



Leveraging Disease Funding to Advance Health for All

The Global Fund and Universal Health Coverage



Susan Hubbard
Maya Wedemeyer

Leveraging Disease Funding to Advance Health for All

The Global Fund and Universal Health Coverage

Susan Hubbard

Maya Wedemeyer



Copyright © 2017 Japan Center for International Exchange

All rights reserved.

Copyediting by Kimberly Gould Ashizawa and Marie Louise Keen.

Cover photographs: (l.) Global Fund/Jonas Gratzner; (r.) Global Fund/Petterik Wiggers

Back cover: (l.) Global Fund/ Georges Mérillon; (r.) Global Fund

Printed in Japan.

Japan Center for International Exchange

Meisan Tameike Bldg. 7F 1-1-12 Akasaka, Minato-ku Tokyo 107-0052, Japan

www.jcie.or.jp

Japan Center for International Exchange, Inc. (JCIE/USA)

135 West 29th Street Suite 303 New York New York 10001

www.jcie.org

Table of Contents

05	Acknowledgments
06	How the Global Fund Contributes to UHC
16	Ethiopia: Extending the Reach of Healthcare
24	Rwanda: Improving the Affordability of Healthcare
34	Notes
37	About JCIE and the FGFJ

Acknowledgments

Many people have contributed their time and expertise to help this report come to fruition. The research team would like to thank the staff of the Global Fund Secretariat for their support. The portfolio managers and their teams in Geneva provided the research team with extensive background information on each of the country cases, responded to questions and requests for additional information, and helped the team organize its field visits. In particular, we would like to thank Osian Jones, portfolio manager for Rwanda; Saman Zamani, public health and monitoring and evaluation specialist; Sai Pothapregada, portfolio manager for Ethiopia; and Izaskun Gaviria, portfolio manager for Myanmar, for their assistance. We would also like to thank Christoph Benn, Frédéric Goyet, Anne-Laure Aubertin, and Makiko Takayama for connecting us to the right people in Geneva and in partner countries and responding to our many inquiries. Many representatives from Global Fund grant recipients and their partners in Ethiopia and Myanmar took time out of their busy schedules to make sure that we learned as much as possible about their work during our visits, and we appreciate their willingness to share their experience and expertise, without which this project would not have been possible. At JCIE/USA we would like to thank Kim Ashizawa and Marie Keen for their careful editing of the report, as well as Kiyoko Shiromasa for designing and laying out the report and Serina Bellamy for her research assistance. Last but certainly not least, we would like to thank the United Nations Foundation for its generous support for the activities of the Friends of the Global Fund, Japan (FGFJ).

Research team:

Susan Hubbard, Fellow, JCIE/USA

Satoko Itoh, Chief Program Officer, JCIE

Xiao Ying Leong, Program Officer, JCIE

Maya Wedemeyer, Program Officer, JCIE/USA

How the Global Fund Contributes to UHC



THERE HAS LONG been a tension surrounding global health initiatives that focus on specific diseases and those that aim to broadly improve health systems and access to healthcare. That tension derives from the common assumption that channeling resources into one of these objectives diverts it from the other. However, a closer look at the impact on the ground of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) demonstrates that, if properly targeted, disease-specific approaches can complement and support efforts to attain universal health coverage (UHC).

This report is the result of work by a JCIE research team to examine those complementary efforts with the goal of providing examples of how disease-specific programs can create win-win situations in which they attain their specific goals

while also contributing to UHC. The work took the form of desk-based and field research, as well as extensive discussions with staff of the Global Fund Secretariat and insights gleaned from study visits conducted by JCIE's Friends of the Global Fund, Japan (FGFJ), to Global Fund-supported projects. In 2014, JCIE staff visited Ethiopia and Myanmar to meet with Ministry of Health officials and other experts on healthcare in their respective countries, as well as to visit facilities and programs supported by the Global Fund and hold in-depth discussions with the organizations that are carrying out the programs on the ground.

Ethiopia and Rwanda provide perhaps the most straight-forward examples of the Global Fund's contributions to UHC, and this report includes separate case studies of each. In these two countries, a conscious decision was made



to design their grants from the Global Fund in such a way that they would contribute to UHC through expanded access to health services for all without undue financial burden. These case studies are not meant to evaluate the impact of Global Fund grants in these countries but rather to highlight the ways in which Global Fund grants may be designed with the twin goals of expanding UHC and fighting AIDS, tuberculosis, and malaria. Other cases have more subtle impacts on UHC that may have occurred accidentally rather than by design, and lessons from those cases are presented in the following sections, along with lessons from the two countries for which we include full case studies, Ethiopia and Rwanda. While these two cases are more the exception than the rule—requiring strong political will and motivation to negotiate with the Global Fund

for contributions specifically to UHC—the other examples demonstrate that, even without strong political will to design programs supported by foreign aid in a way that will help promote UHC, grants from the Global Fund can still have a positive, albeit subtler, impact in this area.

The Global Fund’s Fight against Communicable Diseases

The Global Fund was established in 2002 to mobilize resources to combat three of the world’s deadliest communicable diseases and to serve as a catalyst for country-led solutions to the challenges posed by these diseases. Since then, it has raised a total of more than US\$40 billion from governments, private companies, foundations, and individuals, which is being invested in the fight against these diseases around the world.¹

The AIDS movement played a major role in achieving rapid growth in funding for communicable diseases at the end of the 20th century and the beginning of the 21st. That global movement successfully raised awareness and money to fight a relatively new disease that was spreading to all corners of the world. While the dedicated work of scientists around the globe eventually produced a treatment for the disease, the movement successfully highlighted the deadly impact that poverty, discrimination, and inequality had on those who could not access lifesaving treatment due to cost and other barriers. But this rather sudden surge of money into what became a very high-profile disease prompted a debate about whether the popularity of fighting AIDS was in fact taking resources away from other important health-related challenges.² Ultimately, what came out of this debate was a general agreement within the mainstream global health community that, despite the increase in funding, global health challenges require far more resources than are currently being directed to the field. At the same time, recognizing that funding is limited and the overall pie for global

health may never be as big as many in the health field believe it should be, efforts have been made to use resources more efficiently and look for greater synergy among different sub-specialties within global health and among various actors.

The Global Fund recognized in its early years of existence that it could not achieve its goals unless it helped to improve the health systems within which its funding was being used. The board first approved funding for health system strengthening components in disease-specific grants and later established a new pillar of funding, allowing countries to apply for grants specifically aimed at health system strengthening rather than targeting one or more of the three diseases, as long as the grant still aimed to improve capacity to fight one or more of the three diseases. The addition was a natural outgrowth of the recognition that a certain level of infrastructure was needed to tackle the three diseases and that there was a potential for disease-specific funding to detract from the broader goals of health systems if not managed appropriately. Roughly one third of support from the Global Fund is classified as contributing to health system strengthening—some of it being provided under the fund's health system strengthening pillar and the rest as a component of disease-specific grants.³

The Rise of UHC

At the same time, global interest in UHC was growing around the world. In 2010, the World Health Organization dedicated its World Health Report to promoting the goal of achieving UHC.⁴ Japan, which achieved universal access to health insurance in 1961 and has made the promotion of UHC around the world a key pillar of its global health strategy in the 21st century, is one of a growing number of countries to recognize the value of UHC to human health and wellbeing.⁵

The Global Fund's mission is specifically to address three major communicable diseases—AIDS, tuberculosis, and malaria—and ultimately it has a responsibility to demonstrate to its donors that it is achieving that specific mission. The intent of this report is not to recommend a shift away from that core mission toward the goal of promoting UHC, nor is it to evaluate the



impact of the Global Fund on UHC. Rather, the objective is to identify the ways in which the Global Fund is already supporting UHC without compromising its mission of dealing with the three diseases and to recommend ways for the Global Fund and other disease-specific initiatives to create similar win-win situations. By doing so, we aim to spark a discussion about how funding mechanisms and other programs can be designed so that they contribute to UHC while also ensuring that funding is targeted appropriately to individual diseases and disorders that may require more attention and resources.

Not every grant or line item can produce this kind of win-win situation, and many of the expenditures made by Global Fund grant recipients may rightly only have a direct impact on one disease. But with careful planning and engagement of multiple stakeholders, it is our hope that the global health community can continue to find ways in which support for specific diseases also contributes to increasing access to health services as a whole rather than detracting from progress toward other goals.

The first thing that comes to mind for many people when we talk about the Global Fund's contributions to UHC is expanded access to preventive, diagnostic, treatment, and care services for the three diseases. This, again, is a core component of the Global Fund's mission, and the progress



it has made in this area has brought essential health services related to AIDS, tuberculosis, and malaria to many people who otherwise would not have had access. By the fund's estimates, this has saved 22 million lives since the Global Fund was created in 2002.⁶ One can also find reductions in other health challenges that are a direct result of reductions in AIDS, tuberculosis, and malaria. For example, an HIV-positive woman who does not develop AIDS because she is on antiretroviral treatment will be spared the opportunistic infections that accompany progression to the disease.

These direct impacts are all very important and represent the success of the Global Fund, but they are also documented elsewhere and therefore are not the focus of this study. Rather, we are looking for the “spillover effects” or “positive side effects” of Global Fund support—whether intended or not—on other health challenges. More specifically, we are looking at the Global Fund's effects on expanding access to quality, affordable health services in general. In other words, what impact is Global Fund support having on people's access to health services beyond the scope of the three diseases?

While the Global Fund's pillar on strengthening health systems is expected to contribute to progress toward achieving UHC, this report looks beyond that classification to find the areas where support from all pillars—disease-specific and

health system strengthening alike—contributes to an expansion of access to a full spectrum of health services. When channeled through the health system strengthening pillar, that might include enhancing health information systems or building and maintaining health facilities that provide a broad range of health services. But it can also happen through funds channeled through one or more of the disease-specific pillars, for example when training healthcare workers to diagnose and treat malaria includes components for them to learn to diagnose and treat other causes of fever in children. In addition, we seek to go beyond the supply side improvements that are inherent to health system strengthening and also look at impact on the demand side. In other words, are more people—particularly those among marginalized populations—increasingly likely to seek out and use health services that are available to them due, at least in part, to Global Fund investments?

Spillover Effects

Drawing on these cases and our broader research on the impact of the Global Fund's support, we have identified five general categories of spillover effects that contribute to the expansion of UHC, which are outlined below.

Expanding Health Insurance Coverage

Universal access to health insurance is, for many experts, the cornerstone of UHC. Without some kind of pre-paid pooling mechanism, families—particularly low-income families but also those in the middle class—face the threat of either foregoing necessary preventive, diagnostic, and care services or falling into poverty because of payments for such services. Therefore, universal protection against financial devastation due to payments for health services is a key component of any UHC system. While more and more countries have committed to ensuring universal health insurance coverage within their populations, many countries still have large segments of their populations with no financial protection against healthcare costs. In countries where health insurance is provided primarily by employers, ensuring that people outside of the formal employment sector have access to affordable insurance is particularly challenging.

Rwanda offers a vivid example of how Global Fund support is being used to expand universal access to health insurance through its disease-specific and health-system-strengthening grants. In 2006, Rwanda began using support from the Global Fund to fully subsidize premiums for orphans, people living with HIV, and those in the lowest income brackets regardless of serostatus, so that they can participate in the community-based health insurance scheme. This insurance scheme covers access not only to services related to communicable diseases, but also to a broad range of primary, maternal, and child health services, as well as to more advanced services at district- and national-level hospitals. Global Fund support also provides subsidies for poor Rwandans who do not qualify as “poorest-of-the-poor” to purchase the complimentary insurance that covers advanced services at hospitals. Approximately 2 million Rwandans receive subsidies of some sort through Global Fund support, ensuring that individuals who would not be able to afford insurance on their own are able to access health services without falling into financial devastation, and thus helping Rwanda to move toward its goal of UHC.

Increasing Availability of Health Services

If health services are not available, affordability and financial protection become moot points. There is no doubt that support from the Global

Fund helps increase availability of services related to AIDS, tuberculosis, and malaria, as the Global Fund has demonstrated with its regular results reports.⁷ While there may be some cases where it is necessary to create discrete, parallel platforms to provide disease-specific services, in many instances that is not the case. There are frequently opportunities to make investments in such a way that expands access to a broader range of services while simultaneously bolstering, or at the very least not jeopardizing, progress toward fighting the three key target diseases.

One large expense in any health system is constructing and equipping health facilities. In both Ethiopia and Rwanda, money from the Global Fund has been used to support the construction of small basic clinics—referred to as health posts—throughout the country, helping bring basic health services to many people who would otherwise lack access. The clinics provide services related to HIV/AIDS, tuberculosis, and malaria, but they also offer prenatal care, clean childbirth support, childhood immunizations, family planning, and other basic primary healthcare services, as well as referral systems for patients who need more advanced care. Once Global Fund support is used to build the facilities and equip them to address HIV, tuberculosis, and malaria, other services can be offered at a marginal additional cost.

Another major expense is training and retaining health workers at all levels of the health system, and the Global Fund makes significant investments in community health workers, who are the frontline care providers responsible for expanding access to care in many low-resource settings. Ethiopia’s Health Extension Program (HEP) has garnered praise for training 38,000 health extension workers (HEWs) to date so that there are two for every 3,000–5,000 people and no one is more than a 10-kilometer walk from a health post staffed by an HEW. The Global Fund has been one of the top funders of support for these community-based healthcare workers. While Global Fund support is concentrated on the AIDS, tuberculosis, and malaria components of the training program—with other funders supporting other components of the curriculum—many of the expenses that are covered by Global Fund support carry over to other portions of the training, allowing other health challenges



to be covered at minimal additional cost. Moreover, specific training related to AIDS, tuberculosis, and malaria naturally spills over into other health conditions. For example, HEWs who learn how to diagnose malaria also learn how to diagnose other common causes of fevers, particularly diarrhea and pneumonia, so that they can still help patients who test negative for malaria.

Similarly, some of the equipment purchased with Global Fund support for health facilities and laboratories that is used in combatting AIDS, tuberculosis, and malaria is also used in services for other conditions, including some noncommunicable diseases. For example, microscopes purchased for tuberculosis diagnosis and treatment monitoring are also used to look for other bacterial infections. At a large national laboratory in Mandalay, Myanmar, a generator purchased for the clinic with Global Fund dollars keeps all of the equipment in the lab running during the frequent blackouts there, regardless of the purpose of the equipment. And equipment in the same laboratory that was purchased with Global Fund support to monitor liver function, creatinine levels, and other

health indicators in patients taking antiretroviral treatment for HIV infection is also being used to check liver function for other patients as well.

In Ethiopia, Global Fund support has been used to strengthen the country's drug procurement and supply chain management system by supporting the construction of warehouses for drugs and equipment in every region of the country and purchasing trucks to transport drugs and equipment to where they are needed most. The warehouses and trucks are used for the full spectrum of drugs and equipment needed in the health system, not only those used for AIDS, tuberculosis, and malaria. The trucks tend to move the drugs and equipment in one direction—from the warehouses to hospitals, health centers, and health posts—but when they return to the more centralized warehouses, they bring surveillance data back with them, allowing for better understanding of epidemiological trends throughout the country on all health conditions for which patients seek care.

Support for Rwanda's health system has included solar panels for health centers, allowing them to operate more consistently,⁸ as well as

funding to secure ambulances, medical equipment such as microscopes and X-ray machines, and operational costs for the warehouse of the central procurement agency (CAMERWA), including renovation costs, overhead, staff salaries, and procurement system software.⁹

Building Capacity within Ministries of Health

The Global Fund recognizes that not every Ministry of Health or local organization is capable of managing large grants from international donors, so it supports its partners in building that capacity. For example, following Myanmar's political transition in 2011, an influx of aid came in from governments and other donors from around the world that had withheld aid—including health-sector support—during the reign of the military junta. Ministries found themselves trying to rapidly make their fragmented systems conform to international standards of financial management and inclusive service delivery. The Global Fund, which had suspended its support for Myanmar in 2005 due to government restrictions on grantees' ability

to carry out programs in the country,¹⁰ began providing funding again in 2011, but insisted on having only well-established international nongovernmental organizations or intergovernmental organizations as principal recipients and sub-recipients of its grant funds until government agencies in the country had demonstrated that they could effectively manage large grants without falling prey to corruption and mismanagement. The United Nations Office for Project Services (UNOPS) has been the primary recipient, but it is working closely with Myanmar's Ministry of Health so that the ministry can one day take over that role. In doing so, UNOPS conducts financial and management training for the ministry under its grant from the Global Fund, enabling ministry officials to learn important skills that can be applied to their current and future duties within the ministry, well beyond the three diseases. As in many other settings, Ministry of Health staff who have learned on the job through their positions related to Global Fund-supported activities may move into higher positions in the ministry where



they are responsible for a broader range of health programs, and the management skills they learned in their positions working specifically on AIDS, tuberculosis, or malaria are then transferred to their work in other areas of the health system.

Every country preparing to apply for a grant from the Global Fund starts by creating a country coordinating mechanism (CCM), a multisectoral group of experts who are responsible for designing in-country programs, submitting proposals, monitoring program progress, and holding the grant recipients accountable for their work. One strict requirement that the Global Fund has for CCMs is that they all include a diverse group of experts, including governmental and nongovernmental representatives, multilateral agencies and bilateral donors where appropriate, and people representing communities directly affected by the three diseases.¹¹ The CCM in Myanmar proved to be such a valuable resource for the Ministry of Health and Sports in implementing its Global Fund grants that the ministry decided to create the Myanmar Health Sector Coordinating Committee based on that model to oversee all health-sector aid, not just those aspects related to communicable diseases.¹²

Increasing Marginalized Populations' Use of Health Services

Just because health services are available within reasonable geographic proximity for free or at an affordable cost does not mean that everyone who needs the services will actually use them. Many factors affect whether or not a person will access services. Whether or not they feel understood and respected by healthcare providers is a common one. The AIDS movement in particular has made significant contributions by pushing for more recognition of the rights of key affected populations, most notably men who have sex with men (MSM), commercial sex workers (CSWs), and injecting drug users (IDUs). Because of that pressure, more people in these key population groups are receiving critical prevention, treatment, and care services related to their risk for HIV infection. As a result, HIV-related services have the potential to serve as a kind of gateway to bringing these populations into the health system so that they can access other health services that have nothing to do with their HIV risk or serostatus, including the growing burden of noncommunicable diseases.

One cornerstone of the Global Fund's support for the fight against HIV/AIDS in Myanmar is drop-in centers that provide HIV prevention education and contain sexually transmitted infection (STI) clinics for MSM and CSWs. While the focus is on HIV and other STIs, the doctors in the clinics also see clients of the drop-in centers (and children of the CSWs) for other health concerns and either treat them or refer them for care outside of the clinic. Without these services, many of them would not be comfortable going on their own to other clinics, and several of the CSWs the research team interviewed at a drop-in center explained that in the past they were more likely to self-diagnose and self-medicate with drugs purchased at private pharmacies. Population Services International has provided training, with Global Fund support, to healthcare providers outside of the drop-in centers on providing competent and respectful care for MSM and CSWs, and whenever the drop-in center doctors have to refer a patient outside of the drop-in center's clinic for health services that are outside the clinic's scope of practice, they are careful to refer them to a provider who has been trained through this program and understands some of their unique concerns. In these cases, some populations who were effectively prevented from accessing healthcare before are better able to secure a broader range of healthcare services now using Global Fund-supported (AIDS-specific) services as an entry point.

Increase in Government Budget for Health

When the Global Fund provides much-needed support to a country to help it address the devastating toll of communicable diseases, it also brings with it a certain degree of influence. The Global Fund uses this influence to work closely with all of its grantees to make sure that they have plans in place to continue funding their fight against AIDS, tuberculosis, and malaria through domestic budgets once they reach the stage of economic development at which Global Fund support gets phased out. These efforts also support countries in their efforts to expand domestic spending on other components of their health systems, thereby helping them to reduce their dependency on development assistance for health. More specifically, together with government officials and other partners in countries that it funds, the Global



Fund conducts transition readiness assessments to assist countries in determining how they will continue to fund their own health systems going forward, with an emphasis on ensuring that the most vulnerable people in their societies have access to health services by focusing on bottlenecks and inefficiencies in their existing systems as well as best practices that they will want to continue. These efforts all assist countries as they prepare to achieve UHC and sustain it on their own.

Contributions from Outside of the Global Fund

The Global Fund is not the only funding source for communicable diseases, and examples of contributions to UHC can be found from other areas, both historical and current. For example, tuberculosis bore a heavy toll on Japan's citizens and its health system in the late-1940s and early 1950s. The government responded by targeting funding specifically at fighting the spread of tuberculosis, resulting in the 1951 Tuberculosis Control Law. That law promoted and provided government funding for regular health check-

ups, vaccinations, and treatment as needed. This emphasis on tuberculosis prevention and government subsidies to ensure that everyone could access services regardless of their income level or health insurance status led to universal coverage of health check-ups in 1955, six years before Japan achieved universal health insurance coverage. While the goal of expanding health check-ups was fighting the spread of tuberculosis, patients were brought into the health system through this mechanism, and their check-ups covered their total health picture, not just tuberculosis.¹³

Cambodia also offers a useful example of how support for a specific communicable disease has been used to expand universal access to other health services by integrating HIV-related services with those for other chronic disorders—i.e., diabetes and hypertension—in chronic disease clinics. In addition to the efficiency gains of providing multiple services under one roof, the clinics target two major challenges in Cambodia's health system: providing long-term, consistent care to people with chronic conditions; and overcoming the stigma that often keeps people living with HIV/AIDS away from clinics known to deal only with that condition, which may prevent them from

accessing life-saving treatment. By addressing HIV/AIDS in tandem with other chronic disorders, the clinics are a safe space for HIV-positive patients to go without the stigma that comes along with their neighbors seeing them go into an AIDS clinic. And the marginal additional cost of addressing diabetes and hypertension in these clinics supported by funding for HIV/AIDS allows Cambodia's health system to address two wide-spread chronic disorders for which there is much less funding available, despite their devastating toll and cost of treatment.¹⁴

Nongovernmental organizations dedicated to the fight against specific diseases have also successfully brought people into the health system for other reasons when needed. For example, the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO) has been working with people living with HIV since 1982, focusing specifically on opportunistic infections that result from AIDS. But when the earthquake struck in January 2010, GHESKIO found that many members of the Port-au-Prince community began flocking to their organization for healthcare and other basic needs because

GHESKIO already had the trust of the community. They were then able to leverage that trust to link patients to appropriate services.

The scientific research field also offers examples of ways in which funding aimed at a specific disease has helped lead to the development of vaccine and treatment candidates for other diseases, improving prevention and treatment options for people around the world. According to amfAR, the Foundation for AIDS Research, there are numerous instances in which AIDS research has led to improved treatment options for other diseases. Drugs originally developed as AIDS treatment have been used to treat certain cancers and hepatitis B and C, and research on how the virus affects the body is helping scientists understand the effects of disorders like Alzheimer's, heart attacks, and strokes.¹⁵ Product development partnerships created by the International AIDS Vaccine Initiative in the search for a preventive HIV vaccine have also generated new knowledge about viruses, which contributed to the development of a vaccine candidate for Ebola that is currently being tested in clinical trials in Guinea.¹⁶



At the beginning of the 21st century, the international community made a commitment to drastically increase funding for AIDS, tuberculosis, and malaria, marking their recognition that these three diseases were taking a devastating human toll and that a significant influx of financial resources was required in order to stop the growth of these epidemics and bring them under control. The commitment resulted in the birth of the Global Fund and other bilateral investments that have led to significant progress in the fight against communicable diseases. But as death rates from these three diseases began to come down, countries around the world—and low-income countries in particular—found that they were faced with a growing challenge from noncommunicable diseases and that their health

systems were ill-equipped to ensure affordable access to health services for everyone who needed them without patients and their families facing the threat of financial devastation. Focus in the global health field then expanded to include UHC, raising new questions about the ideal allocation of limited resources. What the cases examined here suggest is that, rather than focusing on the competition for funds, it would be useful to explore ways to design disease-specific programs so that they contribute to UHC without compromising their disease-specific goals. The Global Fund offers multiple examples of efforts to meet both goals, both by design and by accident, and these examples should be further studied to inform the global health field more broadly.

Ethiopia

Extending the Reach of Healthcare



OVER THE PAST decade and a half, Ethiopia has made considerable progress in the development of its primary healthcare infrastructure, in large part through the effective channeling of foreign aid to help build its HEP. The HEP is a community-based primary care model that has created a network of health posts throughout the country. As a part of the program, HEWs have been trained to provide basic primary health services to Ethiopia's many remote communities. Disease-specific funding, such as that provided by the Global Fund, has also been effectively used to support the development of the HEP, with the argument made by Ethiopia's Ministry of Health that disease-specific interventions cannot be delivered without a community-based platform that can effectively deliver primary healthcare to the country's hardest-to-reach populations.

Ethiopia is the 10th largest and 2nd most populous country in Africa, boasting incredible geographic and topographic diversity and a population that speaks more than 80 different languages. The country has seen major economic gains with a growth rate that shot up from negative 11.4 percent to more than 10 percent between 1985 and 2013. What started as one of the worst under-5 mortality rates in the region in 1990 (the baseline year for the millennium development goals, or MDGs) had surpassed the target of a two-thirds reduction by 2013, two years ahead of schedule.¹⁷ However, its maternal mortality ratio was more than twice the global average in 2010 (523 per 100,000 live births in Ethiopia versus the global average of 246) and was still much higher than the global average in 2015 (353 in Ethiopia versus the global average of 216).¹⁸

Ethiopia adopted its first constitution in 1994 and has since been run as a federal parliamentary democracy. With more than 70 percent of the population still employed in agriculture and more than 80 percent living in rural areas, the government is pushing to industrialize its economy.¹⁹ However, large-scale infrastructure projects and other economic drivers of internal mobility and migration have contributed to the country's communicable disease burden—particularly its HIV/AIDS prevalence, which has become more concentrated in urban areas and along major transportation routes. But rates have been declining, with the urban HIV infection rate having peaked at 14.3 percent in 2001 and declining to 4.4 percent in 2012, and rural prevalence peaking at 4.1 percent in 2003 and declining to 1.8 percent in 2012.²⁰

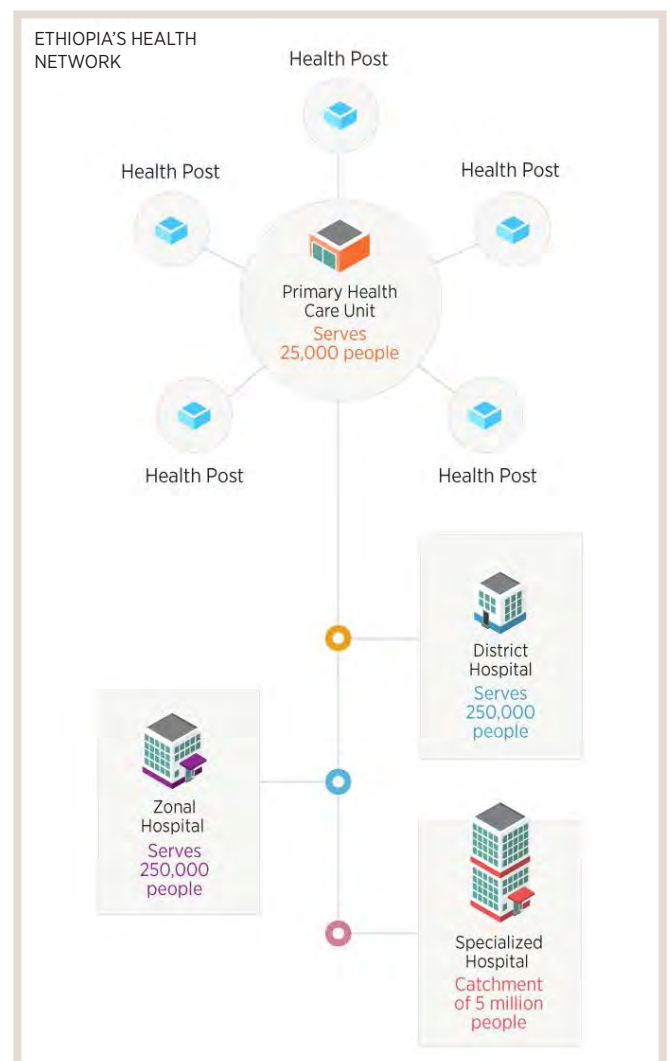
In 1991, after a brutal dictatorship was overthrown, the country embarked on an ambitious roadmap to achieve middle-income status by 2025. Recognizing the importance of external aid as a source not only of financing but also of institutional and administrative capacity building, efforts were made to persuade funders to channel their foreign assistance toward this comprehensive goal. Since then, Ethiopia's macroeconomic indicators have steadily improved while its foreign aid has risen to become the highest in the region.²¹ The government's ability to effectively channel this aid can be seen in the transformation of the country's health sector from a centralized national system with highly fragmented provision of services, to a much more seamless and integrated healthcare delivery system with responsibility devolved to municipal governments that are expected to be better able to gauge the needs of their geographically and socially diverse communities. These achievements are reflected in Ethiopia's almost 50 percent reduction in poverty—from 60.5 percent in 1996 to 30.7 percent in 2011²²—and the successful implementation of its HEP.

Ethiopia's Health Sector

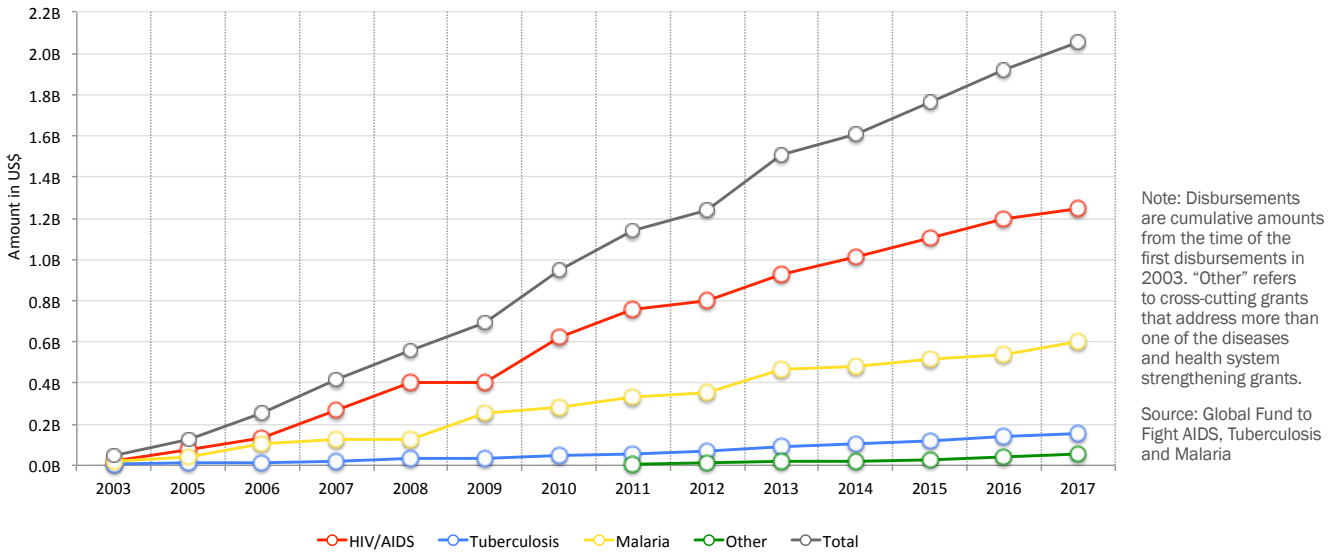
Ethiopia's population health, like that of many emerging economies, is a story of encouraging trends alongside a number of persistently poor health outcome indicators. Average life expectancy in Ethiopia has risen significantly, from 49 years in

1994 to 64 in 2014.²³ Preventable communicable diseases and nutritional disorders remain key health challenges, along with persistently high maternal mortality rates.²⁴ Due to its mountainous topography, large parts of Ethiopia are not malaria-endemic. Yet despite the fact that only roughly 60 percent of the population is living in altitudes below the 2,000-meters-above-sea-level threshold for being at risk,²⁵ malaria remained the third greatest cause of premature death in the country in 2010,²⁶ and Ethiopia remained among the five countries in sub-Saharan Africa with the highest prevalence of the disease.²⁷

HEWs working in health posts, the frontline of Ethiopia's primary healthcare system, are overseen by staff from their nearest health center or primary healthcare unit, and HEWs often refer patients to the health centers for care that they are not able to provide at the health posts or in their communities. More advanced care is



Global Fund Disbursements by Component



provided in district and zone hospitals, as well as specialized hospitals.

The overall vision for Ethiopia’s health sector is outlined in four-year Health Sector Development Plans, which are developed in coordination with broader economic development goals. The Ministry of Health launched the HEP, recognizing that 60–80 percent of health problems were preventable through basic public health measures, but that physical access to health services was a major barrier. HEWs are predominantly female and are considered salaried civil servants. Two are selected from each *kebele* (i.e., ward or neighborhood) to service its population of 3,000–5,000 people. As of 2015, the country had trained more than 38,000 HEWs operating out of more than 16,000 health posts, which covered each *kebele* in the country.²⁸ Ethiopia’s ability to extend the frontlines of basic primary health services access to

each community has been driven in large part by political will from within the Ministry of Health to achieve the health-related MDGs by 2015.²⁹

Ethiopia and the Global Fund

Ethiopia was one of the Global Fund’s first grantees and is one of its largest recipients to date. The Global Fund, in turn, is one of Ethiopia’s main health sector donors—it was the largest donor to channel funds through the Ministry of Health, and the US government and the Global Fund together are the largest donors to the country’s three disease programs. (In 2013–2014, approximately 86 percent of HIV/AIDS funding in Ethiopia came from external donors, 80 percent of which was from the Global Fund and PEPFAR.³⁰) A new civil society law in Ethiopia has outlawed nonprofit

HEWs provide preventive and curative services to people in their *kebele* (ward):

Disease prevention and control

- TB, HIV/AIDS, other STIs
- malaria
- first aid and emergency measures

Family health services

- maternal and child health
- family planning
- immunizations
- adolescent reproductive health

- nutrition
- common childhood illnesses (e.g., diarrhea, pneumonia, malaria, severe malnutrition)

Hygiene and environmental sanitation

- excreta disposal
- solid and liquid waste disposal
- water supply and safety
- food hygiene and safety

- healthy home environment
- insect and rodent control
- personal hygiene

Health education and communication

- cross-cutting approach

Source: UNICEF, “The Health Extension Program,” Briefing Note (August 2014).



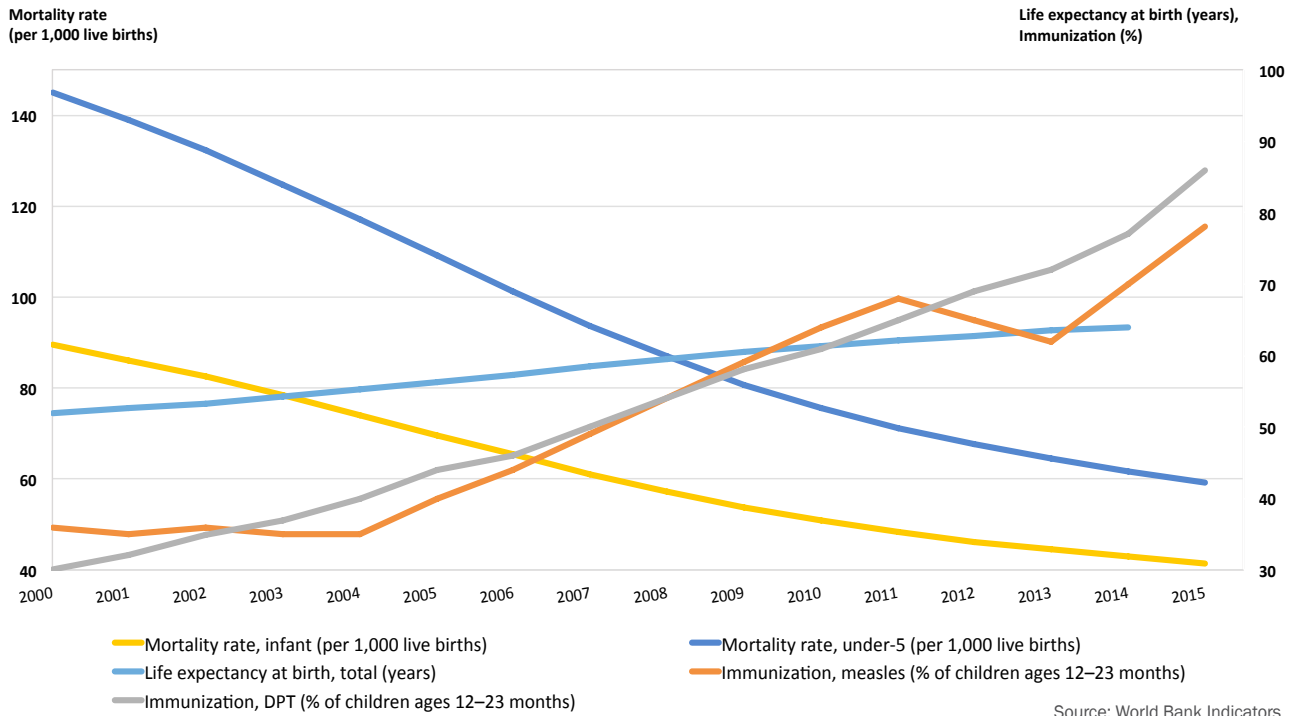
organizations seeking more than 10 percent of their financial support from international sources. While the law bodes ill in general for civil society-driven initiatives that advocate for politically controversial or stigmatized populations, the Global Fund requires strong civil society involvement in all of its grants, and several organizations receive Global Fund support as sub-recipients, providing them with some of the resources they need to carry out their mission. At the same time, the considerable funding flowing through national programs and strong oversight by the Global Fund has created opportunities to strengthen national health strategies and financial management capacities from the central to the local levels.

Since the Global Fund approved its first grant to support the national HIV/AIDS response in 2003, adult HIV prevalence has declined from 2.6 percent to 1.2 percent in 2014.³¹ The number of health facilities providing HIV counseling and testing, malaria diagnosis through rapid diagnostics or microscopy, and malaria treatment has also increased fivefold. Mortality from malaria fell by 43 percent (60 percent among children under the age of five) between 2000–2001 and 2010–2011,

and total incidence fell by 50–75 percent in the same time period.³² Tuberculosis remains a public health challenge despite the country's achievements in having seen prevalence decline from 426 per 100,000 in 1990 to 211 in 2013, and in reducing mortality from tuberculosis from 89 per 100,000 to 32 during the same period.³³

Perhaps the most meaningful contribution that Global Fund grants have made to Ethiopia's fight against the three diseases has been through its support for the HEP, which has greatly extended access to basic preventive, diagnostic, and treatment services through the construction of health posts and the training of HEWs, who split their time between providing care at the health post and traveling to the communities within their catchment area to deliver their services. HEWs have effectively enhanced community engagement and ownership over the delivery of basic services, and through them, specific disease programs have also effectively extended their reach, ensuring that remote communities are properly diagnosed, can access evidence-based treatment for tuberculosis and malaria, and can be referred to appropriate health facilities for

Impact of immunizations on mortality and life expectancy



further treatment as needed. Global Fund support has also helped to ensure access to pharmaceuticals for the three diseases by strengthening the national Pharmaceutical Fund and Supply Agency and its ability to procure, store, and distribute necessary medication and medical supplies.

Global Fund Contributions to UHC

Human Resource Development

Global Fund support covered 50 percent of the annual HEW training budget in 2013–2014.³⁴ Other funders included GAVI and the MDG Pooled Fund. The Global Fund only directly supports those components of the training curriculum that focus on the three diseases, but Global Fund support covers the full training-of-trainers curriculum (three diseases plus other common diseases that HEWs frequently encounter) as well as supplies and materials for the full training curriculum, meaning that it indirectly supports the delivery of training on other components of the curriculum. In addition, when a patient goes to an HEW with common symptoms such

as fever, diarrhea, and a persistent cough, the physical exam by the HEW may lead to a diagnosis of HIV, tuberculosis, or malaria, or it may lead to a diagnosis of something else, such as pneumonia, flu, or malnutrition. In other words, HEWs need to be prepared to accurately diagnose ailments with similar symptoms to the three diseases and then be able to either treat the patients or refer them to the nearest health center.



Building Health Facilities

Global Fund support has also been used to build health posts, which increased 16-fold between 2000 and 2015 so that every person in Ethiopia is now within a 10-kilometer walk from healthcare.³⁵ Prevention, diagnosis, treatment, and care services related to AIDS, tuberculosis, and malaria are provided in the same spaces where other primary care services are provided, notably prenatal care, clean delivery services, vaccinations, and family planning services. No distinction is made between the two types of services, which are all provided in both health posts supported by the Global Fund and those built using funds from other sources. In addition, every health center has at least one microscope, many of which were purchased using Global Fund support, and which can often be used to diagnose and monitor multiple diseases.

Procurement and Distribution Systems

A strong system for procuring, storing, and distributing drugs is an important component of any health system that aims to ensure access to services for everyone who needs them. Accordingly, the Global Fund is supporting construction of warehouses for drugs and equipment in every region of the country. The warehouses are used to store drugs and equipment for AIDS, tuberculosis, and malaria as well as for other conditions. Global Fund support has also been used to purchase trucks to transport drugs and equipment to hospitals, health centers, and health posts. Here again, the trucks transport drugs and equipment used both for the three diseases and for other conditions, and they are also used to collect surveillance data from health posts and health centers. In addition, the staff training and procurement and distribution systems that have been put in place with Global Fund support for drugs and equipment related to HIV/AIDS, tuberculosis, and malaria have broader applications as well.

Challenges

Despite the success that Ethiopia has had in expanding access to health services and reducing child mortality, serious challenges remain. While it achieved MDG 4, reducing child mortality by two thirds, it did not achieve MDG 5, which called for reducing maternal mortality by three quarters.

In addition, while Ethiopia is widely cited as a model for bringing HEWs to every community, retention rates for doctors remain dismally low.³⁶

While the Ministry of Health states that health service coverage has reached 100 percent based on the number of health facilities that have been built around the country,³⁷ physical access remains a barrier to the delivery of health services to some, particularly for Ethiopia's pastoralist communities, who follow their livestock around the northeast and southeast regions of the country, posing challenges with respect to access and continuity of care. The growing burden of noncommunicable diseases also requires the scale-up of Ethiopia's HEP and training provided to its HEWs. Traditional communicable disease interventions are also becoming more complicated due to the rise of multi-drug-resistant TB and of mosquitoes resistant to insecticide-treated bednets.

Recognizing that much of the remaining burden of HIV/AIDS, tuberculosis, and malaria clusters around vulnerable populations, Ethiopia has started to focus more on the equity of these interventions by directing its more recent donor aid toward key populations such as orphans, women, female sex workers, truck drivers, and the prison population. However, in order to successfully ensure access to care for these populations, who are often the most difficult (and costly) to reach, domestic financing will need to be increased to fill the funding gap in its ambitious national health plans. Government contributions are projected to cover only 31 percent of the total cost of its fifth Health Sector Development Plan (2013–2018). But government support for the health sector has already been gradually replacing donor support, with foreign aid funding 50 percent of the country's health expenditures in 2010–2011 and only 36 percent in 2013–2014, while the government share rose from 16 percent to 30 percent during the same period. Meanwhile, out-of-pocket payments and contributions by private employers and individuals remained steady at 33–34 percent and 1 percent respectively.³⁸



The Ethiopian case offers a useful example of how disease-specific support can be targeted toward broader UHC goals through strategic negotiations between a recipient government and the funder without compromising on the disease-specific goals that form the funder's mission. In Ethiopia, strong political will and domestic commitment to expanding health services to all corners of the country were critical to the suc-

cessful pooling of development assistance for health. While the most visible contributions to UHC came from Global Fund investments in HEW training and the construction of health posts in hard-to-reach areas, investments in more subtle areas, such as strengthening the drug procurement, storage, and distribution system, have helped make health services of all sorts available to more people around the country.



Rwanda

Improving the Affordability of Healthcare



PROTECTION FROM undue financial burdens resulting from healthcare costs is the cornerstone of UHC. In many settings, that protection takes the form of health insurance. Rwanda has been on the forefront among countries in Africa in moving toward universal health insurance coverage, primarily by expanding its community-based health insurance (CBHI) scheme and subsidizing premiums for Rwandans who are not able to afford to pay for insurance on their own. Since 2006, the Global Fund has been helping Rwanda reach that goal by providing subsidies for the country's poorest families to cover health insurance premiums—insurance that can be used for a broad range of primary health services, going far beyond the three diseases that make up the core of the Global Fund's mission.

Rwanda is a small, landlocked, densely populated country with more than 70 percent of its 12 million citizens employed in agriculture, most of which is subsistence rather than cash crop farming.³⁹ In 1983, it became one of the first African countries to document AIDS cases and its early responses to the epidemic were rapid and largely effective.⁴⁰ But then civil war broke out in 1990, culminating in the 1994 genocide that left millions dead or displaced. During this time, real GDP fell by 50 percent, the country's health infrastructure was destroyed, many health workers either fled or were killed, and among the host of physical and psychosocial injustices that were perpetrated, HIV was "weaponized" and willfully transmitted to rape victims.⁴¹ Many donors discontinued aid during and immediately after

the genocide, and for a time, Rwanda received the least health aid of all sub-Saharan African countries, written off as an unstable investment.

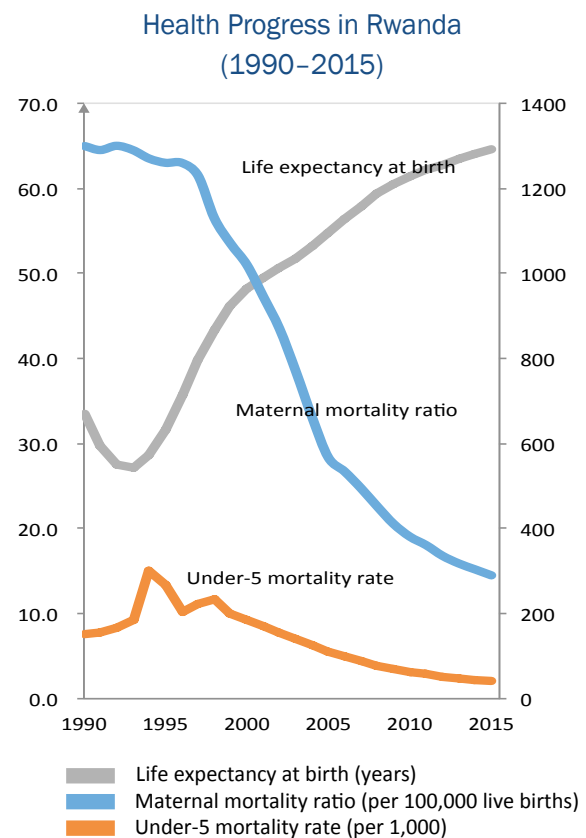
However, by 1998, the Ministry of Health was receiving 11.8 percent of its health financing from external sources.⁴² Since 1994, Rwanda has become something of a poster child within the international community for its impressive gains in poverty reduction and population health. The government overhauled its policymaking to prioritize sustainable and socioeconomic development and has worked to align donor aid with its national development strategies. Over the last two decades, the country has seen life expectancy more than double from 27 years in 1993—the lowest of any country in the world—to 64 in 2013. In the decade after the Global Fund made its first grants to Rwanda in 2003, deaths from AIDS, tuberculosis, and malaria dropped by 80 percent, while maternal mortality fell by 60 percent.⁴³ One of the country's most renowned achievements, however, is its near-universal insurance coverage. Enrollment in an insurance plan was made compulsory in 2006, and attempts have been made to implement this mandate equitably through a community-based health insurance equitably through a CBHI system that subsidizes insurance premiums for impoverished Rwandans, who made up as much as a quarter of the population in 2011.⁴⁴

Much of Rwanda's success has been attributed to the government's strong centralized planning, which—although not without criticism—emphasizes concepts such as equity, coordination across sectors, systems-based approaches, and the monitoring and evaluation of impact.⁴⁵ In 1997, the government launched its “Rwanda Vision 2020,” aimed at building sound institutions as the foundation for sustainable development and at elevating the country from low- to middle-income status by 2020. While the Rwandan government has been gradually increasing the portion of its budget that it covers domestically, it is still heavily reliant on foreign assistance to finance its social infrastructure, with official development assistance (ODA) still comprising one third of the government's overall budget in 2015–2016.⁴⁶ Rwanda's ability to achieve this comprehensive vision will thus come down in part to its effective use of foreign aid, most of which is traditionally earmarked for specific causes. Over the

past decade, Rwanda has received most of its health sector funding from the Global Fund and US government (through the President's Emergency Plan for AIDS Relief, known as PEPFAR, and the President's Malaria Initiative), and as funding from these two disease-specific sources grew, other aid agencies scaled back their contributions accordingly. Experts argue that Rwanda's success in channeling this funding toward building comprehensive and inclusive foundations for social service provision has helped it in part to achieve the health-related MDGs development goals as well as many other development targets, and has been politically motivated in part by a need to build cohesiveness and solidarity in a nation recently torn apart by genocide.⁴⁷

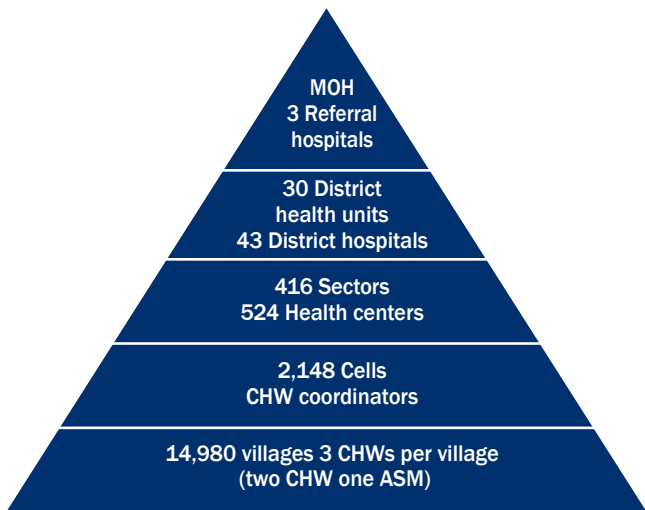
Rwanda's Health Sector

Rwanda's major health burdens remain driven by communicable diseases. Lower respiratory infections, malaria, and HIV/AIDS remained three of the top five causes of premature mortality between 1990 and 2010,⁴⁸ and communicable diseases



constitute 90 percent of major complaints registered at health facilities.⁴⁹ While the major health threats themselves have not changed, Rwanda has seen an 80 percent drop in mortality due to the three diseases and HIV prevalence has remained at a stable 3 percent over the last decade.⁵⁰ Yet levels of childhood malnutrition and neonatal mortality remain high, and noncommunicable diseases are on the rise.⁵¹ In addition, there have been recent spikes in malaria prevalence, which may be due to various factors, including an increase in temperatures and rainfall levels, the increasing size of bodies of water, disruptions in mosquito net supply chains, and the emergence of mosquitos that are resistant to insecticides.⁵² These challenges serve as reminders of the fragility of these gains and the need to continue to bolster the health sector’s systemic and community-based roots.⁵³

Rwanda has a five-tiered health system, with much of the financial and administrative responsibility decentralized to the country’s 30 districts.



MOH: Ministry of Health, CHW: community health worker, ASM: animatrice de santé maternelle (maternal health mobilizer) Source: President’s Malaria Initiative (2015)

Each district has its own pharmacy as well as a health unit that administers the district’s CBHI risk pool. Health posts are the lowest point of care for health services, but because they are inadequate in both number and capacity to fully service the roughly seven villages per *cellule* catchment area, a network of 45,000 community health workers (CHW)—three from each village, chosen by the community—has been trained to provide basic services and referrals.⁵⁴ While Rwanda has decentralized basic health-related services to nurses and community health workers,⁵⁵ a shortage in trained health professionals—particularly doctors and nurses—remains a major challenge and barrier to scaling up the provision of services and achieving UHC.

As noted above, the country’s health system is perhaps most recognized for its CBHI or Mutuelles de Santé, and Global Fund support has been key to its success. With this support, the insurance scheme was able to extend basic coverage to a remarkable 91 percent of Rwanda’s population in 2010, up from 44 percent in 2005 before the Global Fund started subsidizing insurance premiums.⁵⁶ The CBHI is designed to cover the poor and informally employed with a clearly defined minimum package of services provided at health centers (listed in the box below), as well as a complementary package that includes more advanced services provided at district hospitals and some that are provided at national hospitals.⁵⁷ Rwanda’s CBHI subsidizes the entire insurance premium for those deemed poorest of the poor while partially subsidizing premiums for many others. The Global Fund has been instrumental in helping to build a sound financial basis for this scheme by funding the insurance premiums—in full or in part—for approximately 2 million Rwandans. The Global

Rwanda’s Minimum Package of Activities (MPA)

Services provided at health centers include the following:

- vaccinations
- consultations
- medical surgery
- dental care
- medical radiology and scanning
- laboratory tests
- physiotherapy
- hospitalization

- supplying of medicine that is on the list accepted by mutual health insurance scheme
- provision of prenatal, perinatal, and postpartum care
- ambulance service
- provision of prosthesis and orthosis not exceeding the value

approved by the mutual health insurance fund (src: Law n° 62/2007 Article 30).

Politicians are currently lobbying to have NCDs covered by the MPA in some capacity as well.



Fund's support for premiums covers orphans, people living with HIV/AIDS, and the poorest segment of the population in an attempt to enhance the financial sustainability of the scheme.⁵⁸

Rwanda's CBHI is one of three national insurance schemes, dedicated to covering the poor and informally employed along with key affected populations such as orphans and people living with HIV/AIDS. The other two schemes are its Military Medical Insurance (MMI), which covers military personnel, and Rwandaise d'Assurance Maladie (RAMA), which covers public servants and the formally employed. One unique aspect of Rwanda's CBHI system is that, rather than being a concept introduced externally through aid and development programs, it is rooted in traditional Rwandan concepts of solidarity and risk pooling that have existed in the form of health insurance associations in rural communities since the 1960s.⁵⁹



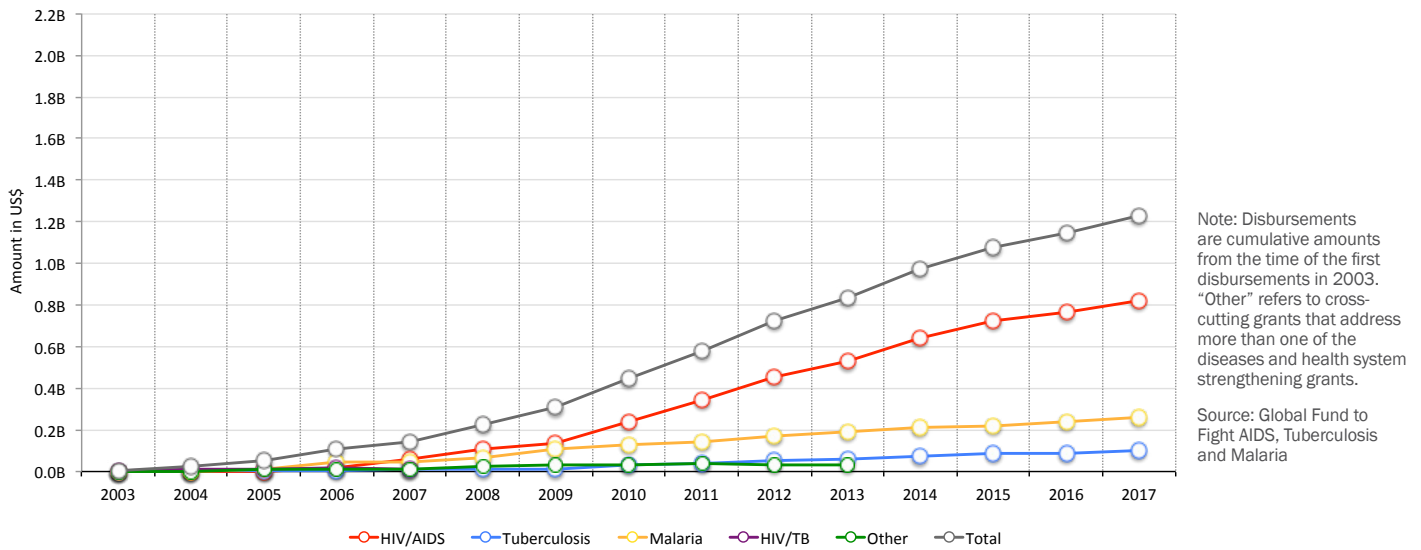
First piloted by the government in 1999, a national CBHI framework was developed in 2004 as a voluntary insurance scheme with a flat-rate annual premium and 10 percent copayment for health facility visits. Premiums were subsidized for the poorest Rwandans according to a socioeconomic stratification system called *ubudehe*, whereby individuals rate themselves and their neighbors based on wealth to determine eligibility for social benefits.

By 2006, the program had been standardized and implemented nationwide, allowing Rwanda to make insurance coverage with a flat-rate annual premium of 1,000 Rwandan francs (RWF; US\$1.48) mandatory for all citizens. In 2011, to bolster financial sustainability, improve equity, and mitigate the overuse of limited resources, a three-tiered premium contribution system was introduced whereby those ranked in the top two *ubudehe* categories pay RWF 7,000 and RWF 3,000 respectively, while those ranked in the lowest category have their entire RWF 2,000 premium—roughly US\$2.96—subsidized by the Global Fund and the Ministry of Health.

CBHI funds are managed at the district level, and mayors are held accountable by signing performance contracts listing the specific health-related targets they deem most critical. Each district disburses funds to health facilities as needed in a process that is managed by officials elected by the community, and a CBHI office located in each health center is responsible for maintaining enrollment, collecting premiums, and managing subsidies. Cross-subsidization is managed at the central level, with the national CBHI authority channeling support to underfunded districts with funds collected from the MMI, RAMA, and private insurance programs.

Ubudehe means “collective action” and traditionally refers to the practice of communities coming together to collectively solve individual problems such as building a house or working each other's farms to prepare for planting season. The Ministry of Local Government made this into a socioeconomic ranking system to track poverty rates and determine social benefits. It is uniquely community based: individuals rate themselves and their neighbors based on context-specific metrics such as whether one owns land or livestock, how many meals a day one consumes, and level and regularity of income.

Global Fund Disbursements by Component



Rwanda and the Global Fund

Rwanda was one of the first countries to receive Global Fund support in 2003, and it boasts a long track record of success in administering and implementing its grant programs. Due largely to this successful track record, Rwanda was chosen in 2014 to pilot the Global Fund's results-based financing funding model, which explicitly allows for more flexibility in the use of grant funds and thus better alignment with national strategic plans.

Rwanda has been working with the Global Fund to alleviate its greatest health burdens for more

than 10 years, and in this time has seen deaths from AIDS, tuberculosis, and malaria drop by more than 80 percent.⁶⁰ It achieved these gains through disease-specific grant programs that have worked steadily to achieve universal access to antiretroviral treatment, universal distribution of long-lasting insecticidal nets (LLINs), and a 90 percent success rate for smear positive tuberculosis case treatment. Voluntary counseling and testing for HIV is now offered at 99 percent of Rwanda's health facilities, and a full package of services to prevent transmission from pregnant women to their babies is offered at 96 percent of health facilities.⁶¹ Global Fund grants have also helped Rwanda to test more than 90 percent of tuberculosis patients for HIV—the two infections are known to frequently co-exist—and to achieve more than 90 percent of tuberculosis patients having their treatment managed by community health workers. These successes in controlling the three diseases have allowed the Global Fund and other major health sector funders to scale back their funding, but if this is done too quickly, it risks jeopardizing these gains. LLINs need to be replaced every two to three years, requiring robust procurement and distribution systems, and an upsurge of malaria incidence in 2009 due in part to delayed distribution and another in 2012 due in part to procurement of substandard nets serve as cautionary reminders of what is at stake when new and vulnerable systems lapse.⁶²



Global Fund Contributions to UHC

Infrastructure and Governance

None of Rwanda's epidemiological gains to date would have been possible without the support for health infrastructure and for capacity building in health system governance that has been written into both the disease-specific and health-system-strengthening grants from the Global Fund. These funds have been used to support Rwanda's pharmaceutical procurement and supply chain, monitoring and evaluation systems, warehouse and health facility renovations, as well as human resource training and education. All of these investments have bolstered the health system's ability to address health challenges overall, not only those related to HIV/AIDS, tuberculosis, and malaria.

Broader "spillover" effects of the Global Fund's disease-specific funding on Rwanda's capacity to meet health needs beyond the three diseases are also evident in the very structure of the funding flow. The Ministry of Health has acted as the primary recipient of Global Fund grants, channeling these funds through its sub-recipients, which include all 30 district hospitals, health centers, national reference laboratories, and the ministry's Medical Procurement and Production Division. These funding flows have the potential to bolster the financial management and account-

ability of these systems, in turn strengthening health facilities and agencies from the central to rural levels. Furthermore, the Global Fund's new results-based financing model allows for greater country ownership over the use of grant funds, with funding tied to key results rather than inputs. This should give the government of Rwanda more freedom to use grant funds to build systemic capacity and increase access to and utilization of health services in general, as long as the disease-specific targets are also met.

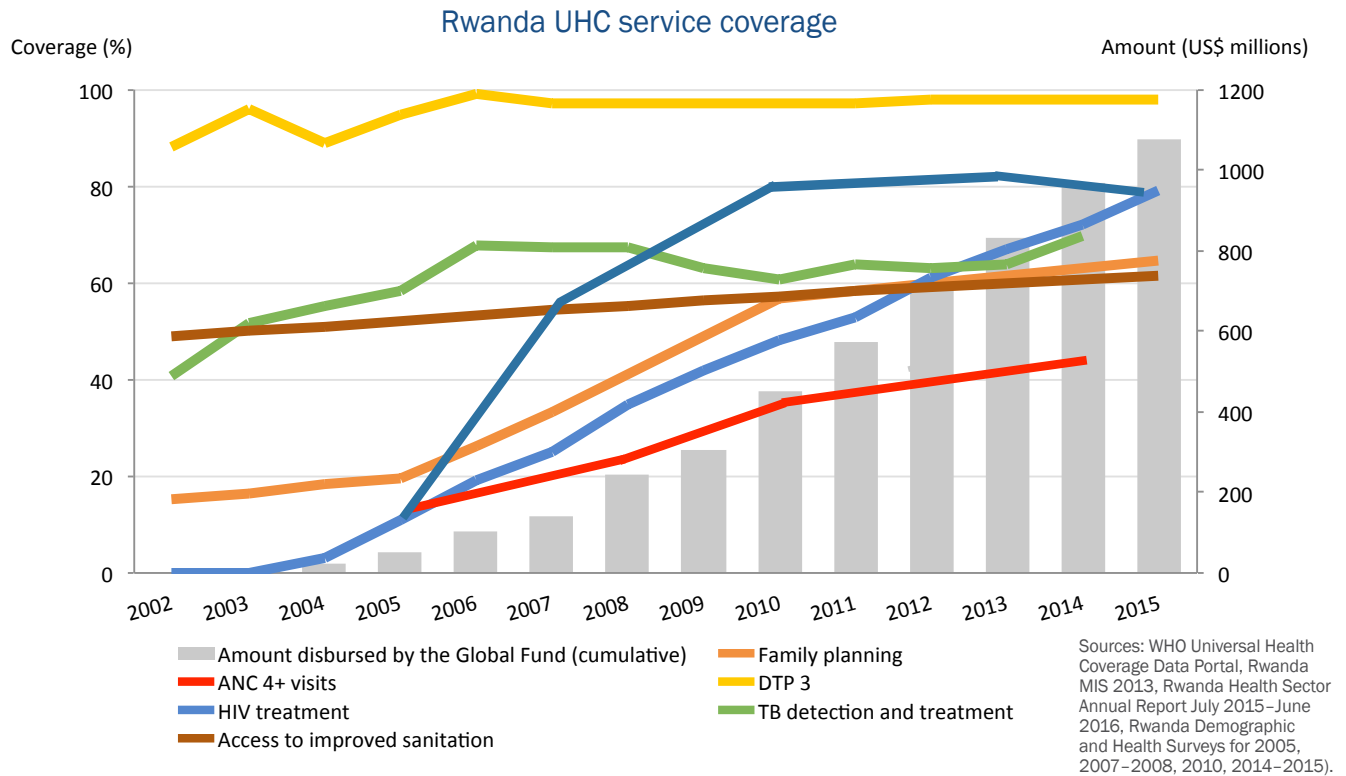
Human Resource Development

Human resource training covered by the Global Fund's disease-specific grants also yields broader systemic benefits. CHW training on malaria requires that they test each fever case in their community and be able to distinguish malaria from other common causes of fever—pneumonia or diarrhea, for example—and provide the appropriate treatment or referral. In a move to address Rwanda's broader human resource shortage and the bottleneck this poses to scaling up access to healthcare services and therefore to achieving UHC, the Global Fund committed US\$77.8 million for salaries and training over five years to strengthen the quality assurance and health financing capacities of a range of human resources, from health center staff and Masters in Public Health students to hospital managers and



CHWs are trained to

- provide referrals
- screen children for malnutrition
- provide growth monitoring and nutrition surveillance
- treat under-5 children for malaria, diarrhea, pneumonia (community case management)
- provide family planning services and products
- provide directly observed treatment for tuberculosis in the community
- support adherence for chronic conditions
- accompany pregnant women to health facilities
- provide community sensitization on malaria and diarrhea prevention, immunization, hygiene and sanitation, and water treatment solutions



deputy mayors in charge of health affairs.⁶³ Salaries were increased in rural areas to encourage retention, and while CHWs are volunteers and not salaried, quality care is incentivized through performance-based remuneration that is also supported by Global Fund grants. These healthcare workers provide health services going well beyond the three diseases, in particular providing prenatal care and family planning services to families that did not have access in the past. Utilization rates at district hospitals have subsequently increased from 35 percent in 2005 to 83 percent in 2010, and at health center facilities from 39.8 percent in 2005 to 90 percent in 2010, exceeding expectations.⁶⁴

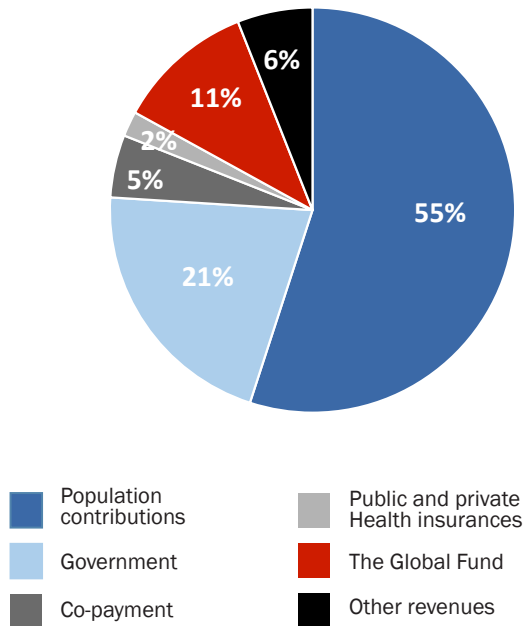
However, Rwanda still falls short of its target of 2.3 doctors, nurses, or midwives per 1,000 people, as set forth in Vision 2020. To address this, the Global Fund joined Rwanda's other major health sector donors by contributing US\$6.4 million to the country's Human Resources for Health Program, helping to kick-start a nationwide residency and training program designed to address this human resource gap.⁶⁵

Health Insurance Premiums

The Global Fund's biggest contribution to Rwanda's efforts toward UHC to date has been its subsidization of insurance premiums for the impoverished, orphans, and people living with HIV/AIDS,

helping to achieve near-universal insurance coverage when enrollment was at its peak in 2011.⁶⁶ Community-based insurance coverage rose from 44.1 percent prior to the grant period to 90.7 percent of Rwanda's population in 2011 after its completion. Throughout the course of the grant, the Global Fund paid premiums covering both minimum and complementary packages of services for people living with HIV/AIDS, orphans, and the portion of the Rwandan population ranked poorest according to the *ubudehe* household welfare classification system that year. Other Rwandans who ranked poor but not impoverished were required to pay their own premiums to cover the minimum package of services but had the complementary package of services subsidized with Global Fund support. This brought the total number of people with Global Fund-subsidized insurance premiums up to 2 million.⁶⁷ The remaining insurance premiums and costs associated with managing the CBHI system are covered by cross-subsidization from those able to pay their premiums, the Ministry of Health, and the other public and private health insurance plans being operated in the country. Preliminary evaluations have shown that the CBHI system has in fact resulted in increased utilization rates, proving to be an effective mechanism for achieving UHC in a resource-constrained setting.⁶⁸

CBHI Funding Sources



Source: Government of Rwanda, Ministry of Health, *Annual Report: Community Based Health Insurance FY2011/2012* (October 2012), 19.

Challenges

Rwanda has made great progress, but one major challenge it faces in the coming years lies in the financial sustainability of the country's broad and comprehensive health sector gains. While there has been an overall reduction in foreign assistance, external aid still finances roughly 61 percent of the country's health sector.⁶⁹ The government recognizes this vulnerability, as well as the fact that costly noncommunicable diseases are on the rise, and it has increasingly prioritized financial sustainability through improved cross-subsidization mechanisms, efficiency in spending, and the mobilization of public- and private-sector resources. But the government struggles nonetheless to keep up with the pace of the cuts in ODA funding.

The CBHI system is particularly sensitive to Global Fund support because that has been its sole external funding source. While premium subsidies are written into the current grant request for Rwanda's HIV-TB program, the government is also developing mechanisms to increase domestic support for its CBHI program, such as increasing the contributions to CBHI required of private insurance companies from the current 1 percent to

5 percent of their annual subscription premiums.⁷⁰ The evolution of Rwanda's CBHI system from a flat-rate premium to a tiered premium system was also a move to bolster the scheme's financial sustainability in an equitable way and was one of the key recommendations made by the Global Fund's Office of the Inspector General in its audit report submitted after the completion of Rwanda's health system strengthening grant.⁷¹

Measures also need to be taken to enforce mandatory insurance enrollment, as CBHI coverage rates dropped to 74.0 percent in 2013, down from 80.7 percent in 2012 and 90.7 percent the previous year, a trend that has been associated in Rwanda with a decrease in fiscal space and therefore in quality of care.⁷² Major causes of this have included inadequate sensitization to the idea of risk-pooling,⁷³ combined with difficulties faced in paying premiums on time given the payment cycle being out of sync with the harvest season, which is when the vast majority of Rwanda's agrarian population makes its earnings.⁷⁴ Improved adherence rates will have the dual effect of expanding population access to affordable and quality health services as well as increasing domestic funding for the CBHI system, and are therefore key to achieving UHC.

In addition to financial sustainability, the major bottleneck to Rwanda's ability to scale up access to health services is its shortage of human resources. While Rwanda's human resource gap has narrowed from one doctor for every 500,000 people in 2005⁷⁵



to one doctor for every 15,428,⁷⁶ it will take years for the country to train and deploy the specialized health professionals it needs to adequately care for its population. There are, for example, only 11 practicing radiologists in the entire country.⁷⁷ Developing an adequate human resource base will be crucial to the country's ability to deal with its increasing noncommunicable disease

burden as the economy develops and people live longer with HIV, as well as to combat its childhood malnutrition and neonatal mortality rates, which remain high. As discussed above, this is an aspect of Rwanda's health system to which Global Fund support has been targeted, but more needs to be done going forward.



Rwanda's dramatic health improvements over the last two decades, which it has striven to achieve with relative equity and at low cost, can be attributed first and foremost to strong political will and a clear set of priorities. This has enabled it to consistently make the case that in order to combat specific health threats, extremely they would need to first build robust and equitable national systems to which all Rwandans have access. Having a clear set of centrally defined priorities has been key to this success, and the guidelines set forth in Rwanda Vision 2020 have provided a measurable path forward. As a testament to Rwanda's strength and consistency in vision, Global Fund grants have been channeled to fund the initial phases of two very ambitious and comprehensive initiatives that have helped make strides in Rwanda's journey toward UHC: the CBHI system that provides financial protection from catastrophic healthcare spending for the poorest citizens, and the Human Resources for Health Program that helps fill Rwanda's human resource gap in highly skilled health professionals.

With these systems in place, Rwanda has increasingly been able to focus on disease prevention. Vaccination campaigns have been extremely successful, showing consistently high coverage rates,⁷⁸ and there is increased awareness of how major diseases are transmitted.⁷⁹ After more than one decade of Global Fund grants in the country, Rwanda has been able to home in on prevention and elimination strategies for the three diseases. This was precisely because of—not in spite of—earlier Global Fund support for broader financial access and human resources for health—two key components of UHC. In other words, the Global Fund's decision to support premiums for services that go well beyond the three diseases has not only helped the most vulnerable populations in Rwanda access a basic package of health services, it has also helped make progress toward the Global Fund's core mission of reducing the burden of AIDS, tuberculosis, and malaria on Rwandan society.



NOTES

How the Global Fund Contributes to UHC

1. Written correspondence with Global Fund staff.
2. See, for example, Laurie Garrett, “The Challenge of Global Health,” *Foreign Affairs*, 86, no. 1 (January/February 2007): 14–17; and Paul Farmer and Laurie Garrett, “‘Marvelous Momentum,’ to Health Care for All: Success Is Possible With the Right Programs,” *Foreign Affairs*, 86, no. 2 (March/April 2007): 155.
3. Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter Global Fund), *Results Report, 2017* (Geneva: Global Fund, 2017), https://www.theglobalfund.org/media/6773/corporate_2017resultsreport_report_en.pdf. The health system strengthening pillar is now referred to as building “resilient and sustainable systems for health” in the Global Fund’s grant-making guidelines.
4. World Health Organization, *Health Systems Financing: The Path to Universal Coverage* (Washington DC: World Health Organization, 2010).
5. See, for example, “Japan: Universal Health Care at 50 Years,” *Lancet* (September 2011); and Akiko Maeda et al., *Universal Health Coverage for Inclusive and Sustainable Development A Synthesis of 11 Country Case Studies* (Washington DC: World Bank, 2014).
6. Global Fund, *Results Report, 2017*.
7. *Ibid.*
8. Collins Mwai, “Ten Years of Global Fund in Rwanda,” *New Times*, February 16, 2014, <http://www.newtimes.co.rw/section/read/73132/>.
9. See Rwanda’s Round 8 malaria proposal and Round 7 HIV proposal to the Global Fund, <https://www.theglobalfund.org/en/portfolio/country/?k=a76e4125-b5f5-41c8-8bcc-82d9dc5d1342&loc=RWA>.
10. Lynn Eaton, “Global Fund Pulls Grants to Myanmar and Uganda,” *BMJ*, 331(7515): 475, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1199018/>.
11. Global Fund, “Country Coordinating Mechanism,” Global Fund website, <https://www.theglobalfund.org/en/country-coordinating-mechanism/>.
12. Myanmar Health Sector Coordinating Committee (M-HSCC), “What Is the M-HSCC?,” M-HSCC website, <http://www.myanmarhssc.org/what-is-the-m-hssc/>.
13. Keizo Takemi, “Proposal for a T-Shaped Approach to Health System Strengthening,” *Health Systems & Reform*, 2(1): 8–10, <http://www.tandfonline.com/doi/full/10.1080/23288604.2015.1123339?scroll=top&needAccess=true>.
14. Bart Janssens et al., “Offering Integrated Care for HIV/AIDS, Diabetes and Hypertension within Chronic Disease Clinics in Cambodia,” *Bulletin of the World Health Organization* 85(11): 880–5, <http://www.who.int/bulletin/volumes/85/11/06-036574.pdf>.
15. amfAR, “The Broad Benefits of AIDS Research,” amfAR website, http://www.amfar.org/uploadedFiles/_amfarorg/About_amfAR/amfar_broad_benefits_5.5x8.5_021716-2.pdf.
16. International AIDS Vaccine Initiative (IAVI), “2016 PDP Annual Funders Report,” New York: IAVI, 2017.
17. Elissa Jobson, “Ethiopia Achieves Development Target on Reducing Child Mortality,” *Guardian*, September 13, 2013, <http://www.theguardian.com/global-development/2013/sep/13/ethiopia-achieves-development-target-child-mortality>.
18. UNICEF, “Maternal Mortality: Current Status + Progress” (updated February 2017), <http://data.unicef.org/topic/maternal-health/maternal-mortality/>.
19. Central Intelligence Agency, “The World Factbook: Ethiopia,” https://www.cia.gov/library/publications/the-world-factbook/geos/print_et.html.
20. UNAIDS, “Country Progress Report on the HIV Response, 2014: Federal Democratic Republic of Ethiopia,” March 31, 2014, 13–14, http://www.unaids.org/sites/default/files/country/documents/ETH_narrative_report_2014.pdf.
21. Lorenzo Piccio, “Top Aid Donors to Ethiopia,” *Devex*, September 19, 2014, <https://www.devex.com/news/top-aid-donors-to-ethiopia-84370>.
22. World Bank Group, *Ethiopia Poverty Assessment 2014* (Washington DC: World Bank, 2015), 3, <https://openknowledge.worldbank.org/handle/10986/21323>.
23. World Bank, “Life Expectancy at Birth,” World Bank website, <http://data.worldbank.org/indicator/SP.DYN.LE00.IN?view=chart>.
24. Federal Democratic Republic of Ethiopia Ministry of Health, “Health Sector Development Program IV, 2010/11–2014/15,” October 2010, <http://phe-ethiopia.org/admin/uploads/attachment-721-HSDP%20IV%20Final%20Draft%2011October%202010.pdf>.
25. President’s Malaria Initiative, USAID, “President’s Malaria Initiative: Ethiopia Malaria Operational Plan FY 2015,” <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy-15/fy-2015-ethiopia-malaria-operational-plan.pdf?sfvrsn=3>.
26. Institute for Health Metrics and Evaluation, “GBD Profile: Ethiopia,” http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_ethiopia.pdf.
27. Henry Perry et al., “Case Studies of Large-Scale Community Health Worker Programs: Examples from Bangladesh, Brazil, Ethiopia, India, Iran, Nepal, and Pakistan,” *Maternal and Child Health Integrated Program (MCHIP)*, USAID, October 28, 2013, http://www.mchip.net/sites/default/files/mchipfiles/17_AppB_CHW_CaseStudies.pdf.
28. Johnny Magdaleno, “In Ethiopia, a Young Boy Holds the Promise of a Healthy Nation,” October 20, 2015, UNICEF website, https://www.unicef.org/infobycountry/ethiopia_85894.html.
29. Jacquelyn Caglia, Annie Kearns, and Ana Langer, “Health Extension Workers in Ethiopia: Delivering Community-based Antenatal and Postnatal Care,” *Harvard School of Public Health*, May 2014, <https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH-Ethiopia4.pdf>.
30. Federal Democratic Republic of Ethiopia Ministry of Health (Ethiopia MOH), *The Ethiopia Sixth Health Accounts, 2013/14: Statistical Report* (Addis Ababa: Ethiopia MOH, 2017).
31. World Bank, “Prevalence of HIV,” <http://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=ET>.
32. Written correspondence with Global Fund staff.
33. National Planning Commission and the United Nations in Ethiopia, “MDG Report 2014 Ethiopia,” October 2015, <http://www.undp.org/content/dam/ethiopia/docs/EthiopiaMDG%202014%20Final%20ofinal.pdf>.
34. Written correspondence with Global Fund staff.
35. *Ibid.*
36. See, for example, “Surge of Doctors to Strengthen Health System,” *IRIN News*, August 14, 2012, <http://www.irinnews.org/news/2012/08/14/surge-doctors-strengthen-health-system>. World Health Organization, “Analytical Summary—Health Workforce,” *African Health Observatory*, http://www.who.int/profiles_information/index.php/EthiopiaAnalytical_summary_-_Health_workforce.
37. Ethiopia MOH, “Fact Sheet—Ethiopia 2015,” <http://www.moh.gov.et/sk/web/guest/fact-sheets>
38. Ethiopia MOH, *The Ethiopia Sixth Health Accounts*.

Rwanda: Improving Affordability of Healthcare

39. National Institute of Statistics of Rwanda, "Fourth Population and Housing Census, Rwanda, 2012: Labour Force Participation," January 2014, http://statistics.gov.rw/system/files/user_uploads/files/books/RPHC4_labour_Force.pdf.
40. Early responses to the HIV/AIDS epidemic in Rwanda included collaboration between the Red Cross and the Ministry of Health to establish one of the first and most effective blood screening programs in 1985, as well as an extensive education program using radio and public health educators in 1986. Eugénie Kayirangwa et al., "Current Trends in Rwanda's HIV/AIDS Epidemic," *Sexually Transmitted Infections* 82, no. 1 (April 2006), doi: 10.1136/ti.2006.019588.
41. World Bank, "Rwanda Poverty Note—Rebuilding an Equitable Society: Poverty and Poverty Reduction after the Genocide," no. 17792-RW (June 19, 1998), http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1999/06/03/000009265_3980929125140/Rendered/PDF/multi_page.pdf. Obijofor Aginam, "Rape and HIV as Weapons of War," June 27, 2012, United Nations University website, <http://unu.edu/publications/articles/rape-and-hiv-as-weapons-of-war.html>.
42. Pia Schneider et al., "Rwanda National Health Accounts 1998," *Partnerships for Health Reform Technical Report* no. 53 (September 2000), http://orbi.ulg.ac.be/bitstream/2268/179789/1/Porignon_NHA1998_Rwanda_2000.pdf.
43. Neal Emery, "Rwanda's Historic Health Recovery: What the US Might Learn," *Atlantic*, February 20, 2013, <http://www.theatlantic.com/health/archive/2013/02/rwandas-historic-health-recovery-what-the-us-might-learn/273226/>.
44. Ministry of Health of Rwanda (Rwanda MOH), "Annual Report: Community Based Health Insurance," October 2012, http://www.moh.gov.rw/fileadmin/templates/Docs/CBHI-Annual-Report-2011-2012f-3_1_.pdf.
45. Emery, "Rwanda's Historic Health Recovery."
46. Government of Rwanda, "The 2015-16 Budget to Prioritize Infrastructure Development for Social and Economic Transformation" (press release), June 6, 2015, http://www.gov.rw/news_detail/?tx_ttnews%5Btt_news%5D=1216&cHash=aco385d5boofbd87f6be2489fc63ac20.
47. Pamela Abbott, Roger Sapsford, and Agnes Binagwaho, "Learning from Success: How Rwanda Achieved the Millennium Development Goals for Health," *World Development* no. 92 (2017): 103–16.
48. Institute for Health Metrics and Evaluation, "GBD Profile: Rwanda," http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_rwanda.pdf.
49. World Health Organization (WHO), "Rwanda: Country Cooperation Strategy at a Glance," http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_rwa_en.pdf.
50. Emery, "Rwanda's Historic Health Recovery."
51. Paul Farmer, "Reduced Premature Mortality in Rwanda: Lessons from Success," *BMJ* 346, no. f65 (2013), doi: 10.1136/bmj.f65. 14. External Evaluation Team, Rwanda MOH, "Mid Term Review of the Rwanda Third Health Sector Strategic Plan (HSSP III, July 2012–June 2018)," http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP_III_MTR_final_report.pdf.
52. External Evaluation Team, Rwanda MOH, "Mid Term Review of the Rwanda Third Health Sector Strategic Plan (HSSP III, July 2012–June 2018)," http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP_III_MTR_final_report.pdf.
53. One spike in malaria cases occurred in 2009 after a mass LLIN campaign was delayed until 2010. A second spike occurred at the end of 2012 through the beginning of 2013, directly after a mass distribution of over three million LLINs. Investigation found that the nets were of substandard quality, showing premature loss in bioactive insecticide and therefore in efficacy. Rwanda MOH, "Standard Concept Note: Investing for Impact against HIV, Tuberculosis or Malaria" (document submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria, hereafter, Global Fund, March 10, 2014).
54. Brienna Naughton, "Health Equity in Rwanda: The New Rwanda, Twenty Years Later," Harvard International Review website, June 15, 2014, <http://hir.harvard.edu/article/?a=5732>.
55. Agnes Binagwaho et al., "The Human Resources for Health Program in Rwanda—A New Partnership," *New England Journal of Medicine* 369, no. 21 (2013), doi: 10.1056/NEJMSr1302176.
56. Rwanda MOH, "Annual Report, July 2012–June 2013" (November 2013), http://www.moh.gov.rw/fileadmin/templates/Press_release/MoH_Annual_Report_July_2012-June_2013.pdf.
57. Joint Learning Network for Universal Health Coverage, "Rwanda: Mutuelles de Santé," <http://programs.jointlearningnetwork.org/content/mutuelles-de-sante>.
58. "Rwanda: RWN-505-G05-S Grant Performance Report" (external print version; last updated: 19 October 2010), Global Fund website, <https://www.theglobalfund.org/en/portfolio/country/grant/?k=e49de007-0bb2-4762-8db7-725e12f2687b&grant=RWN-505-G05-S>.
59. Muvandimwe de Kibungo was the first mutual health insurance association established in Kibungo province in 1966. The second was Mubantu de Butare, established in Butare province in 1975. By 1998, there were six mutual health initiatives around the country, forming the basis of the government's pilot programs launched the following year.
60. Neal Emery, "Rwanda's Historic Health Recovery."
61. Rwanda MOH, "TB and HIV Concept Note: Investing in Impact against Tuberculosis and HIV," (document submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria, hereafter, Global Fund, March 10, 2014).
62. Rwanda MOH, "Standard Concept Note."
63. Global Fund, "The Global Fund 2010: Innovation and Impact" (2010), http://www.theglobalfund.org/documents/replenishment/2010Replenishment_2010HagueInnovationAndImpact_Report_en/.
64. "Rwanda: RWN-505-G05-S Grant Performance Report."
65. Binagwaho et al., "The Human Resources for Health Program in Rwanda."
66. "Rwanda: RWN-505-G05-S Grant Performance Report."
67. "Rwanda: RWN-505-G05-S Grant Performance Report."
68. Chunling Lu et al., "Towards Universal Health Coverage: An Evaluation of Rwanda's Mutuelles in Its First Eight Years," *Public Library of Science* 7, no. 6 (June 18, 2012): 1–16, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0039282>.
69. Rwanda MOH, "Health Financing Sustainability Policy," March 2015, http://www.moh.gov.rw/fileadmin/templates/policies/Health_Financing_Sustainability_Policy_March_2015.pdf.
70. Eugene Kwibuka, "Private Health Insurers Mull Stakes in Mutuelle Reforms," *New Times*, March 17, 2014, <http://www.newtimes.co.rw/section/article/2014-03-17/73906/>.
71. Office of the Inspector General, Global Fund, "Audit Report on the Global Fund Grants to Rwanda," report no. GF-OIG-10-003, March 11, 2011, http://www.theglobalfund.org/documents/oig/OIG_RwandaCountryAudit2011_Report_en/.
72. Rwanda MOH, "Rwanda Annual Health Statistics Booklet 2014," http://moh.gov.rw/fileadmin/templates/HMIS_Docs/MOH_Statistical_Booklet_2014.pdf.
73. Edwin Musoni, "How Probe Uncovered the Rot in 'Mutuelle de Sante,'" *New Times*, February 3, 2015, <http://www.newtimes.co.rw/section/article/2015-02-03/185585/>.

74. WHO and Rwanda MOH, "Health Financing Systems Review 2008: Options for Universal Coverage," Geneva, 2009, http://www.who.int/health_financing/documents/hsfr_e_09-rwanda.pdf.
75. Rwanda MOH, "National Human Resources for Health Policy," October 2014, http://www.moh.gov.rw/fileadmin/templates/policies/Human_Ressource_for_Health_Policy.pdf.
76. National Institute of Statistics of Rwanda (NISR), *Statistical Yearbook: Rwanda 2013* (Kigali: NISR, 2013), <http://www.statistics.gov.rw/publication/statistical-yearbook-2013>.
77. David A. Rosman et al., "Imaging in the Land of 1000 Hills: Rwanda Radiology Country Report," *Journal of Global Radiology* 1, no. 1 (March 2015), doi: 10.7191/jgr.2015.1004.
78. WHO and UNICEF, "Rwanda: WHO and UNICEF Estimates of National Immunization Coverage: 2014 Revision," July 9, 2015, http://www.who.int/immunization/monitoring_surveillance/data/rwa.pdf.
79. Rwanda MOH, "Standard Concept Note."

Photo credits: p. 6: (top) Global Fund/Petterik Wiggers, p. 8: (r.,top) Global Fund/Mia Collis; p. 9: (l., top) Global Fund/John Rae; (r., top) Global Fund/John Rae; p. 11: (top) Global Fund/John Rae; p. 12: (bottom) Global Fund/John Rae; p. 14: (top) Global Fund/John Rae; p. 16: (top) Global Fund/John Rae; p. 19 (top) Global Fund/Petterik Wiggers; p. 20: (r., bottom) Global Fund/John Rae; p. 23: JCIE/Patrick Ishiyama; p. 24: (top) Global Fund/John Rae; p. 27: (l., top) Global Fund/John Rae; (l., bottom) Global Fund/John Rae; p. 28: (l., bottom) Global Fund/John Rae; p. 29: (l., bottom) Global Fund/John Rae; p. 31: (r., bottom) Global Fund/John Rae; p. 33: Global Fund/John Rae

About JCIE and the FGFJ

Japan Center for International Exchange (JCIE)

JCIE is a foreign policy institute that sponsors research, exchanges, and policy dialogues that bring together policymakers and opinion leaders from diverse sectors of society, both in Japan and overseas, to advance international cooperation. Founded in 1970, it is an independent, nonpartisan and nongovernmental organization that operates with offices in Tokyo and New York. It played a leading role in the 1990s in Japan's adoption of human security as a pillar of its foreign policy, and its work in this area paved the way for a series of major initiatives on global health, including the 2004 launch of the Friends of the Global Fund, Japan.

www.jcie.or.jp

www.jcie.org

Friends of the Global Fund, Japan (FGFJ)

JCIE launched the FGFJ in 2004 to educate leaders and the public in Japan about the work of the Global Fund to Fight AIDS, Tuberculosis and Malaria and to mobilize support in Japan and internationally to battle the three deadly diseases. It engages Japanese legislators through the FGFJ Diet Task Force, which sponsors regular briefings and occasional overseas site visits, and it mobilizes key leaders from government, business, and the nonprofit sector through the FGFJ Advisory Board. FGFJ works to educate government officials on developments surrounding the Global Fund, conducts site visits and briefings for Japanese journalists, and serves as an information source on developments involving the Global Fund and the three deadly diseases for policy experts and the Japanese public. FGFJ also carries out policy studies that analyze how the fight against the three diseases fits into Japan's broader foreign policy and where there are opportunities for international cooperation. Moreover, it works to encourage Japanese businesses to contribute to the battle through their corporate strategy and workforce program and facilitates corporate donations to the Global Fund.

<http://fgfj.jcie.or.jp/en>



JCIB FGFJ