TRP Lessons Learned from Review Window 2 2020-2022 Funding Cycle

OVERALL LESSONS

1. TRP expectations are evolving

- Generally, the funding requests reviewed in Window 2 were of good quality (over 90% of W2 funding requests were rated good/very good by the TRP) however the TRP has increasingly higher expectations to deliver better impact: the TRP is expecting to see more focus on results in the proposals; it is no longer sufficient to simply propose a technically sound disease program.
- One of the biggest overall opportunities the TRP has identified is the need for significantly increased coordination with other partners. The Global Fund (GF) will need to work differently in the 2020-2022 cycle and beyond, to more intensively synergize efforts with partners, donors and domestic resources, to leverage the full potential of the $14 billion and to maximize the impact of funding from different sources.
- The TRP also recognizes how essential it has become to significantly increase the attention to and investment in Community System Strengthening (CSS) and Health System Strengthening (HSS) as this is now recognized as underpinning sustainable results for the diseases. The TRP has still not seen enough understanding/commitment from applicants on either CSS or HSS; applicants frequently assume investment in community health workers is sufficient, although this is not what is meant by CSS or HSS. While guidance on Community System Response exists, funding requests seen to date indicate it has not yet been well understood or applied.
- While the TRP has seen increased attention to key populations in funding requests, differentiation in programming at country-level, tailoring program delivery to different key populations, is still lacking. Programming should be designed with a people-centered approach and, while there are commonalities across groups, the one size fit all model is not appropriate and must be adapted depending on generalized vs. concentrated epidemics or epi stratification in-country.
- Specifically, the TRP reviewed a number of funding requests with interventions for adolescent girls and young women (AGYW) and had mixed reactions to the programming proposed. In many cases, AGYW interventions were unsuited to the epi context (not value for money), in other cases the programming was disappointing as it was 'more of the same' in terms of general education and information, but without sufficient differentiation or contextual richness (e.g. missing interventions on gender-based violence, male engagement, gender inequality). In a few funding requests, the TRP was satisfied that applicants had put together a thoughtful proposal.
- While the TRP has seen positive trends in HMIS integration and data collection, data use to drive programmatic optimization is key for an effective, mature program and this was disappointingly absent in almost all funding requests. The TRP has become increasingly strict on expecting data-based justification for programming priorities.
- Applicants need to look at their overall training investment more critically: while the TRP supports capacity-building, it is concerned by the number of requests for training that do not

address the underlying needs, or why previous training was seemingly ineffective and not institutionalized.

2. The TRP requests applicants and technical partners ensure the basics are in place and encourages simpler solutions

- The TRP observed requests for increasingly expensive and complicated interventions when simple alternatives would be equally effective and likely easier to implement.
- The TRP observed a tendency to include requests for technological advances when essential, basic investments for program success were missing (e.g. case management, transport costs, reporting systems). As a value for money imperative, the TRP strongly recommends that applicants prioritize investment in the basics before investing in new technology that will also require supportive system integration investment.
- The TRP was concerned to see applicants increasingly using global mathematical models developed and interpreted without taking into consideration the country context. Also concerning, some of these models provide solutions that are outside current normative guidance. The TRP strongly advises applicants to follow normative guidance adapted to their epidemiological context, allowing for learning from country-specific innovation.
- The TRP welcomes innovations observed over 2020 in response to the COVID pandemic and encourages applicants to learn from low-cost, low-risk creative solutions such as multi-dispensing and linkages between community and peer groups. In addition, adult learning on-line training platforms should be considered for health care workers/peer group training over the more resource-intensive in-person approach.
- The TRP encourages the adoption of digital health tools (which can be very cost-effective) when basic conditions can be met: these tools should be additive to basic care and only adopted when the systems supporting the digital health and national health platforms can speak to each other and data is easily transferable. An open-sourced, common system interface likely has the best potential for success.
- The TRP requests that partners deliver new normative guidance advising when and how new technologies should be adopted, and what old interventions should be dropped or deprioritized. Technical support from partners should also be tailored to the national context to the extent possible.

3. The TRP is concerned about two emerging areas

- The TRP observed worrying examples of countries where on-going GF investment has not translated into programmatic results/impact over time. The TRP advises the Global Fund to focus even more on national program results over grant performance driven by absorption, and adjust investment value and disbursements downwards if results are not achieved. TRP also advises GF to consider a more practical (less resource-intensive) approach to funding small islands/countries where the disease burden is low. Applicants should be increasingly accountable for their program results.
- The TRP observed a decreasing number of civil society Principal Recipients and advises the GF to carefully examine the implementation arrangements of PRs and SRs for the 2020-2022 cycle to ensure that there is sufficient funding for civil society implementers to ensure the sustainability of key programs and service delivery. While social contracting is theoretically ideal it may be naïve to assume that governments are uniformly willing to engage with CSOs, or that governments will sustain these efforts.

4. Learning from current application approaches

- In Window 2 there was a disproportionate number of Tailored for NSP funding requests submitted and the TRP requests further guidance for applicants on how to most effectively use this approach, and ensure that any gaps in the NSPs are sufficiently addressed in the funding request. Further, the TRP requests that the Secretariat and partners qualitatively and quantitatively analyze this modality over the funding cycle to improve this application approach.

TECHNICAL LESSONS

HIV

1.1 Missed opportunities to minimize leakage in the HIV clinical cascade and maximize impact

Inconsistent and often incorrect reporting against Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 goals: The TRP observed that not all funding requests presented the country epidemiological achievement as the 95-95-95 targets are understood, i.e. 95% of people living with HIV know their HIV-positive status, 95% of those who know their status are on antiretroviral treatment (ART), and 95% of those on treatment are virally suppressed. The data to report on the cascade was often not presented, especially the data on viral suppression. Data was presented in different ways across different countries.

Access to viral load testing is still suboptimal and plans to expand access often lacked detail e.g. in specimen transport and how results will get back to clinicians and patients.

HIV testing targets still lack ambition: The TRP noted that some funding requests included HIV testing targets with low coverage goals, particularly among key population groups.

Differentiated and innovative HIV testing not planned systematically: some funding requests lacked clear details regarding HIV testing approaches. There is still an over-reliance on facility-based testing and a slow pace of scaling up impactful testing approaches, including index testing, optimized network-based testing and HIV self-testing.

There are still countries that have **not yet adopted the "Test and Start" approach to ensure initiation on ART without delay.** While countries are in the process of transitioning to optimized ART regimens, including dolutegravir- based regimens, some countries have **delayed transition to TLD** (proposing up to three years to fully transition) **with unclear transition plans** (neither time-bound nor costed).

Opportunities to address leakages across the PMTCT cascade and reduce MTCT are not fully leveraged: while many countries are considering interventions across the pillars of PMTCT, critical opportunities to reduce MTCT are not being addressed and MTCT of HIV is still high. Testing of partners, to allow primary prevention in discordant relationships and also to allow for better retention on ART, is frequently not prioritized. Access to early infant diagnosis is still not adequately prioritized.

Lack of innovation and differentiation of HIV treatment tailored to the specific needs of the patient to ensure high retention on ART or PMTCT was observed in funding requests from a number of countries.

TRP observed that critical **interventions to improve the clinical cascade** – e.g. scale-up of self-testing in ART uptake and viral load coverage – were **placed in the PAAR**.

Recommendations for applicants:

- Clearly articulate progress towards 95-95-95 goals and analyze and present data to highlight gaps in each element of the cascade, using data to analyze the gaps, including analyzing and presenting cascade data for specific key populations.
- Adopt, adapt, plan, and systematically implement the good practices known to optimize HIV testing, including index-testing and HIV self-testing
- Plan and accelerate the pace of rapid ART initiation, of transition to TLD and of access to viral load and early infant diagnosis

- Plan to minimize leakage of the PMTCT clinical cascade with clear strategies that include primary prevention, family planning and support for adherence to antiretroviral therapy (ART) for pregnant and breastfeeding women.
- Ensure that critical interventions in the HIV and PMTCT cascade are fully budgeted for within the allocation rather than the PAAR

Recommendations for partners:

- Support applicants to carefully analyze their data to identify critical gaps and assist them to include innovative strategies to address the gaps.

1.2 HIV prevention interventions insufficiently prioritized

While the TRP has seen substantial progress in prioritizing prevention activities, many funding requests still have gaps in prevention programming:

Slow pace of implementation and limited coverage of PrEP: Many countries have unambitious targets, with limited budgeted for PrEP in the main allocation (PreP is often included in the PAAR).

The prevention package is **not sufficiently tailored to the specific needs of various segments of key and priority populations**: e.g. some funding requests did not include comprehensive interventions for people in prison; lack of ambition, scale and scope of comprehensive prevention for PWID including NSP/OST/ART combination; often prevention programming is not tailored for younger key and priority populations.

HIV prevention **interventions are not adequately funded**. Many countries are not reaching the prevention coalition's target of 25% of funding being allocated to prevention and critical HIV prevention interventions (e.g. primary prevention for women of childbearing age) are found in the PAAR and not in the main allocation or funded through domestic resources.

Prevention still often includes a range of **untargeted, low-impact/non-specific interventions**, such as education, awareness-raising, workshops and facility-based services with less attention to outreach with combination prevention services. Many countries with concentrated or mixed epidemics are focusing on low impact interventions in general population groups, such as young people, without considering differentiation to reach subgroups of young people, such as those with intersecting vulnerabilities.

Condom programming is being revived in some countries, but limited details are provided on how this will be sustainable and impactful to increase condom use.

Recommendations for applicants:

- Prioritize and budget PrEP within the main allocation, especially for key and priority populations with the highest vulnerabilities.
- Tailor HIV prevention packages to the need of specific segments of key and priority populations considering age, specific vulnerabilities and intersectionality of vulnerability. Aim for well-budgeted combination prevention programming.
- Addressing the legal environment in which prevention is provided will directly impact clients' ability to access services.
- Deprioritize low impact interventions (such as awareness and knowledge raising activities) in the prevention module and reallocate funds to prioritize high-impact, evidence-based interventions. In all but generalized epidemics, general population prevention should also be deprioritized, and all generalized epidemics are not the same, so general population prioritization should reflect the epidemiology.

Recommendations for partners:

- Assist countries with PreP programming as there is still some ambiguity in guidance for implementation and evaluation of programs.

1.3 Key and priority population programming is still sub-optimal

The TRP notes significant improvements by several countries paying critical attention to key and priority population programming. There has been an increasing focus and attention to priority populations, especially adolescent girls and young women. However, the TRP note that these could be better targeted and focused based on the following:

- While some countries improved inclusion of the broader range of key populations in line with normative guidelines, funding requests, especially from the African region, continue to ignore **men who have sex with men, transgender people, people in prisons, and people who inject drugs**. Some countries have remained silent about these key populations despite multiple previous TRP recommendations. (see also section 5.2 and 5.5)
- **Lack of reliable data** and size estimations for transgender people and other key populations remains a major issue globally and particularly in Sub-Saharan African states. (referenced in section 5.4)
- Interventions for adolescent girls and young women are **not differentiated well and lack a comprehensive focus.** Furthermore, there are several missed opportunities for integration and synergy with RMNCAH programs and broader sexual and reproductive health. (referenced in section 5.3)
- Interventions for key populations are **insufficiently differentiated and do not consider intersectional vulnerabilities.** Transgender people are often subsumed under programming for men who have sex with men, without consideration of their specific needs and vulnerabilities. There is limited consideration that sex workers and men who have sex with men may also use drugs, and little tailoring for people using different drugs – opioid, amphetamine-type stimulants and/or new psychoactive substances. Programming is often not differentiated by age or the specific needs of subgroups of key and priority populations. (see also section 5.7)
- Increasing attention is being paid to reach the partners of key populations but **activities to reach these partners are poorly described** and metrics for monitoring the outcome of these interventions (e.g. coverage indicators) are often absent or lacking ambition.
- Conversely, some progressively ambitious **targets are not backed by realistic resources in allocation,** resource requests are included in PAAR, or targets are based on low size estimates of key populations**.**
- **A lack of ambition and investment for an impactful scale of harm reduction,** including needle and syringe programming and opioid substitution therapy, is still observed in several countries. Few countries plan **harm reduction in prisons despite high levels** of criminalization of drug use.

Recommendations for applicants:

- Recognize the evidence of the existence of key populations and subgroups within them, and as a matter of urgency, generate appropriate data related to all segments of key populations.
- Plan key populations related interventions (i) accelerate rapid assessments and understanding of their needs; (ii) differentiate interventions according to the unique specificities of each segment within the key populations, (iii) involve key populations in

planning, implementation, and monitoring of interventions, (iv) make interventions comprehensive, and (v) secure appropriate resources to support their implementation.

- Pay more attention to differentiation within programs for AGYW including interventions to address the causes of vulnerability, such as helping girls to stay in school and improving the treatment of STIs. Consider a broader focus on the partners of AGYW by improving coverage of testing and ART among men.
- Address legal, policy, and cultural context of interventions, ensuring community systems are strengthened appropriately and leadership of CCM is inclusive.

Recommendations for the Secretariat and partners:

- Provide TA to enable applicants to use available evidence and information to adequately segment, plan and fund focused interventions for key and priority population, especially in African countries where key population programming has proved difficult in the past, and in Asia with persistent barriers to programming for PWID.
- Monitor and report on Global Fund investments in harm reduction, including analyses of coverage, of quality trends and of gender-responsiveness.

Tuberculosis

2.1 The entire TB care cascade is not yet well addressed within interventions to find the missing persons with TB

The emphasis on finding the missing persons with both DS and DR TB continues to be prominent in most funding requests. Interventions to address treatment coverage gaps were included in almost all funding requests reviewed in Window 2.

However, there is a need for attention to what happens throughout the course of care. Only four of the 19 funding requests in Window 2C included an analysis of the cascade of TB care. Even then, these were not comprehensive: only one included an assessment of pre-treatment gaps; and of the 14 applications with HIV/TB components, cascade analysis was restricted to HIV in all but two. Information on the proportion of TB patients with catastrophic costs is often lacking. Similarly, very few mentioned robust data collection and maintenance of high-quality data through routine data quality audits.

The TRP is concerned that the applicants cannot address the problem if it is not well defined. The absence of an analysis of the entire care cascade diminishes the focus and impact of proposed interventions towards finding the missing people with TB.

Recommendations for applicants:

- Look beyond finding the missing cases to construct and analyze the entire care cascade, including TB prevention and care.
- Identify gaps that can be targeted for interventions, including losses during diagnosis, and linkage to treatment.
- Analyze the root causes of the key gaps and use Operational Research to solve the gaps identified in programs.
- Prioritize geographical areas and populations using the country's epidemiological data.
- Develop differentiated and innovative interventions to meet these gaps.

Recommendations for the Secretariat and partners:

- Assist in construction and analysis (Root Cause Analysis) of entire diagnostic and care cascades, from presumptive evaluation to cure/completion of therapy to prevention of TB infection.
- Emphasize tracking tools and ongoing data use, data quality, and analysis of cascade indicators.
- Besides interventions finding the missing people with TB, the TRP observed that little strategically focused activities were devoted to the other two End TB targets of reduction of mortality and zero catastrophic costs: the TRP encourages partner and Secretariat attention on these areas as well as finding missing people.

2.2 Introduction of new diagnostic tools without an analysis or plan for their implementation and logistical support, and without an inclusive algorithm

All funding requests reviewed during this window included the introduction of new diagnostics recommended by WHO, including the recently endorsed TrueNat and TB LAM, in order to move towards universal coverage with rapid molecular testing for all presumptive TB and the diagnosis and screening of active TB in people living with HIV.

Many of these requests embrace innovation, including digital radiology and artificial intelligence, and attempt to introduce the new rapid molecular diagnostics at the lower levels of the health care system.

However, more than a quarter of the funding applications requested new tools without i) an analysis of the entire diagnostic landscape, human resource needs or a logistical plan for implementation and support (including infrastructure, procurement, supply chain management, training, maintenance, quality assurance, etc.), and ii) algorithms adapted to the universal use of these new tools.

Specimen transport systems and reporting systems, which are needed to offer rapid molecular tests as the first test for diagnosis and universal DST and to provide timely feedback, are not sufficiently scaled to the required level.

Many countries introducing WHO recommended diagnostics continue to have algorithms that restrict their use to particular groups of people that they deem to be at higher risk.

The insufficient analysis leading to the proposed introduction of new diagnostic tools raises questions for the TRP around the value for money and overall sustainability of the investments.

Recommendations for applicants:

When introducing a new tool:

- Analyze why this tool is chosen, what are the implementation and logistical requirements to support not only its introduction but its ongoing use under quality conditions.
- Identify how the new diagnostic tools will fit in the diagnostic network and complement or replace other diagnostics and adapt algorithms accordingly.
- Map their preferred positioning within the laboratory services and the necessary access to complementary diagnostics (e.g. LAMP-positive samples need to be tested for DST and therefore need access to facilities with GeneXpert/TrueNat/Line Probe Assays).
- Plan the network development including procurement, supply chain management, maintenance and training jointly with other disease programs when multiplexing. E.g. Viral load assessment, EID
- Specimen transportation systems and reporting systems must be incorporated into the use of every diagnostic test.

- Prepare aspirational plans to test all people with presumptive TB with a molecular test and match these expectations to the specimen transport networks required and how to provide timely reports. Make long-term plans with clear milestones to work towards these targets.
- Promote the creation/strengthening of multi-disease specimen transport networks.
- Utilize operational research to test and refine placement and use of new tools
- Incorporate the new tools within the quality assurance program of the laboratories.

Recommendations for the Secretariat and partners:

- The TRP supports the introduction of new technologies to increase the detection of people with TB. However, it needs to be recognized that merely introducing new diagnostic tools does not resolve system challenges in making quality laboratory services available and accessible for people with TB. These challenges need to be assessed and a root cause analysis carried out to reveal the reasons for unsatisfactory laboratory support so that the right solutions can be put in place.
- The introduction of these technologies needs to consider additional logistical requirements, which can be complex. Funding requests indicate the intention of programs to locate the new rapid molecular diagnostics in former microscopy centers. These centers however lack minimal infrastructure and require extending the current supply chain management, training and maintenance beyond the reach of current systems.
- The transport of specimens continues to be a major bottleneck to increase access to rapid molecular diagnostics. Although most funding applications include activities to strengthen the specimen transport network, there is little analysis of the total needs and capacity required.
- Most transport specimen networks use a hub and spoke approach. Although this is reasonable on a small/medium scale, there are increasing opportunities to optimize the services by applying network science and technologies for national scale-up. Moreover, the implementation of integrated sample transportation systems for TB, HIV, at least in urban areas should be encouraged. The Secretariat may consider this as an area that may benefit from strategic investments.
- Design and implementation of robust external and internal quality assurance systems, to ensure that the results obtained with the new tools are of quality.

2.3 Acknowledgement that children and adolescents with TB are missing but there are no large-scale plans for finding them.

Children are increasingly acknowledged by NTPs to be missing among reported people with TB (Children comprise 2-7% of all TB in most funding requests reviewed). Despite this, interventions to reach them are either not planned, on a small scale, or lack the necessary ambition to close the detection gap. Moreover, no funding requests addressed TB in adolescents.

Similarly, the introduction of TPT for children has been identified in several intervention modules. However, most interventions are not of an ambitious scale. Funding requests are also generally silent on TPT provision beyond children under 5 years of age.

Current WHO normative guidance prioritizes provision of TPT for children <5 who are household contacts of people with bacteriologically confirmed TB. However, in countries where most people with TB are clinically diagnosed (access to bacteriologic diagnostics is limited), the majority of child contacts do not meet this requirement and are therefore excluded from TPT, reminding all of the urgency to scale universal access to diagnostic testing.

Recommendations for applicants:

- • Adhere to and operationalize the roadmap towards ending TB in children and adolescents (https://www.who.int/tb/publications/2018/tb-childhoodroadmap/en/) .
- • Design quality improvement interventions to increase awareness of TB in children among the staff of TB and children's health services.
- • Ensure children are included in interventions to intensify the detection of TB at all opportunities: as part of contact investigations among household contacts, as part of TB screening in people attending health facilities, and as part of routine TB screening among people living with HIV.
- • Emphasize and train health care workers regarding child contact management systems, including M&E materials that track the care cascade for children.
- • Narrow the gap on provision of TPT to WHO high priority populations - those living with HIV and children less than 5 years who are household contacts of a bacteriologically confirmed person with TB.
- • Consider introducing the WHO short TPT regimens to increase acceptability and treatment completion .

Recommendation for the Secretariat and partners:

- • Contact investigation (CI) is the most important program intervention for finding children, both with disease and for TPT; thus, CI is not an optional exercise.
- • The TRP supports the WHO Call to Action to overcome barriers to scale up TPT (13 May 2020) and to work towards overcoming both knowledge and implementation gaps that continue to hamper the Global Call for TB Prevention. All partners are called upon to work to fill these knowledge and implementation gaps as well as increase universal access to quality TB prevention.

Operational Research Considerations for applicants and partners

- Conduct operational research to identify bottlenecks for the large-scale implementation of contact investigation and provision of TPT in children.
- Consider conducting operational research to identify barriers and facilitators to implementation of WHO's widening recommendations for TPT, specifically for those above the age of 5 years who are household contacts of a bacteriologically confirmed person with TB.
- In many settings, a clinical diagnosis of pulmonary TB is made because there is no access to WHO recommended diagnostics. The absence of bacteriological confirmation in these circumstances results in many children missing out on TPT. Consider operational research in settings where children under 5 do not qualify for TPT due to clinical diagnosis of the index case resulting from lack of access to a bacteriologic diagnostic test. Such TPT provision should be piloted within an operational research framework that generates evidence of its effectiveness and should be conducted in parallel with efforts to expand access to tests for the bacteriological confirmation of diagnosis.

2.4 Lack of support for the key role of national leadership and management capacity

While all funding requests include components to strengthen program management, these are mainly focused on technical aspects for coordinating and managing programs. There is scant attention given to the development of national, intermediate and district-level leadership capacity

and to where this is included; it is often directed to sub-recipients, community organizations and communities, and not to program staff.

Funding requests often have a large training component, although program management focuses on high-cost traditional in-person trainings and meetings, without a translation into meaningful infrastructure and HR building.

Strong program managers and motivated HRH are a critical investment to drive program efficiencies and ensure targets are reached., However, very few programs have requested new digital modalities for training that have become more common with the COVID-19 epidemic.

Recommendations for applicants:

- National TB programs require strong leadership and highly-skilled program managers to drive the success of national and regional Programs. Leadership development and program management skills require the creation and implementation of a leadership development strategy, brought to life in a cost-efficient way.
- Funding requests should include leadership and management capacity building strategies as core components to ensure that the capacity at the national, intermediate and district level of the NTP is strong. This is particularly important where countries are undergoing decentralization and roles and responsibilities are changing.

Recommendation for the Secretariat and partners:

- There are now many examples of energetic and ambitious TB Programs that have benefitted from strong leadership. However, many programs with new NTP managers need capacity building, as some of them may not have come from a TB background.
- Multi-country or strategic investments could support the development of future leaders to drive the ambition and desire for innovation of countries. These could include twinning of programs, targeted digital technical assistance, the development of regional networks, and similar tools, to encourage the development of future leaders and senior Program Managers.

Malaria

3.1 Lack of evidence or justification in the selection of vector control interventions

A few applicants requested different interventions for vector control and proposed plans to enhance their vector control strategies by combining LLINs and targeted IRS in high-burden areas to drive down transmission; however, often there was not enough rationale or justification of the added impact and **value for money** for the decision.

IRS was requested (in replacement of, or additional to LLINs) by some applicants with the aim of strengthening their malaria response and increasing vector control coverage without addressing operational challenges. However, this is **not aligned with normative guidance** except when used as an insecticide resistance management (IRM) strategy. The mix-vector control interventions approach is inappropriate where there is no proven evidence (available insecticide resistance data) of either its feasibility and/or adequate technical and operational capacities to implement it. PBO LLINs were also frequently requested without evidence of insecticide resistance data, as per WHO guidance.

Further, six funding requests prioritized the implementation of Larval Source Management (LSM) out of other vector control methods, without sufficient evidence-based analysis to ensure **efficacy and cost-effectiveness.** Generally, none of the funding requests that requested LSM had compelling evidence of its **feasibility or appropriateness for the targeted areas**.

Recommendations for applicants:

- Applicants should work with partners in the selection of the most cost-effective and appropriate interventions for their targeted areas, and decisions must be based on evidence and normative guidance.
- Applicants need to provide compelling justifications for the need to combine IRS and LLINs, especially to demonstrate that both can be operationally and efficiently deployed, and the combination is not meant to cover for deficiencies in adherence to an ongoing strategy. Justification might include information on: i) locations where vectors bite and rest for residual insecticide applications, ii) QA/QC of insecticides in use, and iii) a robust implementation oversight/supervision structure.
    - Applicants should establish a robust M&E framework and implementation plan, possibly at the district-level, with feasible and realistic input, output, and outcome targets, allowing for comprehensive monitoring of programmatic progress, quality, coverage, and effectiveness of critical malaria control interventions. The framework and its implementation should also include activities to monitor data collection, and validate timeliness, completeness, and quality of reported data.
    - Applicants and partners should work to generate evidence on LSM effectiveness and cost-effectiveness in malaria elimination settings, in lowering malaria transmission, and in tackling residual transmission of malaria parasites in comparison with other vector control interventions.

Recommendations for partners:

- WHO should tailor general normative guidance to context-specific situations and consider the importance of additional vector control strategies, especially in "residual transmission settings" which cover all forms of transmission that are beyond the reach of conventional LLINs and IRS, even when used optimally.
- The marginal unit cost of reducing malaria cases lies on a spectrum, with the cost increasing steadily as the country context shifts from malarial control to near-elimination, and then to post-elimination (i.e. a focus on reintroduced cases). The TRP has observed situations of budgets allocated to malaria case reduction which may not be cost-efficient, especially when the number of cases expected is small and the cost per case to reduce them to zero is high. WHO should consider updating its normative guidance on how to allocate malaria vector control and case management resources based on context, where cost-efficiency analysis may be used to understand the value for money of going the last mile.

3.2 Insufficient use of empirical data for decision-making and prioritization of interventions

A few applicants did not use empirical data to justify the **prioritization** of the proposed interventions. Although there was more use of sub-national level data in the applications, interventions were not always linked to **epidemiological scenarios** of the countries or did not justify the **prioritization of the proposed interventions**.

Some did not use existing data to identify **key and vulnerable (most affected) populations**, with specific activities to reach them. There was limited information or ideas provided on how to address service provision among different vulnerable populations, especially along border areas.

Only a few countries presented **cross-border issues** as critical bottlenecks to eliminate malaria. A “one size fits all” approach does not work, and each country should try to develop appropriate border area responses based on their context.

Recommendations for applicants:

- Applicants from countries with a considerable malaria burden are encouraged, with the support of Technical Partners, to use approaches such as those applied to HBHI countries and to carry out the extensive use of epidemiological and other data to guide the choice of interventions through stratification and contextual modeling analysis to project impact. These broad principles are also applicable to elimination settings.
- The TRP encourages applicants in all malaria settings to use robust surveillance data from routine assessments (integrated within HMIS) and surveys to inform stratification to the lowest subnational levels and to describe the tools and reasoning used to make program decisions in the funding request narrative and annexes.
- Increase in-country collaboration to analyze and use the latest data to: (1) continuously update sub-national epidemiological profiles, (2) identify all vulnerable populations and strategies to reach them, and (3) prioritize interventions.
- Engage in strategic partnerships to address cross-border issues, including vulnerable populations.

Recommendations for partners:

- WHO, in coordination with partners, should continue to assist countries in their surveillance and evidence gathering efforts to update data to support the intervention prioritization process and measure progress. Where skills are low or non-existent, the necessary capacity, especially in National Malaria Control Programs (NMCPs), should be built.
- Support countries to build a robust cross-border agenda and identify opportunities within regional projects to address malaria along and across border areas.

Optimal diagnosis and treatment of malaria cases

The TRP noted **low coverage** of malaria diagnosis and treatment, and sub-optimal use of **community case management** and the **private sector** to reach all malaria cases.

Some applicants faced many challenges regarding respect for and compliance with **national case management guidelines** and the T3 strategy.

Some funding requests lacked clarity on how community case management would be **scaled up and integrated** (for example, with assessment and treatment of acute respiratory infections, diarrhea, and malnutrition) rather than approached as a stand-alone malaria intervention.

Recommendations for applicants:

- Map all sectors valuable and relevant to the provision of malaria service delivery to reach the last mile. In the control phase of programming, this means finding those at risk and those hard to reach. In the elimination phase, it means finding the last malaria infections.
- Update national treatment guidelines, including for different sectors and approaches, to improve malaria case management in order to reach all malaria cases.
- Ensure that case management is prioritized and integrated, to improve access to malaria diagnosis and treatment through community-based approaches. While expanding access to prompt diagnosis and treatment, at the community level, countries should as much as possible ensure these services remain free, to mitigate the issue of user/consultation fees that are often levied at facilities.

Recommendations to partners:

- Support countries in updating their treatment guidelines, including different sectors and approaches to improve malaria case management and reach all malaria cases, including through the community health system.

3.3 'New' interventions or deviations from intervention protocol

New interventions and approaches were proposed in some funding requests, including LSM, SMC and interventions targeting key and vulnerable populations. There were also proposals to extend SMC to older children and to increase additional rounds; deviations from the current protocols.

The available normative guidance and protocols do not provide direction for these types of modifications. It is necessary to have clear guidance to enable the TRP to give uniform advice across all applications, context notwithstanding.

Even where TRP recommended pilots of these 'new' approaches, it was crucial to stipulate that robust M&E frameworks were wrapped around these activities so that the (cost) effectiveness and impact of these pilots' efforts could be adequately analyzed and documented.

Recommendation for applicants and/or partners:

- Develop and have in place a robust M&E framework to document the impact and cost-effectiveness of new interventions/approaches/deviations in the protocol. The M&E framework and implementation plan, possibly at the district-level, should include feasible and realistic input, output, and outcome targets, allowing for comprehensive monitoring of programmatic progress, quality, and coverage of implemented interventions. The framework and its implementation should also include activities to monitor data collection, and validate timeliness, completeness, and quality of reporting.
- Conduct implementation research and rigorous evaluation of the impact and cost-effectiveness of new approaches in a limited number of districts. Evidence generated from this research would inform and guide the large-scale implementation of the particular intervention (if the evidence supports it).

Recommendations for partners:

- WHO: update normative guidance and provide clear, unambiguous advice on contextually appropriate deviations from current protocols.

Strategic Investment and Sustainable Finance (SISF)

4.1 Quality of evidence submitted on co-financing commitment remains poor; application of STC Policy-related flexibilities is unclear, threatening sustainability

First, the TRP finds that evidence submitted by applicants to demonstrate how they met co-financing commitments has been of low quality and/or out of alignment with the intentions of the STC Policy. For one large funding request, the applicant's stated value of disease-specific government spending differed significantly from the government-supported analysis included in an annexed document.

- In the absence of Secretariat Briefing Note (SBN) analysis of the co-financing commitment letters, TRP has used its judgment to evaluate the threats to sustainability for programs and Global Fund investments. Lack of evidence on past ability to meet co-financing commitments or on future co-financing incentive requirements could suggest poor sustainability.
- As an example of inappropriate evidence, applicants have attempted to demonstrate co-financing through exemptions granted on levies charged on donated commodities such as import taxes or VAT.

Second, it is unclear what flexibilities are being offered in grant negotiations around co-financing obligations for challenging operating environments (COEs), and whether there is strict implementation of the need for disease specificity in co-financing for middle-income countries that are COEs.

- Discussions with Secretariat suggest flexibility is applied in practice in such contexts, yet the modalities for such are unclear, leading to a complex TRP review.
- For long-term sustainability and to safeguard progress, the TRP considers that all countries attempt to meet their minimum obligations and innovative mechanisms, such as Debt2Health, be offered in this context.

Recommendations for applicants:

- The quality of evidence presented and of the calculations used in co-financing commitment letters should be improved and a check should be performed against STC Policy guidance.

Recommendation for the Secretariat:

- Improve the SBN's discussion of the quality of co-financing evidence and the implications thereof and provide more context to how the STC Policy will be implemented in COEs or in other countries with challenges in their fiscal space.
- Improve the funding request instructions to request more specific information on the applicant's intended co-financing to ensure that it is more robust as appropriate, considering COE situations, highly commoditized grants, and past performance on meeting co-financing obligations. Sections on co-financing in program continuation and tailored to NSP funding request formats should be made more comprehensive.

4.2 Despite the applicants' responses in the new value for money (VFM) section, budgets for funding requests continue to demonstrate poor efficiency

The TRP finds that many funding request budgets continue to have high program management (PM) and travel costs as a share of the total budget. Often these costs are in the form of per diems.

For example, one funding request had PM costs at 28%, travel costs at 22%, and an HRH budget at 34%. Another had 31% in PM costs, and 25% in travel costs.

Overall charges related to procurement and supply chain management (PSM), usually a levy charged on the value of Global Fund purchased commodities, are high – reaching up to 50% of the total value of the procured value in some Central African funding requests. We understand that the context is important for understanding whether these requests are justifiable. Also, sometimes costs are miscategorized between cost types and modules, artificially inflating the PM share.

In one Window 2 funding request, the travel costs were estimated to be 37% but were lowered to 26% after correcting for such miscategorization.

Another issue contributing to high PM costs are inefficient implementation structures, such as multiple PRs and SSRs, or creating new project management units, without consideration of shared resources.

Certain types of costs, such as per diems, need to be more strictly controlled. While the Secretariat asserts that it manages these matters during grant negotiation/making, the TRP considers these as egregious issues in VFM that are not being addressed in funding request submission.

Recommendations for applicants:

- Use guidance (to be supplied) around value thresholds, ranges, and/or ceilings for unit costs as well as the shares of total budgets that PM, travel (per diem), PSM, and other headings should represent.
- Mis-categorization should be avoided.
- Stronger justifications should be supplied if costs exceed these benchmarks.

Recommendation for Secretariat:

- The TRP considers that analyses generating reasonable threshold values for PM, PSM and travel/HRH costs as a share of the appropriate denominators would be helpful.

4.3 Contracting of civil society and nongovernmental service providers needs to be encouraged, systematized, and broadened to include funding from multiple sources

Over the 2017-2019 cycle and the current cycle, funding requests from Eastern Europe and Central Asia have shown encouraging progress in social contracting mechanisms to flow funds from government budgets to civil society and nongovernmental providers (CSO/NGOs), especially for key prevention, outreach, and care and treatment services for HIV and TB. This experience should be translated to other geographical regions and epidemic contexts, especially for applicants from lower-middle and upper-middle income countries.

The TRP recommends that technical partners should provide more best practice guidance around contracting of CSO/NGOs and around important considerations to protect the independence and watch-dog functions of CSO/NGOs.

It is also critical that smaller, less stable CSO/NGOs receive training and support to become eligible for and receive such funding.

The TRP also considers broadening who may contract CSO/NGOs for disease program-related services, such as in-country philanthropies, etc. The continuing gap in forward-looking, rigorous guidance on social contracting affects neutral review and application of best practice during TRP discussion.

Recommendations for partners:

- Issue technical guidance on best practices for social or other contracting of CSO/NGO capacity for services related to disease programs, including how to build capacity to contract/be contracted, develop regulations, tariffs, and service packages.
- Broaden guidance to allow multi-sectoral contracting of CSO/NGOs and the blending of funds.

4.4 Lack of clarity on the broad definition of sustainability

For the “sustainability” aspects of the STC Policy, funding requests do not currently clearly address or show an understanding of the fact that sustainability is broader than the financial element. A synthesis of issues is usually missing for sustainability across VFM, as well as program, institution, rights, and politics-related aspects.

Without a systematic approach to addressing these points, the funding requests are of diverse quality and overall, do not present a coherent picture of whether the proposed grants demonstrate high or low sustainability.

Recommendations for applicants:

- Use guidance (to be supplied) to analyze sustainability holistically, and systematically, including incorporating the VFM lens.

- The guidance to be provided can learn from approaches used by agencies such as PEPFAR.
- In considering long-term sustainability, applicants should engage more proactively with how the disease programs will leverage universal health coverage-oriented health finance platforms/initiatives.

Recommendation for the Secretariat and partners:

- Issue technical guidance on analyzing sustainability for funding requests that considers the issue holistically and incorporates the VFM lens.

4.5 Inadequate response to significant commoditization of funding requests

In this cycle overall, many funding requests, especially for low-income and lower-middle income countries, have seen the bulk of the within-allocation budget devoted to the purchase of commodities. Sometimes critical commodity purchases extend to the PAAR.

With an increasing dependence on the Global Fund as the only purchaser of anti-TB medicines and the bulk of antiretrovirals in many countries, there is a critical need to start requiring health product co-financing from countries, with or without the disease specificity requirement of the STC Policy. This applies even to those LICs where the TRP notes that commoditization of the program has reached 75% or more of the allocation funding request.

Recommendation for the Secretariat:

- Encourage applicant countries to initiate budgetary line items or other protected, predictable domestic financing of commodities within the grant period, and then progressively increase the commitment over time, especially as they move from low-income status to lower-middle-income and upper-middle-income status.

4.6 Donor mapping and description of engagement with other partners is often missing from funding requests

To fully understand funding requests, it is important to know what other development partners are doing in the countries broadly for health and specifically for the disease programs being financed by the Global Fund.

As a part of this review, it should be established if these other funders are engaged in dialogue with the Global Fund or the grants; what duplications are being avoided and what coordination achieved to maximize impact, such as through compacts to deal with host government or formation of joint investment platforms.

Recommendation for applicants:

- Applicants should give more information on coordination with and activities of other donors in their countries active in the health sector as well as with the program specifically.

Recommendation for partners:

- Share information on coordination with the Global Fund, such as the information shared by PEPFAR on the funding levels and investment analytics in Window 2C, but more specifically on coordination and joint investment platform propositions.

Human Rights and Gender (HRG)

5.1 Community-based vs. community-led activities and monitoring: conflation and/or unclear distinction

The TRP welcomes the increasing attention in many funding requests to the role of communities in the response to the three diseases.

While funding requests often reference community-based activities or community-based monitoring, it is unclear whether the activities are also community-led.

Some funding requests describe elements of community-based activities, without clarifying if community-based organizations involved in the program are community-led, or funding requests mention community-based and community-led organizations in the program without distinguishing one from the other. The terms 'community-led' and 'community-based' are used interchangeably, without a clear distinction between the two.

Funding requests see community-based activities as an extended tier of the health care system to provide services, thus limiting the community-led component, and not recognizing that community-led responses are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.

Recommendations for applicants:

- There is a need for funding requests to distinguish community-based activities from community-led activities, using the Global Fund Technical Brief: Community Systems Strengthening.

Recommendations for the Secretariat and partners:

- Build applicant capacity to distinguish between "community-based" from "community-led," using the CRG Technical Brief: Community Systems Strengthening as a basis.
- Update technical partner guidance to countries on community-led monitoring vs. community-led service provision.

5.2 Key populations continue to be silenced or neglected in Challenging Operating Environments (COEs)

In Window 2 the TRP reviewed funding requests from several African countries which are challenging operating environments with accompanying challenges to maintain the rule of law and with a history of serious human rights abuses, where the applicant ignored or neglected high-risk key populations in their HIV applications. For example:

- Exclusion of programming for men who have sex with men, transgender people, and people who inject drugs thus denying their rights and putting their lives at risk.
- Providing insufficient detail in the funding request on key population-led advocacy to protect against punitive actions and key population-led peer-based outreach and testing, for the TRP to be confident in the integrity and the value of the activity.
- Internally displaced people/refugees and prisoners often face massive human rights violations including gender-based violence, but funding requests were silent on these issues.

Normative guidance requires comprehensive rights-based programs for key populations in order to end the HIV epidemic.

Recommendations for applicants:

- Request for appropriate technical assistance and policy-level guidance from technical partners and the Global Fund on key populations.

Recommendations for partners:

- Be proactive and advise COE applicants on essential key populations programming. Mobilize other donor partners and key population-led CSOs to find do-no-harm approaches to key population-led engagement.
- Ensure key populations, especially key populations excluded from HIV programs, are represented and able to safely engage and influence CCMs, and participate in program design, implementation, and M&E.

Recommendations for the Secretariat:

- Adapt policy to require all applicants to have adequate budget allocations for human rights and key population-led interventions as a condition for funding, backed by a 'do-no-harm' mechanism.
- Develop clearer guidance on a do-no-harm approach for COEs.

Recommendations for the TRP:

- Examine whether interventions exacerbate existing human rights abuses of key populations in the context of the COE and make recommendations to mitigate and end them.
- Consider the most appropriate language to use in review forms for COEs.
- Move away from focusing on identities to using a medical framework on key population-risk factors, and to the general population (i.e. harm reduction as a principle for counseling, mental health support, and gender-based violence/multiple exposures to violence generally).

5.3 Gaps in programs addressing women and girls

Other than programs focused in select countries on Adolescent Girls and Young Women in relation to HIV, and those targeting pregnant women with disease-specific interventions (PMTCT, IPT), there are significant gaps in funding requests in programs addressing cisgender women and girls and their needs. Most notable are:

Cervical cancer is a leading AIDS-defining illness for women and HIV positive women have 4 to 5 times the rate of cervical cancer. Funding requests are often silent on this issue, especially in terms of treatment and care.

Gender-based violence (GBV) is a significant issue for HIV and TB in virtually every country. WHO estimates that 30% of women globally have experienced physical and/or sexual violence. Rates are even higher for key populations, and in many countries submitting funding requests. While funding requests often mention GBV, interventions are limited to a few health centers in the Capital or regional centers. They rarely address the violence experienced by key populations for HIV and TB.

Recommendations for applicants:

- Consider broader issues for women and girls that make them more vulnerable to disease acquisition, including diagnosis of cervical cancer and scaling up GBV services (if not prevention) for technical assistance and funding. Ensure all women have access to basic reproductive health services including contraceptives and quality pregnancy care.

Recommendations for the Secretariat and partners:

- Strengthen awareness and technical assistance on the range of health issues facing women and girls that make them more vulnerable to disease acquisition.
- Strengthen and disseminate guidelines and training to ensure that cervical cancer screening and modern method contraceptives are a part of essential services offered at all Global Fund financed primary health care centers, along with HIV, TB and malaria services.
- Global Fund to clarify support to cervical cancer screening and treatment in policy and information notes.
- Encourage applicants to support GBV in a more comprehensive manner that includes social norm change and engagement with the justice sector as part of disease prevention programming.
- Basic post-rape care, including PEP, EC, trauma care and basic mental health support should also be integrated throughout the primary health care system. Include a system of GBV services for key populations who suffer high rates of violence but may not access services through public health facilities.

5.4 Lack of segmentation of highly vulnerable key populations by age and gender

Virtually every funding request defines high-risk groups as men who have sex with men, (female) sex workers, women having sex with women, people who inject drugs, transgender people, without any identification of age.

Often these groups have significant members under the age of 18; however, without age disaggregation, interventions are rarely tailored to younger age groups who are, according to international organizations, children.

Recommendations for applicants:

- When considering data for key populations, be sure that information systems, surveys and other research disaggregates by age and gender.
- Seek technical assistance and support to tailor prevention and response interventions for those under 18.
- Consider any related legal or policy aspects relative to services for those under 18.

Recommendations for the Secretariat and partners:

- Provide technical assistance and support to strengthen age and gender disaggregation of high risk/vulnerable groups across data and information platforms including in surveys and research. Include research and programming to ensure that programs meet the unique needs across age and gender, in particular children who are engaged in high-risk behaviors, often for example in sex work, against their will.
- Be aware that children 18 and younger are hidden when we use language and acronyms like female sex workers, men who have sex with men, transgender and people who inject drugs.

5.5 Persistent and significant gaps in sustainable financing for local and key population-led NGOs and CBOs

Applicants consistently rely on Global Fund support to fund the bulk of human rights & gender and key population programming, while allocating minimal or no national budget to these programs. This includes countries that had previously transitioned from GF support and subsequently saw increasing HIV infection rates in key populations.

There are multiple examples of countries presenting funding requests in Window 2 that have resisted acknowledging the existence of specific key populations (e.g. MSM, PWID/PWUD, transgender), and have refused to develop any programming for them.

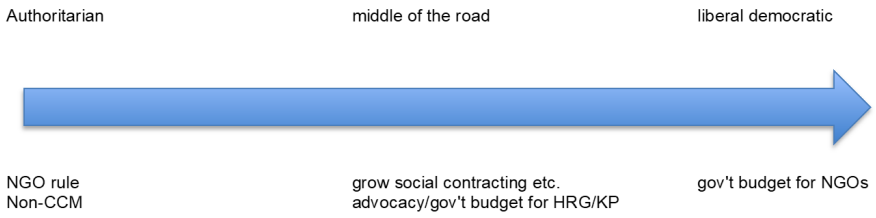
As part of sustainability planning, some countries integrate key population services that were previously Global Fund-funded and provided by NGOs/CBOs, into government health facilities that are not key population-friendly and not suitable to providing services to key populations. This results in dramatic reductions in service quality and coverage.

Recommendations for applicants:

- Strengthen mechanisms to secure sustainable funding for all programs (advocacy, community-based monitoring, human rights and gender interventions, and evidence-based interventions for key and vulnerable populations) for local and key population-led NGOs and CBOs from national budgets, at levels comparable to Global Fund funding and retain key population services within communities, not government facilities, in order to maximize effectiveness and preserve quality.
- Conduct regular population size estimates and IBBS to include all key populations.

Recommendations for the Secretariat and partners:

- Recommend dual-track financing with a PR that has a track record in providing services for the key population at stake.
- Scale-up TA, including from community-led providers and from other implementer countries, for mechanisms such as social contracting and identify other mechanisms to ensure the local and key population-led NGOs/CBOs are sustainably funded from national budgets
- Require countries to fund significant and, as they progress towards transition, *increasing* portions of key population and human rights and gender programming provided by local and key population-led NGOs/CBOs through national budgets, as a pre-condition for receiving a final Global Fund allocation.
- Squarely address the tension between country ownership and human rights and gender issues for countries that routinely violate human rights, by clearly articulating the Global Fund's position that health and human rights, including gender equality, are inter-related and that without addressing local human rights and gender barriers Global Fund investments cannot realize real impact and results.
- Recognize the diversity of country contexts, from authoritarian to liberal democratic, and adapt accordingly. Understand that some countries will not comply with requirements to support or fund NGOs in the foreseeable future and (re)establish mechanisms to address this issue, such as the NGO rule that provided GF funding through a non-CCM mechanism.



5.6 Lack of tailored and/or any interventions for transgender populations

Many funding requests had either no mention of transgender people as a key population or grouped them under men who have sex with men. For countries that have started the process of needs

assessments for TG populations, the proposed interventions are not tailored and planned for later in the implementation cycle.

- Transgender (TG) people may often be overlooked as a population due to small numbers or because their gender expression and characteristics remain invisible due to a lack of hormone treatment and gender-affirming technologies.
- Where interventions are proposed, they are not appropriately tailored (e.g. hormones and ART interactions overlooked)
- TRP also observed undifferentiated interventions (TG/MSM) and no attention for intersectionality (e.g. TG women who are also sex workers, or people who use drugs)
- Legal barriers and implications are often overlooked (lack of legal gender recognition and name change procedures puts the population at continued risk of homelessness and unemployment, criminalization of men who have sex with men often impacts transgender people as well)

Lack of transgender awareness among healthcare workers and self-stigma among transgender people can compound exclusion.

Recommendations for applicants:

- Engage transgender communities in country consultations and in funding request writing
- Ensure that proposed interventions are tailored and reflect existing international guidelines (for example, TRANSIT), and ensure access to GBV services and community empowerment.

Recommendation for the Secretariat and partners:

- Update guidelines for working with transgender populations, ideally creating a concise evidence-based document with clear interventions in which the Global Fund will invest.

Resilient and Sustainable Systems for Health (RSSH)

Technical Observations

6.1 Some positive steps were seen, but generally, there was insufficient integration of service delivery, both between the three diseases and with other health/disease programs

An increasing number of vertical disease programs are improving program efficiencies through shared procurement, integration of disease-specific HIS, and testing.

Several countries were seen to have integrated the delivery of the three diseases programs into broader health system service delivery. Drivers included a desire to provide more people-centered services and to rationalize the use of scarce human resources for health.

Some countries have made progress by creating integrated packages of services covering more than just the three diseases. One RSSH funding request described how HIV/syphilis, TB, and malaria screening have been integrated into the ANC platform over the past three GF funding cycles.

Two countries are planning to invest and enhance the integration of health services in the three diseases and the broader health system. Challenges to integration include the need for complex and demanding reform and time needed for training and organizational changes.

One locus of integration is the use of community health workers to access hard to reach populations across several diseases.

Under pressure to strengthen the three diseases, to bring services closer to people (geographical accessibility) and the needs from the Covid-19 pandemic, one country has started expanding its CHW strategy for the delivery of health services.

As the training of CHWs is lighter than some health professions, it will be easier to expand service delivery to more people, albeit with a limited scope. However, this often translates into adding to the lists of tasks for already overburdened community health workers.

Recommendations for applicants:

- Applicants are encouraged to take a systems approach in considering opportunities for integration and focus on where support will strengthen the system for all programs and the expected more comprehensive health benefits that could result.
- Funding requests should demonstrate that applicants have thought through the strategies and processes that will enable integration, as well as spelling out what can or cannot be integrated during the funding cycle.

Recommendations for the Secretariat and/or partners:

- The Global Fund should support investments for health systems that have a wider health sector or public health program impact, as this will also contribute to the achievement of the three disease goals.
- The TRP requests the GF to clarify guidance on what can be funded concerning key co-morbidities such as hepatitis, cervical screening, and other program support (e.g., ANC and MCH services). Following this, the GF should consider including indicators for these activities to its Core list of indicators.

6.2 Community responses are essential but are often poorly prepared or incomplete

Investment in systems to support community responses is essential to achieving universal health care (UHC) and developing resilient and sustainable systems for health. Community response systems are effective and efficient when linked with health services and integrated, especially for case finding, contact tracing, and treatment follow-up.

Lack of national policy or frameworks for community response systems, or failure to implement them, leads to poor alignment with the National Health Plans and weak harmonization between disease programs. Funding requests often include multiple cadres/ job descriptions that are disease-specific, not coordinated with other similar structures, and not recognized (so not sustainable) in the national human resources for health (HRH) plans and system. In some countries, they are recognized and well-framed.

The lack of a strategy to invest in system strengthening, rather than mere support, results in limited funding for community systems strengthening and missed opportunities to expand the high impact and proven interventions to enhance community ownership and engagement, as well as linking with the formal health system to expand the reach and uptake of most services. In the long run, the sustainability of investments in community systems is limited.

Funding for community systems is often included in PAAR rather than prioritized in the main allocation. As there is no guarantee PAAR will be funded, community systems are effectively deprioritized.

Recommendations for applicants:

- The TRP encourages well-prepared, planned investments in community response systems, with a coherent strategy that is cross-disease, and which strengthens the health system, rather than appearing to be included as an afterthought or highlighted as an added value

- Funding requests should seek to address identified gaps in Community Response Systems.
- Consider Community Response System strengthening from a systems investment approach, linking it to the rest of the health system and, to the extent possible, prioritize it in the main allocation.

Recommendation for the Secretariat and/or partners:

- The TRP recommends Country Teams work within the Secretariat and with the TRP to gather and document good practices and lessons learned from effective community response systems and share to inform and guide other countries.

6.3 RSSH funding requests and RSSH components often reflect short term objectives and may not consider, align with or support the health systems objectives in the National Health Plan

Typically, proposed RSSH investments seen by the TRP are focused on one or more of the three diseases and concentrate on disease program progress during the three-year Global Fund cycle. This has the effect of sidelining medium- and long-term health systems issues and strategies.

The tailored applications were more focused on medium-term needs (for example, by including a plan for capacity building of community health workers). In contrast, full review applications were mostly reflective of short-term needs. The single transition funding request demonstrated better responsiveness to medium-and long –term health system strategies in the NSP, (possibly due to the nature of the funding request).

If the funding request does not explicitly align health system investments with the broader National Health Plan, it is difficult for the TRP to assess the soundness of the proposed RSSH investment's contribution to the more comprehensive health plan. This is especially true where the TRP is not provided with other national health strategy documents that could provide crucial context, such as documents explaining national approaches to healthcare financing, UHC, PHC. National Health Account data is not frequently shared with the TRP, which would support a broader health system analysis, which is required to ensure allocative efficiency and integration of the three diseases into the broader system.

Many proposed actions in funding requests are short term, isolated activities that are not connected to a "system" or the priorities of longer-term, comprehensive national strategies (e.g., digitalization in health, strengthening of the local health systems/health districts). One example from Latin America: recruiting one psychiatrist and providing a series of Mental Health training & counseling is not sustainable if not embedded in a longer-term vision and strategy of gradually developing Mental Health.

Recommendations for applicants:

- National Strategic Plans should be the basis for any Global Fund funding request. In addition to ensuring NSPs are aligned to National Health Strategies, careful attention should be given to medium- and long-term needs of national health policy or strategy to steer the program investments to build a sustainable and value for money response.
- Where no such strategies exist, this could be an opportunity to contribute to the development of a vision & strategy paper (e.g., on Mental Health in the example above) under the leadership of the government and work (within the scope of the GF grant) in a coherent way towards that vision. Applicants should be requested to include the respective national health strategies in the application package and the Secretariat should ensure this is done.

Recommendations for the Secretariat and/or partners:

- Urge applicants to consider the broader health system context and national health plan when designing their RSSH funding requests or components.
- Ensure the TRP is provided with the necessary documentation to allow suitable analysis.
- The Country Teams should be engaged during the development or joint review of National Health Policy or Strategy. The TRP understands that they are involved during the development of disease-specific NSPs, but they are less involved when the National Health Policy/ Strategy is being developed. This enhanced engagement would allow for the base documents for a funding request to be aligned with improved NHPs or NSPs.
- The RSSH components of a funding request should continue to address the system needs of the three diseases, but should do so in a way that is cognizant of the short-, medium-, and long-term systems requirements detailed in the National Health Policy or National Health (Sector) Plans.

6.4 Continue to support countries to invest in well-designed and functioning health information systems such as DHIS2 and ensure integration of disease data

To support the achievement of Universal Health Coverage (UHC), including monitoring progress toward elimination of HIV, TB, and malaria, it is essential to support a well-functioning health information system as it provides valuable information for decision-making, monitoring and evaluating program performance, the progress of indicators, and implementing actions that will lead to the achievement of the goal. An information system not only helps to collect health data, but also to improve data quality, monitor procurement, distribution chain, inventories, and much more.

Many countries around the world are using DHIS2 as a tool to move from basic data collection and analysis toward a more robust form of gathering data, analyzing it, and providing information.

Some countries are in the earlier phases of implementing DHIS2. Supporting these countries during the implementation phase will increase their capacity to monitor and evaluate performance and detect possible complications and problems so they can implement corrective actions.

Health information systems create opportunities to expand the impact of the actions taken not just to reach the general population but also hard-to-reach populations to make access more equitable.

Recommendation for applicants:

- Countries should prioritize investments in strengthening their capacity to collect, compile, analyze and use data with the support of a well-designed and functioning health information system such as DHIS2.
- Countries should address the root causes of resistance of vertical programs to integrate their data into a health information system.

Recommendation for the Secretariat and/or partners:

- The Secretariat, through their Country Teams and approval of the funding request, should support investment in information systems. Well-designed strategies and implementation phases should support these investments.

6.5 Inadequate range of indicators, and poor use of existing indicators - to track coverage, outcome, and impact of RSSH investments

Even substantial investments in RSSH usually lack suitable indicators. Where there are indicators, they tend to track coverage, and very rarely cover outcome or impact. In Window 2, investments in

the health information systems were an exception – they did tend to include reasonable indicators to track completeness and readiness of the HMIS.

In public health, we do what we can measure, and high-quality indicators are routinely used in most health programs (90-90-90, cure rates, % sleeping under nets).

RSSH needs to set and require an improved set of a few, well-targeted indicators for system strengthening, not system support. At present, we only have "% of facilities having all tracer drugs." We need objective measures for HR, community systems, resource allocation, and others.

Recommendation for applicants:

- Identify and define a set of measurable, sensitive, valid indicators to measure system strengthening.

Recommendation for the Secretariat and/or partners:

- Some indicators could become standardized and compulsory: for instance, how will a proposed malaria investment measure increased ANC coverage and utilization; how will an HIV investment measure improvement in counseling for adolescent women and promotion of modern contraceptive methods; how well is a TB investment doing to improve a proposed community health worker strategy?

6.6 Interoperability between the siloed information system remains a significant challenge in many countries

This window has seen many countries seek to invest in systems interoperability: a third of all funding requests noted that health information systems interoperability would be addressed during the 2020-2022 funding cycle. Mostly this refers to interoperability between DHIS2 and other data collection tools such as the logistics management information system and laboratory information management systems. This is a positive step that shows a recognition of the problem, and responsiveness to Global Fund guidance, but also highlights the magnitude of the problem of interoperability.

Recommendation for applicants:

- The TRP encourages applicants to include improving systems interoperability in their planned investments.

Recommendation for the Secretariat and/or partners:

- Continue to guide countries to improve interoperability.

6.7 New technologies and innovative ways of delivering services ("digital health") are essential but are often fragmented, leading to concerns about sustainability, interoperability, and confidentiality

The use of new technologies and innovative ways of delivering services, including mobile phone and related technologies offer much promise, particularly in linking community systems into broader health systems. Window 2 saw requests for the digitization of the health system in many countries, across all health system "building blocks":

- Tools for data collection, analysis, and use for decision making and use/implementation of Electronic Medical Records, incl. laboratory system (18 countries)
- Supply chain management and product distribution to the last mile (10 countries)
- Community-based monitoring tools (9 countries)
- Mobile Apps for improving the continuum of care (16 countries)

- Use of social media for HIV prevention or net distribution (14 countries), e-Learning (5 countries), and telemedicine (5 countries)
- Financial management/money transfer (3 countries).

Despite the importance of digital health, the TRP observed many challenges:

Digital health is often considered to be a panacea that can solve all problems, while it is really a component of a comprehensive and systems approach to service delivery.

Very few countries refer to an overarching national digital health strategy or framework. This is essential to manage the proliferation of digital health solutions deployed by different actors, which are often small–scale, disease-specific, and licensed solutions (rather than open-source solutions), which are expensive and might introduce recurrent costs over the years. Often these fragmented systems are not interoperable with other information systems, so their potential is not realized.

Without critical alignment of funding and implementing partners to existing infrastructure and digital eco-system in-country, the Global Fund support risks deepening fragmentation of digital tools and data silos.

In addition, it is rare to find confidentiality adequately addressed in the digital health context.

Recommendations for applicants:

- An overarching national digital health strategy or plan is essential: it should ensure interoperability, security, confidentiality and promote open-source information systems, which are affordable and sustainable.

Recommendation for the Secretariat and/or partners:

- The TRP would like to see significantly more information related to the national digital health context in future applications. The TRP requests that the Secretariat consider making it mandatory for applicants to include as an annex their national digital health strategy, or where there is no such strategy, request a costed roadmap that addresses the main challenges of confidentiality, privacy, respect of data from individuals, connectivity and access to mobile internet, capacities of the health workforce, the market assessment (justification of the selection between open-source solutions versus licensed software's) and a technical assistance plan to reinforce the existing capacity at the Ministry of Health.

6.8 Financial management systems and health financing

Very few funding requests use Global Fund resources to develop national health financing strategies that improve the overall sustainability of health system investments. Similarly, few invest in strengthening general financial management systems to spend it efficiently and accountably.

Of all RSSH modules, financial management systems (FMS) are the least requested in funding requests (24/70 countries include financial management systems as part of their RSSH request, amounting to 2% of the total RSSH funds requested). When it is requested, it is primarily for the benefit of supporting GF grant absorption, fund accountability, and fiduciary risk management (as allowed for in the RSSH guidance).

This small FMS investment focused on supporting GF grant functioning is incongruent with the apparent need countries in the portfolio have for strengthening financial management capacity in the wider health system (as indicated by the frequency of TRP issues/actions raised concerning health systems functions associated with raising, pooling and distributing/releasing funds to finance procurement or the delivery of services, and then to account for spending back to the center).

Overall, the TRP findings from the 2017-2019 reviews are still relevant. The TRP observed then that very few funding requests used Global Fund resources to develop national health financing strategies to improve the overall sustainability of health system investments. The TRP also observed

that there is an insufficient emphasis in funding requests on adequate implementation arrangements for the effective flow of funds and financial management, which presents risks for systems strengthening and sustainability in disease programs. Specifically, although investing in separate financial management arrangements to implement Global Fund grants may lead to better implementation, it does not support financial management capacity for the broader health system.

Overall, the FMS module is delivering very little sustainable value to countries - in terms of financial systems strengthening - as the module is being used to support the delivery of the grants. While there may be some spillover enhancing benefits to the broader health system, the TRP considers these investments to be health systems support targeted at disease program delivery.

Recommendation for applicants:

- Consider financial grant management problems as symptoms of the wider financial systems and consider actions which could address these broader issues to strengthen the whole financial management system

Recommendation for the Secretariat and/or partners:

- Provide clear guidance to encourage the above approaches and consider revising the modular framework to separate financial management support to a GF grant from strengthening more comprehensive financial management systems.

6.9 Private sector provision of health services is critical in many countries, but it lacks regulation and quality assurance, often fails to provide data to the national HMIS, and national attempts to engage with the private sector mostly fail to engage effectively with the many models of private-sector health service

Designing engagement with the private sector and integrating the private sector into national health systems needs to recognize that there is significant variation in contexts - by locality, by type of provider, and by the disease being addressed.

In many countries, the private sector is independent and not organized. In most cases, the government had a weak understanding of the number and type of private providers (both for-profit and not for profit), and the services they deliver.

DHIS2 generally captures public sector data and, in some cases, the not-for-profit private sector (noted in 3 funding requests).

One TB/HIV funding request from Asia noted that about 40% of HIV and TB services are provided by the non-MoH sector, which provided very little data about service quality or quality.

One African funding request indicated that 54% of health services are provided by the private sector – despite repeated attempts, GF funded disease programs have been unable to engage successfully with the private sector to improve quality.

Most countries experience challenges with private sector regulation, coordination, and collaboration for the effective delivery of quality health services.

Recommendations for applicants:

- Develop a detailed private health sector strategy aligned to NSPs, which includes RSSH modules for service delivery, a strategy to improve regulation and quality assurance, and a communication strategy.
- A careful assessment should inform the development of the private health sector strategy of the for-profit and not-for-profit private sector. It should determine the health services, products, and technologies provided, and identify and make recommendations about the

gaps in policies, regulations, finance, and other barriers that constrain their integration into national health systems.

Recommendation for the Secretariat and/or partners:

- Regulation of the private sector is a critical challenge that can only be addressed if regulatory authorities in countries are playing an effective role by implementing rules and policies that are harmonized across both public and private sectors with efficient integrated supportive supervision systems by these authorities. Most regulatory bodies in LICs & LMICs are weak. This is an area in which the Global Fund and partners could consider for investment.

6.10 Proposed procurement and supply chain management (PSM) interventions under RSSH are not sufficiently strategic and are not always informed by broader national PSM plans and strategies.

Funding requests often include vertical PSM interventions along with disease components and perennial last-mile distribution and stock out challenges. However, there are missed opportunities to strengthen both upstream and downstream supply chain integration. Most funding requests did not clearly explain or take an integrated approach to supply chain strengthening, and interventions continue to be primarily disease-specific. For example, most funding requests do not include integrated logistics and last-mile distribution and LMIS and DHIS2 integration.

The application of findings or lessons from the Global Fund Strategic Initiative on Supply Chain Transformation/Integration was not clearly demonstrated in the funding requests.

Stock-outs are an issue raised in most funding requests across all three diseases as well as broader health systems, as described in integrated or stand-alone RSSH funding requests. However, information on supply chain diagnostics or bottleneck analysis is missing in many funding requests.

Funding requests displayed inconsistency in following the RSSH guidance note regarding systems strengthening versus support. For example, disease-specific PSM operational costs were included under RSSH investments (e.g., distribution of commodities including LLINs, antimalarials, mRDTs, the administration fees, the procurement/warehousing and storage costs, the forwarding and clearing agents and the FDA verification fees).

Benchmarking of PSM fees came up in several funding requests. There is also variable use of Wambo and GDF platforms to drive VFM. This is of particular note in highly commoditized funding requests and countries that lack/or have delays in procurement reforms to enable competitive international procurement.

Transitioning procurement of drugs for the disease programs to domestic funding poses a risk of stock-outs and program continuity, especially in cases where co-financing commitments are not honored.

Recommendation for applicants:

- Where stock-outs are described and to be addressed, applicants should refer to information on supply chain diagnostics or bottleneck analysis in the funding request or, where these are not available, include plans for such analysis in the request.

Recommendations for the Secretariat and/or partners:

- The TRP advises the Secretariat to carefully consider if critical program requirements such as procurement of drugs and essential commodities for the disease programs should be tied to co-financing in COEs or countries with a higher risk of not delivering on commitments.
- The Secretariat should engage in a broad benchmarking review of PSM and continue to encourage countries to use Wambo and GDF.

- TRP recommends that GF shares findings from the Strategic Initiative on Supply Chain Transformation and to consider updating the Global Fund RSSH Guidance Note to reflect lessons from the Strategic Initiative.
- The Secretariat could request that country-specific Strategic Initiative progress reports are routinely included in funding request annexes. Previously, TRP found these diagnostics to be very helpful in understanding supply chain issues in the countries.

6.11 A comprehensive, country-led strategy to address human resources for health (HRH) challenges and meet capacity building needs of the essential workforce at all levels of the health system is critical to increase program efficacy and sustainability, optimize the investment, and consolidate health and community systems strengthening.

Funding requests generally identify health system challenges that negatively impact human resources for health (HRH) (e.g., staff shortages, inequitable distribution, high attrition) and the technical skills gaps that affect program performance. However, the proposed solutions do not translate to comprehensive HRH strategies that address the underlying bottlenecks and delivery of technical assistance in a manner conducive to system strengthening.

HRH components are universally under-budgeted and a fraction of the total budget that goes to training, travel, and consultants. Most of the capacity development investment goes to stop-gap approaches that result in fragmented training activities without linkages to HR policies (e.g., career progression, incentives, and others), exclusion of certain cadres, especially at sub-national and community-based levels, and inefficient use of resources.

There is no clear strategy to move from reliance on international short-term technical assistance (TA) to strong, country-based long-term ones that can respond with timely and relevant TA.

The TRP has observed an increased investment in community health workers (CHW) in Window 2 applications. Still, HRH planning and capacity building approaches may not include them or village health volunteers and key population outreach workers across the HIV, TB, and malaria programs. These may have separate training approaches with weak or no linkages to HR policies, as mentioned above.

Even when countries introduce more robust rationale/approaches to capacity building (e.g., accreditation, distance learning), they are isolated and under-budgeted; most of the activities and budget still goes to salaries, training, consultants, and travel.

Recommendations for applicants:

- Treat capacity building as an essential component of systems strengthening, not an appendix to programming. Organize capacity building activities into comprehensive strategies, and TA plans with linkages to HR policies, prioritizing sub-national levels where the essential health workforce – including CHW, outreach workers and volunteers – has limited access to skills development and career development.

Recommendations for the Secretariat:

- Country Teams should work with technical partners to develop bespoke guidance to countries for developing fit-for-purpose comprehensive, measurable, and costed capacity-building strategies and TA plans across the three diseases that will result in sustainable country-based institutional TA providers that can respond quickly to HRH needs with relevance and local resources.
- Future funding request application forms should explicitly request that the applicant submit the capacity building /TA plans with linkages to national HR policies and programs as part of an RSSH response.

6.12 While many countries continue to focus their RSSH funding requests on support for health systems, there are encouraging signs of system strengthening activities emerging

Positive system strengthening activities observed in Window 2 funding requests include:

- Moves to sustainability for CSOs working with key populations:
  - investment in CSO social contracting processes to enable funding from the government budget in the context of transition
  - investment in CSO capacity building for advocacy and fundraising to enable resource mobilization from a variety of sources (national government, international funders, private sector)
  - investment in CSO management and leadership capacities and also for key population groups
- Optimizing national budget for procurement and supply of health products and pharmaceuticals for TB and HIV
- Consideration of pooled procurement through group purchases at the international level via UNICEF, IDA, and GDF.
- Engagement with the private sector: contracting CSOs for key population service delivery; optimizing the efficiency of the supply chain for procurement and supply of health products and pharmaceuticals; widening the pool of providers for detection/diagnosis and treatment of TB and HIV.
- Governance engagement, noting that lack of strategic engagement in decentralization processes will impact services for the three diseases at the local level and if not addressed will ultimately impact negatively on the capacity to maintain service gains.

Recommendations for applicants:

- Applicants approaching transition should start well before, in considering not just the financial sustainability of their programs but also ensuring the necessary regulations and legislation to allow efficient procurement of commodities and services for social contracting, etc.
- To ensure further engagement with the private sector drives more impact, applicant countries will require institutional investments to understand the private sector; to remove legal and regulatory constraints; to facilitate engagement and to establish performance monitoring processes.

Recommendations for the Secretariat and/or partners:

- The Global Fund should carefully consider a country's position on the development continuum and ensure that adequate TA for governance and institutional capacity building is requested at the appropriate stages.

6.13 Overly cautious, and insufficiently strategic, approach to investments in Challenging Operating Environments

The TRP has noted an approach to investments in challenging operating environment (COE) countries that emphasizes problems and what the country cannot achieve.

It would be more helpful to focus on strategic and practical ways to address structural weaknesses that are common in COE countries – for example, prioritizing investments in human resources, governance, coordination, and quality of services.

Recommendations for applicants:

- COE applicants should address as a priority the structures that need to function regardless of the complexity of context: human resources, governance, coordination, and quality of services.

Recommendations for the Secretariat and/or partners:

- The Secretariat is advised to analyze the types of issues that arise in COE countries, and to identify a shortlist of core areas (such as the ones mentioned above) and to develop guidance on relatively simple steps that a COE might take to create robust systems even in their challenging operating environment. This study might take the form of "success stories."

6.14 The urgent need for Global Fund to invest in building resilience and preparedness – and some positive examples

The threat from climate change and emerging pandemics, with consequent interruptions to operations, makes it necessary to build resilience and preparedness. Some examples have emerged:

- Malaria: One African country proposes to utilize the existing rainfall forecasting & tracking system to support planning and preparedness to prevent and control malaria transmission by a timely response to proactively manage cases, treatment, and commodity supplies & adjustment to the timing of the IRS.
- COVID: countries are utilizing available technologies to circumvent the barriers of continued program implementation
- Remote conferencing technology is being used for consultations, meetings, training, and some aspects of supervision. This could reduce travel-related financial costs as well as the opportunity cost of staff downtime from being away from work.
- Use of drones for particular specimen transport - this could be expanded to medication distribution.

Recommendations for applicants:

- This is a window of opportunity to incorporate the three-disease related service considerations into the preparedness planning process to ensure the GF investments and impact are sustained.

Process lessons

6.15 Awkward positioning of RSSH investment requests

At times, RSSH investments seem to be randomly assigned to a disease funding request. The TRP is not convinced that there has been sufficient consultation in-country with local RSSH experts or across the three diseases, leading to rather skewed, not necessarily impactful RSSH investments that are unlikely to benefit all diseases or integrate effectively with other public health programs.

RSSH investment requests, whether as a stand-alone request or as part of a disease funding request, are often not presented at the same time as the other disease funding requests (they are. sometimes in different windows), making it challenging to assess prioritization and completeness of the RSSH investment request supporting all three diseases and other public health programs.

When RSSH investments are requested as part of one disease funding request, RSSH experts have to consult with the other disease programs funding request review groups to ensure that the RSSH request is also addressing RSSH issues in the different disease programs. This may lead to insufficient time available to address the RSSH investment request widely or in-depth.

Tailored-to-NSP applications do not provide a significantly detailed analysis for the basis of RSSH investments. This is usually to be found in the national health sector policies/strategies and may not necessarily be provided with the funding request.

Changing a health system is a longer-term process, and it requires a well-organized approach by the applicant to achieve significant changes within the three-year funding cycle. Generally, successive finding requests should build upon the achievements of previous investments. Unfortunately, the TRP often sees similar or repeated RSSH investments being made in different allocation periods, without reference to earlier investments in the same. The applicant, the Secretariat, and in-country partners must follow up and ensure that previous investments are built on, and reflected in any subsequent funding request.

The current guidance is not sufficient to support countries to determine whether there is a need for a separate stand-alone RSSH request or should be included as part of a combined disease funding request that also includes RSSH.

Often substantial RSSH investments appear in the PAAR where there is a modest chance of being funded: this is a poor strategy to contribute to systems supporting, strengthening, or sustaining the impact of the GF disease program investments.

Recommendations for applicants:

- Applicants are advised to initiate a broader discussion on RSSH issues and prioritization in the country, preferably in a technical working group that includes both disease and health systems experts and that is also held accountable for Monitoring, Evaluation, and Learning of the RSSH investments.
- Countries should all undertake an RSSH landscape analysis to ensure that funding requests reflect prioritized, focused, and complementary RSSH investments, which refer to and are aligned with national health strategic plans and strategies.
- There is a greater need for domestic financing to support health systems, as these will eventually lead to a more robust and sustainable response to the epidemics.
- Disease and RSSH investment requests should be submitted at the same time.

Recommendations for the Secretariat and/or partners:

- Partners are requested to take a more pro-active and accountable engagement in helping the countries to set a significant RSSH agenda, that will be reflected in robust funding requests. This should include the implementation of technical and coordination mechanisms.
- Country Teams should identify an RSSH counterpart (e.g., a department, a TWG, experts) in each country to have more extensive health systems discussions.
- The Secretariat is advised to consider the expansion of the RSSH experts in TAP, with more differentiated systems experts to provide support to the Country Teams.
- The TRP Secretariat is advised to increase the number of RSSH experts in the TRP reviews and allocate additional time for RSSH investments to be reviewed across the different disease/RSSH funding requests.