Aidspan, online at http://www.aidspan.org/gfo_article/global-fund-board-adopts-new-criteria-eligibility-counterpart-financing-and-prioritisati
[10] Garmaise, D. & Macintyre, K. (2012, November 16). Global Fund Board Approves Design of New Funding Model. Global Fund Observer, Issue 202. Aidspan. http://www.aidspan.org/gfo_article/global-fund-board-approves-design-new-funding-model
[11] See http://www.theglobalfund.org/en/fundingmodel/process/counterpartfinancing/
[12] See http://www.theglobalfund.org/shared/elearning/nfm/NFM-CounterpartFinancingWillingnessToPay/presentation.html

However, according to the Fund's Operational Policy Manual, there are clear and calculable minimum WTP requirements (Table 1). These are calculated as a proportion of a country's allocation and weighted by income level. The Fund's policy states that these minimums are only to provide a frame of reference and to guide negotiations with countries.[13]

Box 1: The Global Fund's willingness-to-pay policy
Quoted from The Global Fund's 2015 Operational Policy Manual. Page 78-79.
www.theglobalfund.org/en/lfa/documents/

This requirement refers to additional government investments for implementation of national disease programs supported by The Global Fund that are beyond the minimum counterpart financing threshold *and/or* current level of spending, whichever is greater. Government investments should be focused on priority areas of national strategic plans; should not be lower than existing commitments; and easily verifiable.

To incentivize additional co-investments by the government in disease programs supported by The Global Fund, the new funding model requires that 15 percent of the allocation amount (subsequent to adjustment by all other qualitative factors) is available to countries based on meeting the additional counterpart financing requirements. In addition, compliance with the additional counterpart financing requirement is one of the factors for determining access to incentive funding.

The actual level of government commitments required to access the 15 percent of the country allocation will be agreed upon during country dialogue and will depend on the funding need, existing commitments, past spending trends, program split, country income, and fiscal space.

Additional investments required for accessing the 15 percent of the total country allocation are not specific to a disease program. If the minimum counterpart financing threshold requirements to programs are met and current investments are maintained, the government can commit additional investments to any disease program supported by The Global Fund, including relevant HSS programs that clearly benefit them, in order to access the last 15 percent of the allocation.

In practice, some countries were informed of their minimum WTP requirement (see Annex 1 for examples) and others were not. This may have been strategic, as some key informants from The Global Fund Secretariat noted that they intentionally avoided communicating a specific WTP dollar amount to some countries in the hopes that it would promote greater commitment than the minimum level required.

The Operational Policy Manual states that the minimum WTP should be determined by taking 15% of the country's allocation amount and multiplying it by a factor based on the country's income level. For each dollar of allocation, LICs should contribute 25 cents, lower-LMICs 50 cents, upper-LMICs one dollar, and UMICs two dollars (Table 1).

[13] Global Fund (2015). Operational Policy Manual. Page 87, online at http://www.theglobalfund.org/en/lfa/documents/. Note that the Operational Policy Manual was accessed by the author in October and November of 2015, and that the OPM page numbers mentioned in this report are the numbers that were current at that time. The numbers were still current when this report was published. However, the OPM is periodically updated; as operational policy notes are added, modified or deleted, the page numbering can change.

Table 1: Calculating Minimum Willingness-to-Pay

Country income level	Minimum additional government investment
Low income	15% of the allocation multiplied by 25%
Lower lower-middle income	15% of the allocation multiplied by 50%
Upper lower-middle Income	15% of the allocation multiplied by 100%
Upper-middle income	15% of the allocation multiplied by 200%

An important aspect of willingness-to-pay policy is the condition that the additional commitments be invested in areas of the national disease programs supported by The Global Fund. In other words, WTP commitments should benefit the sustainability of The Global Fund investment.

How should willingness-to-pay commitments be spent?

Deciding where to invest the WTP funds should be discussed by a wide range of stakeholders during the country dialogue and then negotiated with The Global Fund ahead of concept note development. The Operational Policy Manual lists three priorities areas for where the WTP funds should be spent:

a. potential areas of additional government investments based on country context and requirements;

b. potential areas of take-over of existing Global Fund support which will free Global Fund resources to be reinvested in strategic areas; and

c. potential areas which contribute to regional strategy targets, if applicable.[14]

Point b is particularly interesting, especially in terms of key populations spending. Key informants from The Global Fund Secretariat said it is their preference for countries to absorb treatment and procurement costs, so Global Fund money can be spent on other things: "In those countries, when they take up those costs, it frees up Global Fund money to invest in key populations."[15]

This preference was made very clear by The Global Fund in South Africa, for instance, and as a result the country's concept note stated that "the focus of this request for funding is to promote increased proportional investment in key populations from The Global Fund, while government assumes greater accountability for its treatment programme."[16]

[14] Global Fund (2015). Operational Policy Manual. Page 90, online at http://www.theglobalfund.org/en/lfa/documents/
[15] Key Informant Interview (telephonic), 5 November 2015.
[16] South African TB/HIV Concept Note, pg.43, *not yet online at time of writing. Concept Note received from partners in country.*

How is willingness-to-pay monitored?

Tracking countries' WTP commitments is something that has not yet begun in practice. One key informant from The Global Fund secretariat notes that "For 2015, most of those commitments seem to be coming. They are in the budgets."[17] But even if commitments are in budgets, this may not mean the spending will materialize. So, there are other ways The Global Fund holds countries accountable for their WTP commitments. In some cases, The Global Fund insists on a letter from the relevant Ministry (see Annex 2). Another accountability mechanism for WTP is to include specific conditions in the country's grant agreement. Two examples of specific conditions are in Cameroon and Nigeria's malaria grant agreements (Box 2 and Box 3). For another example, see the Ukraine case study below.

Box 2: Specific conditions for willingness-to-pay in Cameroon's malaria grant agreement

(1) With respect to the Government's commitment to finance part of the LLIN distribution campaign in 2015 (procurement and distribution of 2,587,669 LLINs), The Global Fund acknowledges the potential risk and implications should these commitments not be met. As a safeguard to ensure the Government's commitment for procuring LLINs the Government of Cameroon Ministry of Public Health should provide a signed contract with IDA, in form and substance satisfactory to The Global Fund, for the procurement of the 2,587,669 million LLINs needed for the mass campaign as part of the €9,062,099, which should be provided by the Government of Cameroon, Ministry of Public Health. This signed contract should be provided to The Global Fund prior to or at the date of the signing of the Grant Agreement.

(2) The Government of Cameroon shall distribute the 2,587,669 LLINs in the central region (Yaoundé), while The Global Fund will cover procurement and distribution of LLINs to the remaining 9 regions.

Box 3: Specific conditions for willingness-to-pay in Nigeria's malaria grant agreement

The Summary Budget for the Program as set forth in Schedule 1 contains entries dedicated to incentive funding (the "Incentive Funding") in the amount of USD 45,711,445. The use by the Principal Recipient of the Incentive Funding or the commencement of any activity related to the Incentive Funding is conditional upon the following:

(1) The Incentive Funding shall be exclusively invested in procurement and distribution of Long Lasting Insecticide Nets through mass campaigns in selected states of the Grantee;

(2) The Incentive Funding will only be made available when the Grantee has allocated equal funds for the same purpose.

Civil society and community monitoring will be another important accountability mechanism for WTP, though it is not clear the extent to which these groups are aware of this policy or their governments' commitments. It will be important to ensure that civil society and key populations

[17] Key Informant Interview (telephonic), 5 November 2015.

are empowered and supported to monitor their governments' WTP commitments over the coming years.

Purpose of the study

The purpose of this study is to increase transparency around The Global Fund's WTP policy, especially how it was operationalized at country level. The aim is to provide quantitative and qualitative data on a small number of country case studies, detailing how much money countries committed as part of WTP, and what they committed to spend that money on. The study also aims to describe how these commitments were obtained, including who participated in the process and any challenges which were encountered. Finally, the study set out to determine how the WTP has contributed to spending on key populations, and how it impacted transition processes in UMI countries.

Methodology

A case study approach was used to provide insight into how a small number of countries operationalized The Global Fund's WTP policy. The majority of cases are UMICs, as one of the main objectives of this research is to gain a better understanding of how WTP is linked with sustainability and transition. Ukraine, an upper LMIC, was added to the sample to ensure that there was analysis of an HIV grant in the Eastern Europe and Central Asia (EECA) region. Countries were selected with the intention of sampling diverse regions as well as varying disease burdens. Cases were also selected to purposely compare WTP in concept notes for different disease components.

Willingness-to-pay amounts were accessed from The Global Fund Secretariat. To add depth and context to these numerical commitments, a desk review of concept notes was conducted. The majority of the notes were publicly available on The Global Fund website. For some countries in the sample, concept notes had to be sourced from contacts in country. The desk review also included analyzing country grant agreements for specific language on WTP commitments.

To add further insight into the process which was followed for arriving at WTP commitments, a small number (n=12) of key informant interviews were conducted with fund portfolio managers and members of country coordinating mechanisms who were involved in WTP negotiations. The interviews helped shed light on how negotiations occurred, who was involved, and how decisions were reached about where countries prioritized spending their WTP contributions. Interviews were particularly useful in cases where concept notes were not explicit about WTP commitments.

Table 2: Selected countries and concept notes for case study analysis[18]

Country	Income level	Type of concept note	Window of submission	Date of submission
Belize	UMI	TB/HIV	Window 5	30 January 2015
Botswana	UMI	TB/HIV & Malaria	Window 5	30 January 2015
Bulgaria	UMI	TB	Window 4	15 October 2014
Costa Rica	UMI	HIV	Window 4	15 October 2014
Fiji	UMI	TB	Window 5* 2nd Iteration	30 January 2015
Iran	UMI	HIV	Window 4	15 October 2014
Jamaica	UMI	HIV	Window 6* 2nd Iteration	20 April 2015
Mauritius	UMI	HIV	Window 4	15 October 2014
Romania	UMI	TB	Window 4	15 October 2014
South Africa	UMI	TB/HIV	Window 7	15 July 2015
Suriname	UMI	TB/HIV	Window 5	30 January 2015
Suriname	UMI	Malaria	Window 3	15 August 2014
Thailand	UMI	TB/HIV	Window 2	15 June 2014
Ukraine	Upper-LMI	TB/HIV	Window 2	15 June 2014

A note on terminology

The Global Fund recently changed the name of willingness-to-pay to "additional counterpart financing" (it sometimes also uses the term "increasing future commitments"). However, as this study is a retrospective analysis of how WTP was negotiated at country level during the NFM – while it was still called WTP – the term WTP is used throughout this report for consistency.

It should also be noted that whenever a dollar amount is shown, it is expressed in US dollars.

[18] It is worth noting that Bulgaria had an HIV allocation ($9.2 million) and Thailand had a malaria allocation ($35.7 million) as part of the NFM, but at the time of writing, neither had submitted a concept note for those disease components. It should be noted that minimum willingness-to-pay as presented in the country case studies is calculated as a proportion of the country's *total* allocation – including components for which the country had not yet submitted concept notes.

Country case studies

This section details 13 country case studies, outlining each country's minimum WTP requirement, actual WTP commitment, and where the country has indicated it will be spent. Case studies also highlight interesting elements of the negotiations, and how decisions were reached on spending priorities.

Each case study aims to be as precise as possible. Where WTP tables were sourced from concept notes or from partners in country, they have been included. It was not possible to obtain WTP tables from all thirteen countries.

Where detailed dollar amounts were accessed for specific commitments, they are included. It was not possible to obtain the same level of detail for each country.

Belize

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$1.4 million	**$3.9 million**	**TB/HIV**
Main area(s) of WTP investment: (1) Health products for HIV testing. (2) HIV and TB treatment.		

Belize's TB/HIV allocation was $4,504,323, making its minimum WTP requirement $1,351,297. In Belize, the WTP amount was not formally communicated by the FPM to the country. Key informants for Belize suggested that not specifying the minimum WTP amount was done intentionally in the hopes that the country would commit greater WTP than the minimum level. As such, the Fund and the country entered into a dialogue based on gaps and themes, discussing how WTP contributions might be directed to some of the more critical areas.

The program or intervention areas in which WTP funds will be invested is less specific in Belize compared to other case study examples. Key informants indicated Belize's "specific [WTP] commitments fall on the spectrum between testing and viral load monitoring. It's a bit more general. For whatever reason, we didn't get to the specifics."[19] Testing and then initiating people on treatment is a large priority for the country, in line with the country's national CD4 staging policy which prescribes treatment initiation among people living with HIV at a CD4 count of 500 or less. In some cases, the country is moving towards more of a test-and-treat approach. The real gap in the country, identified during countries dialogue, is encouraging people to test.

The concept note highlights variation in the WTP commitment for each disease, noting that "Compared to HIV, Government's additional commitments in TB are lower."[20] Indeed, government investments in HIV will more than double in 2015-2017 ($7.3 million) compared to 2012-2014 ($3.6 million). For TB, spending was $1.0 million in 2012-2014; the commitment for 2015-2017 is only $1.2 million.

In terms of how formal the WTP commitment is, the country submitted a letter from the Ministry of Finance as an annex to the concept note. This is rather uncommon in our sample. That said, the country's concept note also requests leniency around the counterpart financing and WTP requirements for Belize: "The past and current fiscal margins [...] make it a challenge to regard Belize as an upper middle income country [...]. The NAC therefore take a principled stand for an across-the-board lenient application of the 60% Counterpart Financing (CPF) and the Willingness To Pay (WTP) requirements."[21]

Although the country's WTP commitment does not explicitly target key populations, Belize's grant agreement has some special conditions to this effect. One of these is that the country is required to develop and submit a sustainability plan by 31 March 2017. The Global Fund requires this plan to include a specific strategy for financing the prevention, testing, and

[19] Key Informant Interview (telephonic), 10 November 2015.
[20] Belize TB/HIV Concept Note, pg. 27, http://www.theglobalfund.org/en/portfolio/country/?loc=BLZ
[21] Belize TB/HIV Concept Note, pg. 25, http://www.theglobalfund.org/en/portfolio/country/?loc=BLZ

counselling outreach to key affected populations currently financed by the Fund. Further, when asked if The Global Fund's WTP policy caused the country to invest more money in key populations and human rights, key informants said the answer was No. But, they followed this by noting that the NFM in general has had a positive impact for funding to these areas: "Has country dialogue and concept note process increase The Global Fund's investment in these areas? Absolutely. The Belize concept note talks a lot about human rights, which the government is usually reluctant about."

Botswana

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$8.6 million	**$68.0 million**	**TB/HIV; Malaria**

Main area(s) of WTP investment for TB/HIV: (1) ARV treatment for all sex workers who test positive. (2) Option B+ for PMTCT. (3) Treatment for discordant couples. (4) Treatment expansion when the country moves to CD4 500 adoption. (5) Combination prevention and test-and-treat approaches. (6) Prevention programs for adolescents and youth. (7) Human resources. (8) Management of MDR-TB. (9) Strengthening community participation in DOTS. (10) Strengthening laboratory systems for diagnosis (especially for childhood TB). (11) Improving TB treatment outcomes.

Main area(s) of WTP investment for malaria: (1) Procurement of drugs. (2) Diagnostics. (3) Insecticide for IRS. (4) Larvicide. (5) Community mobilization. (6) Human resources (surveillance officers).

Botswana's total allocation for HIV, TB, and malaria was $28,717,761, making its minimum WTP requirement $8,615,328. The country's TB/HIV concept note explicitly states that "the estimated government funding level in the next three years is projected to increase from $112,807,692 [in 2014] to approximately $131,064,274 by end of 2017."[22] Based on these increasing commitments, the country has demonstrated WTP in the amount of $68 million. This far exceeds the minimum level of $8.6 million.

The country's concept note provides a long and detailed list of interventions expected to be covered by its WTP commitment (see above). The country is clearly prioritizing key populations by, among other things, committing to place all HIV-positive sex workers on treatment, and making adolescents and youth a priority key population. Specific details on how much money would go to the different areas are not provided.

The country's malaria grant will start in October 2015 and will run until September 2018, targeting malaria elimination. The WTP commitment projects decreasing government commitments from 2016 to 2018 as the burden of disease is expected to decline. That said, WTP is still projected to be substantially higher for the period 2015-2017 ($15.2 million) vs. $8.1 million for 2014-2016.

[22] Botswana TB/HIV Concept Note, pg. 69, online at http://www.theglobalfund.org/en/portfolio/country/?loc=BWA

The malaria concept note states that the first five areas of investment listed above (drugs, diagnostics, insecticide, larvicide, and community mobilization) have been traditionally funded by the government of Botswana. The human resources portion of the WTP is a new commitment to help fill the gap in the national response around implementation of case-based surveillance as part of the malaria elimination strategy. The concept note states that the recruitment process has begun, and that the posts will be funded by The Global Fund in 2015 and 2016 while the government posts are staffed. These HR costs will then be absorbed by the government. Botswana said that a similar process had occurred with other projects funded by the (U.S.) President's Emergency Plan for AIDS Relief (PEPFAR) and the African Comprehensive HIV/AIDS Partnerships, a partnership between the Government of Botswana, the Bill and Melinda Gates Foundation, and the Merck Company Foundation.

Botswana's malaria grant agreement does not specify these WTP commitments. It only mentions the standard clause that 15% of the country's total allocation is tied to WTP requirements.

Bulgaria

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$3.1 million	**$14.5 million**	**TB**
Main area(s) of WTP investment: (1) Active case findings among key populations. (2) Adherence. (3) Procurement of second line TB drugs. (4) Procurement of reagents for culture and drug susceptibility testing. (5) Health system reform. (6) Specimen transport. (7) Web-based information systems.		

Bulgaria's WTP requirement was communicated directly by the FPM to the Minister of Health in a formal letter on 27 May 2014: "Under the WTP rules, Bulgaria would be eligible for the WTP component at amount of 1.545 million USD if the total TB government commitment from 2015 to 2017 is higher than the TB government spending in 2012-2014 (38.923 million USD) for minimum of 3.09 million USD."[23] This provided ample time for dialogue before the country's 15 October 2014 submission. That said, key informants noted that the process for discussing WTP was not very consultative: "The CCM is not being used properly as a place to discuss with a wider group of people. It's very much within the Ministry and the circle of NGOs who work under the grant. The letter was not largely discussed."[24]

The country's concept note does not go into detail on WTP, but Bulgaria submitted a Secretariat Briefing Note which does. The briefing note acknowledged the minimum WTP requirement ($3.09 million) and then described how the country's planned spending more than satisfies this: "The government has already committed EUR 11.2 million [$14.5 million] more on top of TB spending which makes country eligible for WTP funds at amount of $1.545 million."

[23] See Annex 1 for Bulgaria's Example WTP Letter.
[24] Key Informant Interview (telephonic), 9 November 2015.

The briefing note provided the following table:

Table 3: WTP data from Secretariat Briefing Note (concept note summary) on Bulgaria

Program	Bulgarian government investment in its national TB program (EUR, millions)								
	Current phase				NFM phase				Additional investment
	2012	2013	2014	**Total**	2015	2016	2017	**Total**	
TB	6.2	6.1	6.5	**18.8**	10.2	9.7	10.0	**29.9**	**11.2**

Bulgaria's TB grant is a transition grant, making WTP spending priorities fairly straightforward. The country will spend its WTP funds on activities which represent the biggest portion of expenditures financed solely by The Global Fund. These include active case finding among key populations and treatment adherence support. The WTP commitment will also help the government gradually take over financing of the procurement of second line TB drugs (starting in 2016) and the procurement of reagents for culture and drug susceptibility testing (in 2017 and 2018). The concept note also states that WTP will include health system reform (a shift from hospital-based treatment to ambulatory care).[25] However, key informants noted that increasing spending levels do not necessarily equate with optimized government funding: "Even though the government is spending more than is required, the money is mostly going to resource-intensive health facilities. It does not cover certain basic interventions. The grant is still paying for second-line drugs, lab reagents for MDR-TB and contact tracing nurses." In terms of monitoring its WTP, the briefing note states that "based on country's history of reporting and measures taken so far, there does not appear to be a need of any special agreement between The Global Fund and the country related to how country will justify TB government spending in the future."

Costa Rica

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$1.5 million	**$11.2 million**	**HIV**

Main area(s) of WTP investment: (1) Funding the Social Protection Board (JPS), a funding mechanism for local HIV NGOs. (2) Developing a key populations prevention policy for the Costa Rican Social Security Fund (CCSS) (which funds the JPS) which specifically includes MSM and transgender women.

Costa Rica's total allocation was $4,883,405, making its minimum WTP requirement $1,465,022. The country has demonstrated WTP which far exceeds this amount, As the concept note states, "Government funding for the response to HIV was $18.4 million in 2012, and this is expected to grow to $25.6 million by 2018."[26] Based on these commitments and further negotiations after concept note submission, The Global Fund Secretariat indicates that Costa Rica's actual WTP commitment is $11.2 million.

[25] Bulgaria TB Concept Note, pg. 21, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=BGR
[26] Costa Rica HIV Concept Note, pg. 30, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=CRI

Key informants indicate there was an assumption that this grant would be the first[27] and last time Costa Rica would receive money from the Fund. They said that knowing this was a transition grant had a very strong influence over what they planned to do with the WTP money. "This is not a standard prevention grant doing outreach," one key informant said. "It's a much more catalytic grant trying to figure out how you better link CSOs that are working on these issues to funding."

The concept note provides a high level of detail in terms of where the country will invest its WTP commitment. Key informants suggest selecting program areas for WTP priorities was not a particularly contentious process: "The CCM and government were already trying to do the right things; there was not a big fight around willingness-to-pay in terms of where to invest."[28] Based on the country's recent national AIDS spending assessment (NASA), it was clear that there were particularly large gaps for prevention among MSM and transwomen. This was the obvious area for WTP funds to be channeled.

Based on the results of the NASA, Costa Rica's WTP commitment is dedicated towards two main areas. The first is funding the Social Projection Board (JPS), a government funding mechanism which ensures local HIV NGOs are able to access public money. Civil society played a big role, with the vice-chair of the CCM (from civil society) pushing much of the negations. As a result, Costa Rica's concept note states that $516,492 per year will go into the JPS, totalling $1,549,476 over the grant cycle.[29]

The second area where the country's WTP commitment will go is to add specific provisions for prevention of HIV among MSM and transgender women in the Costa Rican Social Security Fund (CCSS) (which funds the JPS) operational plan and budget. The intention is to ensure that more NGOs working with MSM and transwomen are able to access government HIV funding. "This grant creates political space to get the commitment that they will fund MSM and transgender and prioritize it," one key informant said. Key informants stressed how vital this part of the WTP investment is, to make sure the JPS funding is used most effectively: "Increases in money is important, but that's not the issue. It's where you spend it." For monitoring, key informants said there are specific elements in the performance framework that reflect this WPT commitment.

[27] The country received a Round 3 grant, but there was no money remaining in country at the start of the NFM.
[28] Key Informant Interview (telephonic), 5 November 2015.
[29] Costa Rica HIV Concept Note, pg. 31, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=CRI

Fiji

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$1.6 million	**$4.3 million**	**TB**

Main area(s) of WTP investment: (1) Human Resources within the Ministry of Health and Medical Services

Fiji is an example of a country where the concept note provides a high level of detail on WTP commitments. The country's minimum WTP requirement is $1,618,206 and the country concept note commits to increase government spending in a very precise way to meet this minimum level:

> "The Ministry of Finance will disburse in 2015, $378,150 (25%) of the willingness to pay total value of $1, 618, 206 million, upon signatory of the MoU. The Ministry of Health & Medical Services (MoHMS) will submit annual disbursement requests to the Ministry of Finance as part of the MoU. The value of disbursements are $620, 028 and $620, 028 for 2016 and 2017 respectively." [30]

Key informants suggest the WTP policy had a positive impact on government funding: "As a result of this requirement the TB national programme got a lot of additional national government funding."[31]

The concept note is also highly specific in terms of what the WTP commitment will go towards – funding human resources within the National TB Program. The MoHMS commits to spending $1.5 million on sustaining the program-linked HR costs that were being paid through the previous Global Fund grant (which ended on 31 December 2014). The concept note lists 11 specific posts to be transferred from the old Global Fund grant onto the MoHMS budget under the WTP commitment.[32] The remaining WTP amount will go towards funding additional posts created as a result of the restructuring of the National TB Program. Key informants from The Global Fund Secretariat indicated that Fiji was strongly encouraged to spend its WTP money on HR: "I wouldn't say we required it, but we mentioned that it's one of the potential ways for how it could be used, and they agreed."

Fiji's concept note was submitted in Window 4 (15 October 2014), but sent back by the TRP for a second iteration. The need for increased WTP and improved transition planning were key reasons for iteration. In Fiji's first iteration of concept note submission, the 11 HR posts mentioned above had been requested in The Global Fund budget. After shifting them to be covered by WTP, this freed up Global Fund money to go towards TB control at service delivery level and active screening of high-risk key populations.

[30] Fiji TB Concept Note, pg. 19, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=FJI
[31] Key Informant Interview (telephonic), 6 November 2015.
[32] Fiji TB Concept Note, pg. 20, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=FJI

Closely linked with Fiji's WTP commitments is its Transition Strategy, which was added during the second iteration. The strategy is a six-pronged approach which includes: (1) sustaining HR posts; (2) HR restructuring; (3) sustaining policy advocacy; (4) leveraging external resources during the NFM period; (5) sustaining and improving case detection; and (6) improving treatment outcomes and reducing costs. Key informants highlighted that the country's transition status definitely influenced how it chose to spend its WTP: "We are exploring how best to allocate the government funding after The Global Fund leaves, looking at different models to allocations. We are also exploring innovative ways to leverage additional funding."

Iran

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$6.1 million	**$77.4 million**	**HIV**
Main area(s) of WTP investment: (1) Harm reduction through the State Welfare Organization. (2) Service provider personnel in prisons. (3) Prisons organization training programs. (4) Ministry of Education training programs. (5) CDC hotline operations. (6) Health products in women's centres. (7) Surveillance studies. (8) Consumables for laboratories.		

Iran's total HIV allocation for the NFM is $20,238,295, making its WTP minimum requirement $6,071,489. Iran has exceeded its minimum WTP requirement, committing to spending $77.4 million, according to The Global Fund Secretariat. Iran's HIV concept note is very specific in terms of the actual items which will be covered by the country's WTP commitment (although the note does not cover the full $77.4 million that was eventually agreed to). This is largely because the country's WTP represents direct absorption of previously-supported areas under The Global Fund Round 8 grant.

In terms of the commitments outlined in the concept note, the vast majority of Iran's WTP commitment is dedicated towards key populations, namely drug users and prisoners. One of the largest proportions of the country's (explicit) WTP commitments is the $2 million per year to be spent on harm reduction programs, which will be channelled through the State Welfare Organization (housed within the Office of Social Vulnerabilities Affairs at the Ministry of Cooperative, Labor and Social Welfare). Following this, the next largest WTP commitment is directed towards activities in prisons, including $560,000 per year on service provider personnel in prisons, and $300,000 per year on prisons organization training programs. Following this, Iran commits to spending $200,000 per year in Ministry of Education training programs, and $385,000 per year for remaining absorption costs such as the CDC hotline, health products in women's centres, surveillance studies, and consumables for laboratories.[33]

[33] Iran HIV Concept Note, pg. 14, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=IRN

Table 4: Specific Willingness-to-pay commitments in Iran's HIV concept note

Program area	Total WTP commitment
Ministry of Education training programs	$200,000 per year
Prisons Organization training programs	$300,000 per year
Service provider personnel in prisons	$560,000 per year
Welfare Organization harm reduction	$2,000,000 per year
CDC hotline, women's centre health products, surveillance studies & lab consumables	$385,000 per year

While Iran's grant agreement does not have any specific conditions related to WTP (just a generic clause), key informants from The Global Fund Secretariat suggest there is concern about oil-dependent countries being able to meet their commitments, given the drop in oil prices: "For 2015, most of those commitments seem to be coming. They are in the budgets. Next year we will see if it is being spent. But in oil dependent countries, with the price of oil going down that looks less likely."[34]

Further, money within Iran's HIV grant will be dedicated towards developing and implementing a Sustainability Plan. The plan is intended to provide a vision for diagnosis, care and treatment services after The Global Fund grant ends in March 2018.

Jamaica

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$5.7 million	**$16.9 million**	**HIV**

Main area(s) of WTP investment: (1) Human Resources. (2) Treatment. (3) PMTCT. (4) HIV testing (test kits). (5) CD4 monitoring.

Jamaica's HIV allocation was $19,133,368, making its minimum WTP requirement $5,740,010. Jamaica submitted its HIV concept note in Window 5, but it was sent back by the TRP for iteration. one of the main reasons being that they wanted to see greater absorption of program costs – especially treatment costs – by the Jamaican government. Key informants note that "With or without the [WTP] policy, there is an ongoing discussion to transition these things."

The country's second iteration concept note states that the Government of Jamaica will invest an additional $960,000 in 2016 (presumed to continue for 2017 and 2018) in five specific line items (Table 5). Similar to Fiji, the most significant portion of WTP investment is dedicated to human resources, specifically to absorb Project Coordination Unit (PCU) staff that was funded by external investment.

[34] Key Informant Interview (telephonic), 5 November 2015.

Table 5: Specific willingness-to-pay commitments in Jamaica's HIV concept note

Program area	Total WTP commitment
Procurement of HIV test kits	$100,000 per year
Procurement of point-of-care CD4 supplies and reagents	$10,000 per year
Procurement of adult ARVs	$250,000 per year
Procurement of replacement feed for HIV-exposed infants	$100,000 per year
Absorption of PCU project funded staff	$500,000 per year

Though the concept note does not detail the entire WTP commitment of $16.9 million, key informants suggest that there are ongoing negotiations with the country: "The country has a global absorption plan for these issues, which is in the concept note, and the amount is higher than the willingness-to-pay requirements. The letter says that 'this is the minimum amount we commit to,' but they plan to commit much more."[35] That said, Jamaica's concept note is interesting and unique in the sense that it provides a discussion in the Funding Landscape section about what happens if the country does not meet its full WTP requirement:

> "The Willingness-to-Pay agreed to as part of Grant eligibility implies that if commitment is not met, disbursement will be decreased proportionally. To this end, it is anticipated that during grant negotiation specific upfront provisions regarding how any redistribution of partial disbursement amount should occur in case of partially meeting the commitment will be included."[36]

This implies that the country has considered the value of partially meeting its WTP for partially unlocking its 15% allocation – which is acceptable under the WTP policy. Jamaica is the only country in this sample to include this level of discussion. One key informant indicated that the country has submitted a letter from the ministry in which it commits the WTP amount for 2016 only, and that the country has said it will provide similar letters in 2017 and 2018, tied to its fiscal reality.[37]

Mauritius

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note(s):
$1.5 million	**$4.7 million**	**HIV**

Main area(s) of WTP investment: (1) Substitution maintenance therapy (SMT). (2) Treatment (ART).

Based on its $5,128,597 allocation for HIV, Mauritius' minimum WTP requirement is $1,538,579. The country has far exceeded this minimum level, committing to increase its government spending by $4,665,772 in this allocation period. The main areas of investment

[35] Key informant interview (telephonic), 9 November 2015.
[36] Jamaica HIV Concept Note, pg. 36, online at http://www.theglobalfund.org/en/portfolio/country/?loc=JAM
[37] Key Informant Interview (telephonic), 9 November 2015.

under WTP are substitution maintenance therapy and ART, as stated in the country's concept note.[38]

Table 6: Mauritius' WTP commitments (as per the WTP table attachment)

Program	Mauritius Government investment in its national HIV programs ($)					
	Current phase			NFM phase		
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
HIV	5,371,621	5,484,134	5,715,531	6,414,108	6,989,400	7,833,550
TOTAL	Total spending on HIV in the current phase 16,571,286			Total spending on HIV in the NFM phase 21,237,058		
WTP	**4,665,772**					

Key informants suggest that the WTP policy had an impact on the money Mauritius was committing, but not a huge amount. The policy did, however, have an impact on the county's willingness to fund women who are in need of substitution maintenance therapy, which the country was not previously funded to an appropriate level.

Key informants also noted that Global Fund guidance on what the Fund would and would not pay for was a factor in WTP priorities: "If The Global Fund was willing to fund any of those things, the country would be happy not to, but it was clear that the government had to pay."[39] At the same time, key informants note that WTP priorities were not largely discussed: "Our country dialogue was purely about activities; what were the major issues facing key populations. What sorts of things would help people get onto ART. WTP wasn't really an issue."

Key informants suggest transition readiness was part of the discussion, "with some saying 'this is almost certainly your last' and people in country saying 'we've heard that before, and we always get more money." There is a transition plan in Section 3.2 of the concept note. However, key informants suggest that it was not the counterpart financing or the WTP policy in Mauritius, rather "the investment case was the important thing. It was the investment case that we saw as the real vehicle for transition."

Of note, key informants indicate that the recent change of government might have implications for the country's WTP commitment: "Government changed and things are terrible. He's shut down the methadone and they've shut down new people coming onto it and made it much harder to get. This will likely have a big impact on the country's commitment towards spending willingness-to-pay on SMT."

[38] Mauritius HIV Concept Note, pg. 21, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=MUS
[39] Key informant Interview (telephonic), 10 November 2015.

Romania

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$3.8 million	**$12.2 million**	**TB**

Main area(s) of WTP investment: (1) Treatment (especially for MDR-TB, prioritizing procurement of second-line anti-TB drugs). (2) TB control in prisons. (3) Case detection and treatment initiation in TB key populations (homeless adults and street children). (4) Treatment adherence. (5) TB-IEC strategy. (6) Funding for TB NGOs.

As Romania's total TB allocation is $12,821,493, the country must make a minimum WTP commitment of $3,846,448 in order to access the last 15% of its allocation. The country's increased government investment from this allocation period as compared to the last was $12.2 million, far exceeding its minimum WTP of $3.8 million.

Although The Global Fund's WTP policy promotes increasing government investments over time, in Romania this is not the case. The country's TB concept note states that "The overall government budget for TB control will reach the maximum peak in 2016 and will gradually decrease by 2019 due to: i. The decrease in the total number of TB patients and ii. The reduction of hospitalization cost by implementation of the ambulatory care system."[40]

Because this involves a transition grant, the country's WTP commitment is based on the country's need to absorb all the elements of The Global Fund program after this three-year grant cycle. While the specifics of the WTP commitments are not detailed in the concept note, they are included in the country's National Strategic Plan for the Control of Tuberculosis in Romania, 2015-2020, which doubles as its Global Fund transition plan. As per the country's NSP, the priority areas for WTP include: Treatment (especially for MDR-TB, prioritizing procurement of second-line anti-TB drugs); TB control in prisons; case detection and treatment initiation in TB key populations, such as homeless adults and street children; treatment adherence; TB-IEC strategy; and funding for TB NGOs.[41] These are all areas that were previously funded by Global Fund grants, which the government is prioritizing for absorption in its NSP to be paid for in part with its WTP commitments.

Leading up to concept note development, The Global Fund made it clear that the country must submit a viable transition plan. Indeed, key informants indicated that The Global Fund grant was conditional on such a plan. With this in mind, when the country developed its new National Strategic Plan for 2015-2020, transition from Global Fund and long-term sustainability was important considerations.

Similarly, with respect to program areas where Romania would invest its WTP, key informants suggest that "the guiding principle was really to make sure the gains made from Global Fund

[40] Romania TB Concept Note, pg. 18, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=ROU
[41] National Strategic Plan for the Control of Tuberculosis in Romania, 2015-2020, pages 20, 21, 30, 43 and 44.

investment could be sustained after transition."[42] Key informants suggest that large portions of the transition from Global Fund to a fully government-supported TB program had already begun to happen before the NFM. "The major [Global Fund] support was for the prison TB system, and to some extent government has already taken over these components for human resources, drugs and infection control. By the NFM, they had already absorbed most of the major components."[43]

South Africa

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$139.5 million	**$1.0 billion**	**TB/HIV**
Main area(s) of WTP investment: (1) ART.		

While the WTP requirement for South African was $139,455,865, the actual planned spending increase for the country is more than seven times that amount, exceeding $1 billion ($1,043,937,109). As a proportion of its minimum level, South Africa's WTP is one of the highest among the countries sampled.

The WTP amount was formally communicated from the FPM to the country, though key informants indicate that this communication came just two weeks before the country's concept note submission. While this meant that very little dialogue could be had, key informants also suggest that it was perhaps not necessary, as the country was already far-exceeding its minimum level for WTP, and it was clear where the money would be spent (treatment). When asked if WTP promoted increased government spending in South Africa one key informant said: "No. We were already meeting it. It was more global pressure to move to 90-90-90 that has forced us to put more money."[44] Indeed, in the WTP section, South Africa's concept note states that "Compared with previous years, government spending on HIV is increasingly aimed at expanding access to testing, treatment and patient monitoring, so as to reach the UNAIDS 90-90-90 targets which have now been adopted by the South African government."[45]

Table 7: WTP data in South Africa's TB/HIV concept note

Program	South African Government investment in its national HIV and TB programs ($)					
	Current phase			NFM phase		
	2013	**2014**	**2015**	**2016**	**2017**	**2018**
HIV	1,437,219,044	1,278,456,509	1,358,803,365	1,512,819,576	1,685,632,106	1,879,821,160
TB	159,900,239	152,948,417	152,802,052	160,442,155	168,464,262	176,887,475
TOTAL	Total spending on HIV/TB in current phase 4,540,129,626			Total spending on HIV/TB in the NFM phase 5,584,066,735		
WTP	**1,043,937,109**					

[42] Key Informant Interview (telephonic), 11 November 2015
[43] Key Informant Interview (telephonic), 5 November 2015
[44] Key Informant Interview (telephonic), 3 November 2015.
[45] South African TB/HIV Concept Note, pg. 45, *not yet online at time of writing. Concept Note received from partners in country.*

Table 7 clearly shows that there is a big difference between the government WTP for HIV compared to TB. One key informant noted that "It was very difficult to show increasing spending on TB. TB funding gap is much more alarming, because government spending is not really growing."

Another interesting aspect of South Africa's WTP is that it is not coming from within a context of overall increases to the health budget. The Global Fund has stated that "one of our requirements is that the government contributions to our programs should be in the context of overall increases in the health sector budget."[46] However, key informants from South Africa suggest this is not the case: "Health spending has stagnated if you adjust for inflation. Within the health budget, they've had to move money around to cover ARV costs."

Suriname

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$2.3 million	**$18.4 million**	**TB/HIV; Malaria**
Main area(s) of WTP investment: (1) Implement treatment 2.0 to expand eligibility to all those with CD4 count of 500 or less. (2) Build and Fund a clinic in Lawatabiki, and fund human resources to serve migrant populations in the mining areas. (3) Roll out Option B+ for PMTCT.		

Suriname's total allocation was $7,692,895, making its WTP minimum requirement $2,307,869. The country has exceeded its minimum WTP requirement, committing $18,409,735.67 in WTP. As with Belize (same FPM), the WTP amount for Suriname was not formally communicated as a figure to the country. This was a strategy to (hopefully) lead to greater increases in government funding than the minimum required level. The same process was followed as in Belize where dialogue around gaps and themes led to prioritization of the three specific commitments for the WTP amount shown in the box above. For selecting these priorities, key informants in country said that "these were discussed during the whole country consultation with the different CSOs."[47] Key informants also noted that while some of the priority areas were already apparent, the value of the WTP policy is in formalizing these commitments: "We were already planning to do [treatment] 2.0. WTP just makes the government more forced to do it. It was discussed and needed, and now it's a formal commitment."

Surname's TB/HIV concept note provides a high level of detail about where it will spend its WTP commitment. Further, the Ministry of Health submitted a formal WTP letter as an attachment to its concept note, committing to the specific three areas listed above (see Annex 2). However, key informants in-country suggest that there are uncertainties around the viability of this WTP commitment from an economic standpoint: "We will have some challenges because at

[46] George Korah, Senior Specialist in Health Financing at The Global Fund, speaking at the Friends of The Global Fund Webinar titled "Increasing Domestic Investment in AIDS, Tuberculosis and Malaria: Global Fund Resource Mobilization in Implementing Countries", 24 February 2015, audio available online at: http://theglobalfight.org/webinars/
[47] Key Informant Interview (telephonic), 16 November 2015.

this moment we are facing financial difficulties with the price of gold and oil, and we have a lot of debt."

Within the TB/HIV concept note, the WTP commitment contains important elements for malaria, too. The clinic in Lawatabiki is an important mining area that is vulnerable to HIV, TB, and malaria. The clinic will serve an important part in malaria control in the country, but from the approach of integrated primary care for mobile and vulnerable populations.

Thailand

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$32.7 million	**$309.5 million**	**TB/HIV**
Main area(s) of WTP investment: (1) Prevention activities for key populations. (2) M&E systems. (3) HIV Testing and Counselling. (4) Condom promotion. (5) Prevention actives. (6) STI control.		

Thailand is a rather unique case for WTP, given that the country has elected to transition over a two-year NFM grant. Despite this, WTP is still calculated by The Global Fund Secretariat as the increase in the three-year NFM period of 2015-2017 as compared to 2012-2014. Key informants said the country was given guidance to prepare a minimum WTP amount, but that this was certainly not going to be an issue. Thailand's government resources for TB and HIV were $863.3 million in 2012-2014, which will grow to $1.17 billion in the NFM period (2015-2017). Based on these increases over the two-year transition period, the country's WTP is $309.5 million, far exceeding its minimum required level.

One key informant relates how the transition and WTP requirements have had a positive impact on the Government of Thailand's funding for key populations: "Funding for key populations actually significantly declined from 2008/09 to 2011/12 until The Global Fund support from Round 10 kicked in. But, as part of the transition there have been new commitments from the government. In 2014, they allocated about $9.5 million specifically for key populations."[48] The concept note specifies that this money will go towards peer-led interventions, community mobilization, demand generation for HIV testing through social and health networks, linkage of services provided at the district, sub-district and community levels and quality of counselling services in the community and health outlets. The concept note says this will include "$0.9 million for prevention activities, $1.3 million for condom promotion, $0.3 million for STI, $2.9 million of HCT, and lastly $3.1 million for M&E system strengthening."[49]

As Thailand proceeds with its transition, the majority of the WTP is dedicated to absorbing important program areas that were previously supported by The Global Fund. One key informant notes that "what was covered by the previous Global Fund grants now will have to be covered by

[48] Key Informant Interview (telephonic), 5 November 2015.
[49] Thailand TB/HIV Concept Note, pg. 42-43, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=THA

the government and domestic resources. This includes female sex workers in areas outside of Bangkok, for example."[50]

Key populations that have historically faced additional barriers to accessing services in Thailand, such as people who use drugs and migrants, will benefit from WTP commitments during the transition. Key informants suggest that the Thai government has issued orders and started a harm reduction package in 19 provinces on a trial basis. The Thai government has also agreed to progressively absorb commodities for key populations, with 50% of the condom and needle/syringe procurement costs being covered by government in Year 1 of the grant, rising to 60% in Year 2.[51] The government has also put plans in place to gradually provide universal healthcare to migrants: "As part of the current grant, The Global Fund is supporting the migrant insurance for the first year, and then Thailand picks up from there."[52]

There is no formal agreement to document these commitments. "In some countries we insist on a letter, in others we don't. For Thailand we did not," said one Global Fund key informant.

Ukraine

Minimum WTP requirement:	Actual WTP commitment:	Type of concept note:
$27.7 million	**$124.1 million**	**TB/HIV**
Main area(s) of WTP investment: (1) Substitution maintenance therapy. (2) HIV and TB prevention packages for key populations (harm reduction, TB active case finding & adherence). (3) ART.		

Ukraine's TB/HIV allocation is $184,578,775, making its WTP minimum requirement $27,686,816. The country's actual WTP far exceeds this, committing to increase its spending by $124.1 million. This is heavily driven by HIV spending, as TB spending is anticipated to fall (by $16.8 million) in the NFM phase.

[50] Key Informant Interview (telephonic), 19 November 2015.
[51] Thailand TB/HIV Concept Note, pg. 22, online at: http://www.theglobalfund.org/en/portfolio/country/?loc=THA
[52] Key Informant Interview (telephonic), 5 November 2015.

Table 8: WTP data in Ukraine's TB/HIV concept note[53]

Program	Ukraine Government investment in its national HIV and TB programs ($ million)					
	Current phase			NFM phase		
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
HIV	55.9 m	41.9 m	28.3 m	75.53 m	81.06 m	110.39 m
TB	135.7 m	131.7 m	122.2 m	124.1 m	124.3 m	124.3 m
TOTAL	Total spending on HIV and TB in current phase 515.7 m			Total spending on HIV and TB in the NFM phase 639.7 m		
WTP	**124.1 m**					

The concept note is not very detailed in terms of WTP, but the grant agreement is. As one key informant noted, "In Ukraine they had a very specific requirement for WTP – it was spelled out what would qualify on what to spend the money on. They also tried to direct how the money would be spent. It's the only case in EECA where it's specifically in the grant agreements."[54]

Box 4: Specific conditions for willingness-to-pay in Ukraine's TB/HIV grant agreement

In order to meet the WTP Requirement, by 31 December of each calendar year, the Grantee acting through the Principal Recipient shall ensure and deliver evidence that the Grantee complies with each applicable Program-specific WTP Requirement set forth below:

(1) On or before 31 December 2015, the Grantee shall budget funding for substitution maintenance therapy (the "SMT") program and implement the SMT program for the duration of 2016, in accordance with the target of the NAP 2014-2018

(2) On or before 31 December 2016, the Grantee shall budget funding for the SMT program and implement the SMT program for the duration of 2017, and provide evidence that domestic funding for 2016 has been effectively provided in accordance with the target of the NAP 2014 2018

(3) On or before 31 December 2016, the Grantee shall budget funding for the HIV and TB prevention packages for key populations, including for the harm reduction component, TB active case finding, adherence and implementation of activities for the duration of 2017 and 2018, in accordance with the targets of the NAP 2014-2018

(4) On or before 31 December 2016, the Grantee shall budget funding for the ARV treatment to transfer all HIV patients from the Grant Funds to the state program, in accordance with the target of the NAP 2014-2018, ensuring treatment continuation.

When Ukraine's TB/HIV concept note was submitted, it was acknowledged that "during the grant making process, it is envisaged to further negotiate linkage of WTP to the specific priority areas. Specifically, OST and prevention services will be tied to WTP, to ensure sustainability and compliance with commitments."[55] This is because financing tracking data is not very robust in the country, and key informants suggest there is often no clear relationship between funding commitments and actual spending in the country. Therefore, the more specific the commitment, the easier it will be to track government follow-through in the Ukrainian context.

[53] Ukraine Willingness-to-Pay Table. *Not publicly available. Sourced from partners in country*. While other case studies provide a more detailed numerical presentation of WTP, Ukraine's WTP table only provides numbers in this format.
[54] Key Informant Interview (telephonic), 11 November 2015.
[55] Key informant interview, 20 November 2015.

In terms of where the country had to spend its WTP, there was very clear direction from The Global Fund. Key informants from The Global Fund Secretariat noted that strong guidance was given for where the country needed to invest its WTP: “SMT. SMT. On a daily basis, we are being systematically clear.”

Analysis and discussion

Looking at countries' WTP commitments as a proportion of their minimum requirements reveals how countries have prioritized increasing government investment to varying degrees. Iran has the largest WTP commitment compared to its minimum requirement, closely followed by Thailand. In this sample, Suriname is the only country which appears not to have met its WTP minimum requirement.

Table 9: Actual WTP as a proportion of minimum WTP requirement ($ million)[56]

Country	WTP minimum requirement	WTP actual commitment	WTP commitment as proportion of minimum WTP requirement
Iran	6.1 m	77.4 m	1275%
Thailand	32.7 m	309.5 m	946%
Suriname	2.3 m	18.4 m	800%
Botswana	8.6 m	68.0 m	789%
Costa Rica	1.5 m	11.2 m	762%
South Africa	139.5 m	1,000 m	748%
Bulgaria	3.1 m	14.5 m	468%
Ukraine	27.7 m	124.1 m	448%
Romania	3.8 m	12.2 m	317%
Belize	1.4 m	3.9 m	289%
Mauritius	1.5 m	4.4 m	286%
Fiji	1.6 m	4.3 m	265%
Jamaica	5.7 m	13.6 m	237%

It remains to be seen whether countries will follow through on their commitments as grant implementation progresses. The Global Fund intends to create an online database of counterpart financing and WTP commitments. If public, this database would add significant transparency around WTP and could help the Fund and watchdogs (like Aidspan) monitor these commitments.

It is vital to monitor WTP commitments to ensure that governments are indeed contributing their "fair share" of shared responsibility in financing health programs. However, there are certainly going to be challenges with respect to how to monitor them. It is very difficult to track whether or not countries actually fulfil their side of deal. As one Global Fund staffer said: "The overall financing for health picture is unclear – budget amounts go up and down with no meaningful trend. However, a larger problem is that budgets are very rarely matched by disbursements – what is budgeted for at the beginning of the year seems to have very little bearing on the amount of funding actually received by a ministry or disease program."[57]

[56] All figures sourced from Global Fund Secretariat. Where possible, figures were verified through secondary sources such as WTP tables submitted as part of country concept notes.
[57] Whiteside, A. & Surgey, G. (2013). Responding to Health Challenges: the role of domestic resource mobilisation.

Another reason why monitoring may be a challenge is because many WTP commitments are not very detailed or specific. Only a few countries, globally, have specific grant agreement conditions relating to WTP. Most countries have generic conditions. Key informants explicitly stated that the Fund requires some countries to submit formal commitments, and not others. One key informant said that the WTP policy "was originally developed to address issues in particular countries. For most of the countries, it's a very mathematical approach."[58] This seems to suggest that for some countries, the policy is a bargaining chip that is necessary, whereas in others it is not. This is perhaps the reason why some countries are required to formally commit while others are not. Therefore, it will be important for civil society to monitor that generic spending conditions translate into actually spending on the priority areas identified during country dialogue.

Just as a consultative and open process was encouraged for negotiating WTP amounts and commitments, a similarly transparent and inclusive process must be encouraged for monitoring and tracking the results.

Civil society (especially) must be able to hold governments accountable for their counterpart financing and WTP commitments. Key informants from this analysis suggested that TB programs in particular were not very open to civil society (this was noted by both South Africa and Romania). Therefore, it may be critical to support civil society working on TB to monitor government WTP commitments in the coming years.

It follows from this that there should be appropriate investment in watchdog activities, especially as key informants from several counties in this sample expressed uncertainty about their country's ability to deliver the promised funding in practice.

Monitoring WTP in terms of specific spending areas has important implications. Commenting on a wide range of concept notes, The Global Fund's Technical Review Panel (TRP) initially expressed concern after the first two windows of submission that not enough of the WTP commitments were going towards key populations programming:

> "While most countries are meeting counterpart financing and willingness-to-pay conditions, they are doing so in a manner that largely excludes key populations, i.e. men who have sex with men, transgender people, people who inject drugs, criminalized populations and female and male sex workers. The TRP remains seriously concerned by the continuing absence of government financial support for these populations such as through community-based organizations."[59]

The TRP then strongly recommended that The Global Fund Board and Secretariat consider including direct government support for key populations programming in the counterpart

[58] Key Informant Interview (telephonic), 11 November 2015.
[59] Report of the Technical Review Panel on the Concept Notes Submitted in the First and Second Windows of the New Funding Model. October 2014. Page 9-10, online at: http://www.theglobalfund.org/en/trp/reports/

financing and willingness-to-pay conditions. It emphasized that this is particularly important for countries facing transition, as there is a serious risk of essential programs being discontinued once Global Fund support ends.

The findings of this study do not confirm the TRP's initial observations: Many counties in this sample do include key populations at priority areas for WTP investment (see Tables 10 and 11). This might be because there have been improvements in WTP commitments to key populations over time, since most of the countries in this sample (except for Thailand and Ukraine) submitted concept notes after the first two windows.

Despite what appears to be improvements in country commitments to key populations through the WTP, it important to remember that most of these (except for Ukraine) are not included as specific conditions in grant agreements. Therefore, there is a critical role for civil society and other Global Fund watchdogs to play in ensuring that the WTP funding countries commit to their HIV, TB and malaria programs does indeed go towards the key populations as outlined in the concept notes.

Some suggest that The Global Fund should support the development of strong national mechanisms to fund civil society in countries that have not yet transitioned, setting up a sustainable way to protect the long-term interests of key populations.[60] Costa Rica's WTP commitment is a very good example of this: The country is spending some of its WTP monies on the JPS, a government body which provides grants to NGOs.

In this sample, a large number of countries expressly committed to dedicating WTP investment towards key populations interventions (Table 10). Indeed, this was one of the more common WTP priorities.

This analysis provides some evidence that countries facing transition might be more likely to invest WTP commitments in key populations than countries likely to receive future Global Fund money. Costa Rica, Bulgaria, Romania and Thailand are all on transition grants (their final funding cycle from The Global Fund), and each is prioritizing key populations in its WTP commitments. This is encouraging, given the TRP's concerns expressed in their report on the first two windows. Other countries that are not facing imminent transition, such as South Africa and Jamaica, appear to be more focused on absorbing HIV treatment costs at this point in time.

[60] ICASO & MSMGF (2014). ICASO (2014, November). Punishing Success? Explanation of Band 4 of The Global Fund to Fight AIDS, Tuberculosis and Malaria and its Implications for Civil Society and Key Populations. Page 11, online at: http://www.icaso.org/?file=23977

Table 10: Overview of common WTP investment areas (as per concept notes), by country

Country	WTP investment area				
	Treatment	Procurement	Testing/ Screening	Human resources	Key populations
Belize	√	√			
Botswana	√		√	√	√
Bulgaria	√	√	√		√
Costa Rica					√
Fiji				√	
Iran		√		√	√
Jamaica	√		√	√	
Mauritius	√				√
Romania	√	√	√		√
South Africa	√				
Suriname	√			√	√
Thailand			√		√
Ukraine	√		√		√

Nine of the countries surveyed said that some of their WTP funds would be invested in key population. Table 11 provides an overview of which key populations were prioritized.

Table 11: Key populations targeted in WTP commitments, by country

Country	Key population							
	Sex workers	MSM	Trans-gender	PWID	Youth	Migrants	Pris-oners	Home-less
Botswana	√				√			
Bulgaria							√	
Costa Rica		√	√					
Iran				√			√	
Mauritius				√				
Romania							√	√
Suriname						√		
Thailand	√	√	√	√		√		
Ukraine				√			√	

In countries that did not allocate some of their WTP monies to key populations, there was a sense from key informant interviews of "staged" investment, with countries prioritizing absorption of what they saw as "core" interventions like testing and treatment first, thinking that key populations, human rights and community systems strengthening program areas would be taken over by government at a later stage. It is worth thinking critically about this approach. The notion that key populations interventions are not "core" interventions is potentially ill-conceived.

We noted in an earlier sections of this report that The Global Fund encourages countries to spend their WTP on "potential areas of take-over of existing Global Fund support which will free

Global Fund resources to be reinvested in strategic areas." In some countries, key informants suggested that the strategic areas were seen as largely key populations programming. Importantly, Global Fund priorities for key populations are also largely geared towards prevention programs, helping to explain the apparent distinction between paying for treatment and paying for key populations. Botswana is an example of a country prioritizing treatment coverage specifically for key populations (sex workers) in its WTP commitments. This distinction between "core" programming and key populations programming may not be helpful, as it could be having the unintended consequence of dis-incentivising countries to spend government money on some programming for key populations (based on a belief that The Global Fund would like to fund these areas).

Concluding remarks

The Future of WTP as a policy within The Global Fund's upcoming Strategy for 2017-2022 is unclear. The Global Fund is expected to finalize the strategy in the first half of 2016.

What is clear is the importance of the next step, which is to monitor the follow-through of these commitments, particularly around commitments to key populations in the context of transition. As one key informant from The Global Fund Secretariat aptly put it, "You can have all the policies you want, but these are sovereign countries. It's an engagement."[61] Part of this engagement must be an informed and supported civil society that can watchdog the implementation of these commitments, particularly tracking whether funds are actually committed to the priority areas identified in the concept notes. This will be particularly vital in countries where commitments were specifically made towards key populations (recall Table 11). Lastly, it will be critical to further investigate how the WTP is linked with other elements of Global Fund investment and impact at country level, particularly in UMI countries facing transition. One key informant noted that viewing WTP within a larger context is really important: "Looking at WTP in isolation is really hard. You tend to bring it up in contexts around challenges, since it's a bargaining chip. It's only one really tiny part of a really big process."[62]

While the counterpart financing and WTP policies have clear monetary value – with more than $6 billion in government resources committed during the NFM[63] – "More importantly, it has started a process of engagement with the country stakeholders which was not there earlier."[64] Understanding WTP as a process – and not just a dollar value – it critical. The real value of this policy lies in how it promotes open dialogue and multi-stakeholder engagement around the need for greater government investment in health. This value underscores the need for that process to continue, even after the dollar commitments have been made. Holding governments accountable for those commitments will be the ultimate measure of how the policy was able to leverage additional resources.

[61] Key Informant Interview (telephonic), 5 November 2015.
[62] Key Informant Interview (telephonic), 10 November 2015.
[63] Recall from the opening paragraph that is amount is $3.5 billion *more* than was committed by governments in the previous phase of Global Fund grants (before the NFM).
[64] Key Informant Interview (telephonic), 5 November 2015.

Annex 1 – Bulgaria willingness-to-pay notice from The Global Fund

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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Chemin de Blandonnet 8
1214 Vernier, Geneva
Switzerland

27 May 2014
Our reference: EECA/SI/111 - 27/05/2014

Dr Tanya Andreeva
Minister of Health of the Republic of Bulgaria
Ministry of Health of the Republic of Bulgaria
5, Sv. Nedelya street
Sofia
Bulgaria

Honorable Minister Andreeva,

By means of this letter I would like to introduce to you an important aspect of the New Funding Model of the Global Fund, namely the concept of "Willingness to Pay" (WTP).

The WTP concept envisages increasing the Global Fund's allocation to the countries depending on their ability to contribute more funding to a given disease component.

Under the WTP rules, Bulgaria would be eligible for the WTP component at amount of 1.545 million USD if the total TB government commitment from 2015 to 2017 is higher than the TB government spending in 2012-2014 (38.923 million USD) for minimum of 3.09 million USD. Therefore, the minimum of TB government commitment for the period 2015 to 2017 should be not less than 42.013 million USD.

I am confident that thanks to your efforts in allocate more domestic funding for HIV and tuberculosis, the government's commitment to tuberculosis can reach the amounts required for the eligibility for the WTP component. Areas requiring additional attention from the Government include but are not limited to second-line drugs for treating multi-drug-resistant tuberculosis (MDR-TB), laboratory infrastructure, equipment, testing commodities, as well as investments in active TB case finding.

In this regard, the Global Fund Secretariat would be grateful to receive from your Ministry information on the government commitments for tuberculosis for the period 2015-2017 based on the National TB Strategy. As I understand, however, the National TB Strategy for the period 2015-2017 is currently being developed, therefore, we would appreciate receiving clarification on when the country is planning to finalize the new budgeted National TB Strategy.

In order to validate our estimations for the WTB component for Bulgaria, we would be grateful to receive a Short or Medium Budget Plan or Expenditure analysis or any other official document/report which can justify government's spending for tuberculosis in 2013 and 2014. Also, we would need an explanation, on behalf of the Country Coordinating Mechanism, on how the commitments for government's spending for tuberculosis will be justified and tracked in future.

If required, the Global Fund Secretariat stands ready to support the Government of Bulgaria in conducting annual National Health Accounts exercise with disease specific sub accounts for HIV/AIDS and TB. We will authorize the use of grant funds for this important exercise,

if the country finds it useful and necessary. For your information, other partners such as OECD and World Bank support System of Health Accounts (SHA) in the region.

We are looking forward to your response as to how the Global Fund can be of support in justifying the WTP component for the Republic of Bulgaria, and to receiving the currently available information on the government's spending for tuberculosis in 2013 and 2014.

Sincerely Yours,

Sandra Irbe
Senior Fund Portfolio Manager, Eastern Europe and Central Asia

Copy to: WHO Country Office in Bulgaria
Dr Tonka Varleva, Director of Programs financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria
CCM members

Annex 2 – Suriname willingness-to-pay commitment letter

Ministerie van Volksgezondheid

Ministerie van Volksgezondheid
in
Suriname

Directie en Centrale
Administratie

No.:
Subject: Willingness to Pay
Bijlagen:

Paramaribo, August 2014

Dear Sir,

With regards to the Malaria Concept note request through the Country Coordinating Mechanism (CCM), herewith the Ministry of Health (MOH) as the Principal Recipient (PR) of the proposed funding would like to inform the Global Fund that for Willingness to Pay the Ministry has committed to the following activities:

1. Build an extra clinic in the interior (Lawa Tabiki) to deliver Malaria, HIV, TB services and basic care within the mining areas of the south eastern border.
2. Fund the Human Resources for the above mentioned clinic.
3. Implementation of Treatment 2.0 in for HIV in Suriname with and expected four to five fold increase in the number of patients treated.
4. Implementation of Option B+ for PMTCT.

The details are provided in Annex 1 - Detailed Work Plan and Budget - Government Contribution. We trust that these commitments will ensure that MOH will be able to fulfil the Willingness to Pay requirement'
MoH is committed to fight against Malaria and reduce mortality and morbidity resulting.
We take this opportunity to thank the Global Fund for its continued support to the national malaria control program. We look forward to a continuation of the successful collaboration in future years in our collective efforts to fight AIDS, malaria and tuberculosis in Suriname.

Kind regards,

Marthelise Eersel
Director

Ministerie van Volksgezondheid HenckArronstraat 64 Tel. 477601 fax 473923 E-mail: minvgz@parbo.net