




EURO HEALTH GROUP

The Global Fund

Strategic Review 2020

Vol 2 - Annexes

Date: 31 August 2020

In consortium with:  itad

In collaboration with: The University of San Francisco 

FINAL REPORT

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Disclaimer: Views expressed in this report are those of the author. The author has been commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to conduct an assessment to provide input into the TERG's recommendations and observations, where relevant and applicable, to the Global Fund. This assessment does not necessarily reflect the views of the Global Fund or the TERG.

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ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent Girls and Young Women
AMR	Antimicrobial Resistance
ART	Antiretroviral Therapy (HIV)
ARV	Antiretroviral Drugs
BDB	Breaking Down Barriers Strategic Initiative
CBO	Community-Based Organization
CCM	Country Coordinating Mechanisms
CDC	The Centers for Disease Control and Prevention
COE	Challenging Operating Environment
COVID-19	Coronavirus Disease 2019
CRG	Community, Rights and Gender
CSO	Civil Society Organization
DFID	Department for International Development
EECA	Eastern Europe and Central Asia
EHG	Euro Health Group
ESA	East and Southern Africa
FLD	First Line Drugs
FPM	Fund Portfolio Manager
FR	Funding Request
GAC	Grant Approval Committee
Gavi	Global Alliance for Vaccines and Immunization
GDF	Global Drug Facility
GMD	Grant Management Division
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	Human Rights and Gender
HQ	Headquarters
iCCM	Integrated Community Care Management
IPT	Isoniazid Preventive Therapy
IPTp	Intermittent Prevention Therapy in Pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
KII	Key Informant Interview
KPI	Global Fund Key Performance Indicator
KVP	Key and Vulnerable Populations

LFAs	Local Fund Agents
LICs	Lower-Income Countries
LMICs	Lower-Middle-Income Countries
LLIN	Long-Lasting Insecticide Nets
M&E	Monitoring and Evaluation
MDR/RR-TB	Multi-drug Resistant/Rifampicin-Resistant TB
MEL	Monitoring, Evaluation and Learning
MENA	Middle East and North Africa
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MSM	Men who have sex with men
MSS	Market-Shaping Strategy
MTR	Mid-Term Review
NCD	Non-Communicable Disease
NFM	New Funding Model
NGO	Non-Governmental Organization
NSPs	National Strategic Plans
OIG	Office of the Inspector General
PAAR	Prioritized Above Allocation Request
PAF	Performance and Accountability Framework
PBO nets	Pyrethroid PBO Nets
PCE	Prospective Country Evaluations
PEI	Partnership Engagement Initiative
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-To-Child Transmission
PPE	Personal Protective Equipment
PPM	Pooled Procurement Mechanism
PRs	Principal Recipients
PSCM	Procurement and Supply Chain Management
PWID	People who inject drugs
RfP	Request for proposals
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSSH	Resilient and Sustainable Systems for Health
SCF	Strategic Cooperation Frameworks
SDG	Sustainable Development Goals
SI	Strategic Initiative

SISF	Strategic Investment and Sustainable Financing
SMC	Seasonal Malaria Chemoprevention
SO	Strategic Objective
SR	Strategic Recommendations
SR2020	Strategic Review 2020
SRH	Sexual and Reproductive Health
SRQs	Strategic Review Questions
SRs	Sub-Recipients
STC	Sustainability, Transition, and Co-Financing
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TERG	The Global Fund Technical Evaluation Reference Group
TG	Transgender
ToC	Theory of Change
ToR	Terms of Reference
TRP	Technical Review Panel
TSR	Treatment Success Rate
TWG	Technical Working Group
UCSF	University of California San Francisco
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
USG	United States Government
VFM	Value for Money
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization

ANNEX 1: RELEVANT SECTIONS OF THE RFP

ATTACHMENT A STATEMENT OF WORK Strategic Review 2020

A. INTRODUCTION

In 2019, the Technical Evaluation Reference Group (TERG), with guidance from the Strategy Committee of the Global Fund Board, will embark on the Strategic Review 2020 (SR 2020). The SR 2020 will assess the outcome and impact of Global Fund investments in HIV, Tuberculosis and Malaria and in building resilient and sustainable systems for health (RSSH). It will also assess the operationalization and implementation of the Global Fund's 2017-2022 Strategy at its mid-term. The main outputs of SR 2020 will provide learning and suggest approaches for strengthening implementation and impact during the remaining period of the current Strategy and for the development of the post-2022 Global Fund Strategy. The recommendations of SR 2020 will consider the evolving global contexts and the resource constraints inherent in the Global Fund's model.

It should be noted that while the main objectives and sub-objectives of the review outlined in table 1 below are reasonably settled, the evaluation questions should be taken as indicative at this point. These will be finalized in discussion with the successful bidder at the onboarding meeting and in the period leading up to the inception report.

Table 1: Objectives and Evaluation Questions of SR 2020

Main Objective 1	To assess the outcome and impact of Global Fund investments in HIV, tuberculosis and malaria and in building resilient and sustainable systems for health.	
Sub-Objectives	Priority areas to cover	Indicative Evaluation Questions
1.1 To assess trends in service coverage and impact by key thematic areas that highlight differences in impact related to geography, population group or other contextual factors.	<ul style="list-style-type: none"> — KPI documentation — HTM service coverage data for the period 2010- 2018, disaggregated where available by key population groups, regions, gender and age, and going beyond key population groups and factors to provide a comprehensive picture of those being left behind. 	<ol style="list-style-type: none"> 1. What are the trends during the period 2010 - 2018 in service delivery, coverage and quality outcomes and impact indicators that can be identified through further disaggregation of Global Fund Key Performance Indicators (KPI's); country data; data modeling; and country case studies, to strengthen understanding of performance against targets? 2. What are the key factors that have enabled and/or hindered achievement of these targets by region, population group, or other contextual factors?
1.2 To assess the performance against service coverage and impact targets of the Strategy at its mid-term, the challenges and root	<ul style="list-style-type: none"> — RSSH indicators and data — Modeling data — Contextual information, e.g. 	<ol style="list-style-type: none"> 3. What are the trends in significant areas that correspond to Strategy sub-objectives that are not directly covered by the KPIs? 4. How appropriate are service coverage targets in the country cases used for this analysis relative to the amount of funds invested by the Global Fund, the government and partners? 5. What progress has been made in strengthening

causes of gaps and slow progress between Strategy targets and projected results.	socio-economic, COE	programmatic assurance to inform trade-off decisions between mitigating fiduciary and programmatic risk so that the grants achieve maximum impact? How can this be improved?
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Main Objective 2		
To provide an independent appraisal of the operationalization and implementation of the Global Fund Strategy 2017-2022 at its mid-term and to suggest approaches for strengthening implementation and impact during the remaining period of the current Strategy.		
Sub-Objectives	Priority areas to cover	Indicative Evaluation Questions
2.1. To assess the extent to which the current funding and business model, policies and strategies, and their operationalization by the Secretariat, position the Global Fund to achieve its Strategy objectives	<ul style="list-style-type: none"> - NFM 2 - KPIs - RSSH - CRG strategies - STC strategies - Partnership strategies - COE strategy 	<p>6. To what extent do the Global Fund's funding model, policies, their operationalization and key Secretariat processes appropriately position the Global Fund partnership to deliver the Strategy's objectives?</p> <p>7. To what extent are the Global Fund's funding model, policies and key Secretariat processes supportive of country priorities (national strategic plans and health sector plans) and able to appropriately influence national health and disease program planning and implementation?</p> <p>8. To what extent have the catalytic investments achieved their aim in catalyzing investments for greater impact?</p> <p>9. How successful has the work undertaken by the Global Fund to enhance grant absorption been in increasing absorption? Are there investment areas where absorption is higher or lower? Has the work to enhance grant absorption led to more quality and impactful programs in-country? What are the barriers to implementation that could affect absorptive capacity and how can these be addressed?</p>
2.2. To critically analyze the efficiency, effectiveness and sustainability of Global Fund investments, including grants, grant management and strategic initiatives.	<ul style="list-style-type: none"> - Disease specific grants - Global commitments to HIV prevention, malaria elimination, etc. - RSSH grants and initiatives - CRG initiatives - CCM evolution - STC initiatives - COE grants - Catalytic investments 	<p>10. Are Global Fund investments (grants and strategic initiatives) focused on the most appropriate interventions to deliver the most impact and the best value for money, in practice and according to country context? How could this be improved?</p> <p>11. To what extent are the Global Fund's procurement mechanisms and market shaping efforts contributing to the value for money of Global Fund investments? How likely is it that any economies and efficiencies that are realized through these efforts, will be sustained post-transition?</p> <p>12. To what extent are Global Fund investments addressing structural barriers faced by programs leading to more effective national program implementation and contributing to national</p>

		<p>outcome targets? In which areas should the Global Fund strengthen its support to address structural barriers to improve program outcomes? Have there been unintended consequences (positive and negative)?</p> <p>13. Is the way that the Global Fund monitors and provides oversight to its investments on a country level adequate, appropriate and done in the most cost-effective way possible? How does this vary across country typologies, e.g. COEs? How could this be improved?</p> <p>14. How effective have the stages of the Global Fund investment and management pathway (incl. the allocation letter, funding request development materials and technical guidance, concept note process, TRP guidance, GAC, reprogramming, evaluation) been in supporting countries to build resilient and sustainable systems for health and in practice delivering impact on the ground? How can they be strengthened?</p> <p>15. How effective have the stages of the Global Fund investment and management pathway been in promoting and protecting human rights (including those of people with disabilities) and gender equality and in practice delivering impact on the ground? How can they be strengthened?</p> <p>16. To what extent are Global Fund investments being designed and implemented most efficiently and synergistically alongside investments through other sectors or areas of health with complementary aims or investment pathways? How could this be strengthened?</p> <p>17. How effective has the Global Fund been in generating sustainable increases in domestic funding and what more can be done to advance this agenda? Is there evidence of Global Fund investments displacing domestic resource allocation for the three diseases?</p> <p>18. To what extent are the programmatic gains supported by the Global Fund likely to be sustained as and when Global Fund investments are reduced and/or completed in countries that are scheduled to transition within the next 10 years? What is the likely consequence for Community Based Organization (CBO)/Civil Society Organization (CSO) activities and for addressing the additional costs related to reaching the 'last mile' for disease elimination? What are the key barriers to sustainability and how can they be addressed?</p>

<p>2.3 To assess the role, enabling factors and barriers to the wider Global Fund partnership in achieving implementation of the Strategy.</p>	<ul style="list-style-type: none"> - Global Fund Partnership Strategy - Strategies, targets and operational plans of technical partners, other external funders, implementing countries and CCMs. 	<p>19. To what extent is the Global Fund's partnership model, as set out in the Partnership Strategy, working as intended at the country level? How can this be strengthened?</p> <p>20. For areas where the Global Fund has only limited influence or less control, what are the enabling factors, barriers and recommendations for actors in the Global Fund partnership for ensuring that grant implementation is supporting achievement of the Strategy and more effective national disease and wider health programs?</p> <p>21. To what extent does the Global Fund use opportunities for collaboration and synergies with other entities at global and country level?</p> <p>22. To what extent are the Strategic Objectives, Global Fund policies and programs aligned with, supportive of and contribute to the Sustainable Development Goals (SDG), Universal Health Coverage (UHC) objectives and as well as with new initiatives such as the global health security agenda and the Antimicrobial Resistance (AMR) initiative?</p>
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The above sub-objectives require both the Main Objective 1 & Main Objective 2 consultant team members to work closely together so that the Main Objective 2 qualitative information can provide context and explanations for the Main Objective 1 quantitative results.

Main Objective 3	To provide recommendations to inform implementation of the remaining phase of the 2017-2022 Strategy and the development of the post-2022 Strategy.	
<p>3.1 To synthesise and recommend, given the limited financial resources available, the possible strategies and approaches the Global Fund should pursue to strengthen achievement of the Strategy, including longer term sustainability and which areas or approaches should be prioritised, differentiated or simplified to maximise outcomes and impact</p>	<ul style="list-style-type: none"> - Based on the learnings from responses to Main Objectives 1 and 2 above. 	<p>23. To suggest key recommendations to strengthen the implementation of the current Strategy and delivery against its outcome and impact targets, including by actors in the Global Fund partnership and by relevant thematic areas (region, population etc.);</p> <p>24. To distill new and emerging themes or drivers of impact against the three diseases and in building resilient and sustainable systems for health that will be critical for achieving the current Strategy, as well as to inform the next Global Fund Strategy; and</p> <p>25. To assess any gaps in the current suite of KPIs in measuring the impact of the Strategy and to suggest any information or indicators that could be used to more comprehensively assess the impact of the Strategy going forward.</p>

B. SCOPE OF SR 2020

Strategically focused evaluation questions have been developed under the three main objectives and sub-objectives of the SR 2020. This was done through the following steps:

- Application of key criteria identified by the TERG, including:
 - Areas of critical strategic importance;
 - Considering the differing pace of implementation of different areas of the Strategy;
 - Availability and quality of existing information; and
 - Implementation status of recommendations from relevant previous TERG reviews.
- Input from Global Fund Secretariat Teams and the Strategy Committee;
- Review and wider discussion by the TERG to identify a comprehensive set of evaluation questions; and
- Approval by the Strategy Committee.

C. APPROACH TO SR 2020 AND METHODS

SR 2020 will be commissioned independently. It will be undertaken as a meta-review and systematic synthesis of secondary data from currently available information sources and those planned up to mid-2020. The information sources will include materials from a variety of sources: TERG-commissioned evaluations and thematic reviews including the Prospective Country Evaluations (PCEs); Secretariat internal evaluations and analyses; Technical Review Panel (TRP) assessments; Office of Inspector General (OIG) audits, advisories and investigations; country disease Program Reviews and other country reviews; modeling and estimation work done collaboratively between the Strategic Information Department of the Global Fund, partners, TERG and others; other materials developed by partner agencies and countries; and relevant areas of the academic literature.

Ten to 12 country case studies will also inform the SR 2020. Additional information needed to fill gaps will be gathered in a judicious manner including focused assessments utilizing the PCE platforms.

The SR 2020 consultants will use a collaborative and consultative approach to ensure a high-quality product with robust findings and recommendations that are ambitious but feasible. The consultants will establish and maintain open communications with key officials of the TERG and the TERG Secretariat, and through them with the Strategy Committee, the Global Fund Secretariat, partners and country stakeholders. The TERG and the SR 2020 consultants will identify and link with other organizations undertaking similar reviews, especially with GAVI, PEPFAR, PMI, WHO and UNAIDS, to facilitate alignment with relevant processes and results reporting. The SR 2020 consultants will report to the SR 2020 TERG steering committee and will be supported by the TERG Secretariat.

Key methods envisaged for SR 2020 include:

1. Document Review

Relevant information sources will be reviewed and analyzed by the consultants. The TERG and its Secretariat are currently identifying relevant data sources that may be required for the SR 2020 including assessing their availability and quality of the data. An online document library of all source material is being developed, which will be provided to the successful consultants at the onboarding meeting. The SR 2020 consultants may also identify other data sources.

2. Key Informant Interviews

Individual interviews will be conducted with key stakeholders best suited to respond to the evaluation questions. The selected informants will ideally be positioned to speak to the four sub-objectives of the Global Fund Strategy, how the Global Fund is operationalizing them, their impact and important areas to consider for the future. Some suggested persons/groups to be interviewed include:

- Global Fund Board and Committee members, TERG members, TRP members, OIG staff, Global Fund Secretariat management and teams;
- Global Fund partner organizations – UN partners, Bi-laterals, 5% partners (e.g. French Government, GIZ BACKUP, USAID), and other international implementing partner representatives;
- Civil Society and other non-governmental organizations; groups at the national and sub- national level;
- Implementers, watchdogs, academia; and
- Others identified by the consultants.

3. Country case studies

- Based on criteria suggested by the TERG, 10 – 12 Global Fund partner countries will be selected for the case studies. These may include SR 2015, SR 2017 and other thematic review case study countries and TERG PCE countries respectively. The final list of countries for case studies will be agreed on between the TERG and the Global Fund Secretariat with input from the SR 2020 consultants;
- Key stakeholders in countries to be interviewed include: Ministries of Health, Finance and Gender/Social Services; other government ministries (at national and sub-national levels as appropriate); community and civil society organizations; country-level principal and sub-recipients, as well as other stakeholders, including but not limited to: Global Fund- related program implementation units, Local Fund Agents, fiscal agents and CCM representatives; disease programme heads and M&E staff; other country-level implementing partners; development partners and UN agencies. Beneficiaries of Global Fund supported programmes will also be interviewed.

4. Consultations

- While the SR 2020 consultants will report to the SR 2020 TERG Steering Committee, a Global Fund Secretariat SR 2020 Working Group comprising Secretariat staff will also assist in facilitating the implementation of the SR 2020. The Working Group will provide guidance on evaluation priorities and planning throughout the Review process while respecting the independence of the TERG in conducting the SR 2020.
- The SR 2020 consultants will discuss with and update the TERG and the Secretariat Working Group on a regular basis on the preliminary findings, analyses and conclusions. The Secretariat Working Group (and other stakeholders within the Secretariat), country stakeholders, the TERG and the Strategy Committee will be consulted in developing the recommendations of SR 2020 to ensure their relevance and that they are disseminated and used.
- The final report will be presented to the TERG. The TERG will present its position on the Review to the Strategy Committee.

D. TIME SCHEDULE AND DELIVERABLES

The SR 2020 consultants are expected to commence work in October 2019. The evaluation will be conducted through August 2020, with a 1st draft report expected in May 2020.

Figure 1: Overview of timelines for SR2020 – left out**Table 2: Detailed timelines and deliverables for SR 2020**

01 June – 30 September 2019	<ul style="list-style-type: none"> • TERG and TERG Secretariat assess data availability and data quality for SR 2020 • Develop and finalize SR 2020 scope and specific evaluation questions
01 August – 18 October 2019	<ul style="list-style-type: none"> • SR 2020 consultant recruitment process <ul style="list-style-type: none"> ○ Develop and publish RFP ○ RFP open for 4 weeks (09 September – 04 October) ○ Select consultants
18 October – 15 November 2019	<ul style="list-style-type: none"> • On-board Consultants • Consultants to develop SR 2020 inception report. • TERG approval
15 November 2019 – August 2020	<ul style="list-style-type: none"> • Conduct SR 2020 including country case studies
Mid-April 2020	<ul style="list-style-type: none"> • Preliminary findings, analysis and key issues for discussion with the TERG and Secretariat stakeholders
End-May 2020	<ul style="list-style-type: none"> • First draft report including draft country case reports
End-June 2020	<ul style="list-style-type: none"> • Slides on SR 2020 to Strategy Committee
End-July 2020	<ul style="list-style-type: none"> • Second draft report
August 2020	<ul style="list-style-type: none"> • Final Report on SR 2020
September 2020	<ul style="list-style-type: none"> • TERG Position Paper on SR 2020
October – November 2020	<ul style="list-style-type: none"> • Presentation to Strategy Committee and Board
November – December 2020	<ul style="list-style-type: none"> • Workshop on SR 2020 with Global Fund Secretariat • Dissemination of findings

ANNEX 2: FULL LISTING OF REVIEW QUESTIONS (PROPOSED AND REVISED)

Module	Original questions from the RfP	Revised questions (only revised questions are listed)
Workstream 1: Achievement of Global Fund Strategic Objectives 1, 2 and 3		
1: Impact/ effectiveness	<ul style="list-style-type: none"> 1: What are the trends during the period 2010 - 2018 in service delivery, coverage and quality outcomes and impact indicators that can be identified through further disaggregation of Global Fund Key Performance Indicators (KPI's); country data; data modelling; and country case studies, to strengthen understanding of performance against targets? 2: What are the key factors that have enabled and/or hindered achievement of these targets by region, population group, or other contextual factors? 3: What are the trends in significant areas that correspond to Strategy sub-objectives that are not directly covered by the KPIs? 12: To what extent are Global Fund investments addressing structural barriers faced by programs leading to more effective national program implementation and contributing to national outcome targets? In which areas should the Global Fund strengthen its support to address structural barriers to improve program outcomes? Have there been unintended consequences (positive and negative)? 	
2: Economy/ efficiency	<ul style="list-style-type: none"> 9: How successful has the work undertaken by the Global Fund to enhance grant absorption been in increasing absorption? Are there investment areas where absorption is higher or lower? Has the work to enhance grant absorption led to more quality and impactful programs in-country? What are the barriers to implementation that could affect absorptive capacity and how can these be addressed? 10: Are Global Fund investments (grants and strategic initiatives) focused on the most appropriate interventions to deliver the most impact and the best value for money, in practice and according to country context? How could this be improved? 11: To what extent are the Global Fund's procurement mechanisms and market shaping efforts contributing to the value for money of Global Fund investments? How likely is it that any economies and efficiencies that are realized through these efforts, will be sustained post- transition? 	

Module	Original questions from the RfP	Revised questions (only revised questions are listed)
Workstream 2: The Global Fund business model		
3: Funding model	<ul style="list-style-type: none"> 6: To what extent do the Global Fund's Funding Model, policies, their operationalization and key Secretariat processes appropriately position the Global Fund partnership to deliver the Strategy's objectives? 7: To what extent are the Global Fund's Funding Model, policies and key Secretariat processes supportive of country priorities (national strategic plans and health sector plans) and able to appropriately influence national health and disease program planning and implementation? 8: To what extent have the catalytic investments achieved their aim in catalyzing investments for greater impact? 14: How effective have the stages of the Global Fund investment and management pathway (incl. the allocation letter, funding request development materials and technical guidance, concept note process, TRP guidance, GAC, reprogramming, evaluation) been in supporting countries to build resilient and sustainable systems for health and in practice delivering impact on the ground? How can they be strengthened? 15: How effective have the stages of the Global Fund investment and management pathway been in promoting and protecting human rights (including those of people with disabilities) and gender equality and in practice delivering impact on the ground? How can they be strengthened? 	<ul style="list-style-type: none"> 6(R): To what extent do the Global Fund's Funding Model, policies, their operationalization and key Secretariat processes (including the allocation letter, funding request development materials and guidance, funding request development process, TRP guidance, GAC approval, grant implementation and grant revisions including Portfolio Optimization) appropriately position the Global Fund partnership to deliver the Strategy's objectives? 14(R): How effective has the Global Fund's Funding Model, its policies and processes (including the allocation letter, funding request development materials and guidance, funding request development process, Technical Review Panel (TRP) guidance, Grant Approvals Committee (GAC) approval, grant implementation and revisions including Portfolio Optimization) been in supporting countries build RSSH and deliver impact on the ground? How can they be strengthened? 15(R): How effective has the Global Fund's Funding Model, its policies and Secretariat processes been (including the allocation letter, funding request development materials and guidance, funding request development process, TRP guidance, GAC approval, grant implementation and revisions including Portfolio Optimization) in: <ul style="list-style-type: none"> protecting human rights, especially with respect to key populations including MSM, transgender (TG), people who inject drugs (PWID), sex workers (SW) and prisoners? promoting gender equality to ensure that the rights of women, men, girls and boys are equitably protected? How can impact in these areas be strengthened?
4: Grant oversight, M&E and risk management	M&E and oversight <ul style="list-style-type: none"> 4: How appropriate are service coverage targets in the country cases used for this analysis relative to the amount of funds invested by the Global Fund, the government and partners? 13: Is the way that the Global Fund monitors and provides oversight to its investments on a country level adequate, appropriate and done in the most 	

Module	Original questions from the RfP	Revised questions (only revised questions are listed)
	<p>cost-effective way possible? How does this vary across country typologies, e.g. COEs? How could this be improved?</p> <ul style="list-style-type: none"> 25: To assess any gaps in the current suite of KPIs in measuring the impact of the Strategy and to suggest any information or indicators that could be used to more comprehensively assess the impact of the Strategy going forward. <p>Programmatic assurance/risk</p> <ul style="list-style-type: none"> 5: What progress has been made in strengthening programmatic assurance to inform trade-off decisions between mitigating fiduciary and programmatic risk so that the grants achieve maximum impact? How can this be improved? 	
5: Partnerships	<ul style="list-style-type: none"> 19: To what extent is the Global Fund’s partnership model, as set out in the Partnership Strategy, working as intended at the country level? How can this be strengthened? 20: For areas where the Global Fund has only limited influence or less control, what are the enabling factors, barriers and recommendations for actors in the Global Fund partnership for ensuring that grant implementation is supporting achievement of the Strategy and more effective national disease and wider health programs? 21: To what extent does the Global Fund use opportunities for collaboration and synergies with other entities at global and country level? 	
6: Sustainability, Transition and Co-Financing	<ul style="list-style-type: none"> 17: How effective has the Global Fund been in generating sustainable increases in domestic funding and what more can be done to advance this agenda? Is there evidence of Global Fund investments displacing domestic resource allocation for the three diseases? 18: To what extent are the programmatic gains supported by the Global Fund likely to be sustained as and when Global Fund investments are reduced and/or completed in countries that are scheduled to transition within the next 10 years? What is the likely consequence for Community Based Organization (CBO)/Civil Society Organization (CSO) activities and for addressing the additional costs related to reaching the ‘last mile’ for disease elimination? What are the key barriers to sustainability and how can they be addressed? 	<ul style="list-style-type: none"> 17a(R): How has the co-financing policy been operationalized, and what have been the successes and challenges of implementation? 17b(R): How effective has the Global Fund been in supporting the move toward increased domestic funding via the co-financing requirement or other efforts? What more can be done to support these efforts? 17c(R): What evidence is there that the Global Fund has affected country-level decision-makers to ensure that Global Fund grants have not displaced domestic resources for health and what measures could the Global Fund take (either singularly or in collaboration with partners) to mitigate this risk? 18a(R): What have been or will be the consequences for community-based organizations (CBOs)/civil society organizations (CSOs)/non-governmental organizations (NGOs) as Global Fund support has been or will be withdrawn? How can

Module	Original questions from the RfP	Revised questions (only revised questions are listed)
		<p>CSOs/CBOs/NGOs be strengthened to ensure that KVP needs are met both currently and in the future?</p> <ul style="list-style-type: none"> • 18b(R): What are the key barriers to programmatic sustainability and how can they be addressed? • 18c(R): What are, have been, and will be the implications of the Global Fund's ability to manage risk as countries transition? • 18d(R): What are the additional lessons learned from the Sustainability, Transition, and Co-financing (STC) Policy and what are its implications for the future strategic direction of the Global Fund?
Workstream 3: Looking forward and strategic positioning		
7: Lessons Learned and Looking Forward	<ul style="list-style-type: none"> • 16: To what extent are Global Fund investments being designed and implemented most efficiently and synergistically alongside investments through other sectors or areas of health with complementary aims or investment pathways? How could this be strengthened? • 22: To what extent are the Strategic Objectives, Global Fund policies and programs aligned with, supportive of and contribute to the Sustainable Development Goals (SDG), Universal Health Coverage (UHC) objectives and as well as with new initiatives such as the global health security agenda and the Antimicrobial Resistance (AMR) initiative? • 23: To suggest key recommendations to strengthen the implementation of the current Strategy and delivery against its outcome and impact targets, including by actors in the Global Fund partnership and by relevant thematic areas (region, population etc.). • 24: To distil new and emerging themes or drivers of impact against the three diseases and in building resilient and sustainable systems for health that will be critical for achieving the current Strategy, as well as to inform the next Global Fund Strategy. 	<ul style="list-style-type: none"> • 16a(R): To what extent are Global Fund investments being designed and implemented most efficiently and synergistically alongside investments through other sectors or areas of health with complementary aims or investment pathways? How could this be strengthened? • 16b(R): To what extent are HIV, TB and malaria services being integrated in efficient, effective, equitable and sustainably delivered packages of health services demonstrating a stepwise movement along a development continuum?

ANNEX 3: PEOPLE MET

People met for forward looking analysis

Name	Position	Organization
Abigail Moreland	Head, Grant Portfolio Solutions & Support, Grant Management Division	The Global Fund
Alain Prat	Sourcing and Supply Chain Team	The Global Fund
Alex de Jonquieres	RSSH focal point	Gavi
Alexandrina Lovita	Technical Advisor, Human Rights, Community Rights and Gender Department (CRG)	The Global Fund
Alexei Sitruk	Specialist Health Product Management, High Impact Africa 1 Department	The Global Fund
Alexey Bobrik	Fund Portfolio Manager Uzbekistan, Eastern Europe and Central Asia Team	The Global Fund
Alfons Van Woerkom	Interim Head Supply Chain Department	The Global Fund
Ali Cameron	Senior Technical Manager, Strategy	UNITAID
Alastair Robb	Senior Advisor of Global Malaria Program (GMP)	WHO
Alwin De Greeff	Fund Portfolio Manager, Latin America and Caribbean Team, Grant Management Division	The Global Fund
Angelica Perez	Manager, Health Product Management, Health Product Management Hub	The Global Fund
Ann Burton	Chief, Public Health Section	UNHCR
Benjamin Loevinsohn	Senior Technical Advisor MNCH, HSS, Technical Advice and Partnerships (TAP) Department	The Global Fund
Bhushan Shrestha	Manager, Health Product Management, Grant Management Division	The Global Fund
Bianca Guarino	Associate Specialist, Applicant Support, Access to Funding Department	The Global Fund
Billy Pick	Vice Chair TRP	TRP
Blanca Gil Antunano Vizcaino	Fund Portfolio Manager, Sri Lanka, South East Asia Team	The Global Fund
Boniface Njenga	Fund Portfolio Manager, Southern Africa Team	The Global Fund
Brian Kanyika	Specialist PHME, High Impact Asia Department	The Global Fund
Bruno Clary	Fund Portfolio Manager, Cameroon, Central Africa Team	The Global Fund
Bruno Viana	Fund Portfolio Manager, Mauritania, Western Africa Team	The Global Fund
Carmen Gonzalez	STC Specialist, LAC team/ Acting FPM Dominican Republic	The Global Fund
Carmen Perez Casas	Senior Technical Manager, Strategy	UNITAID
Caroline Mubangizi	Specialist Health Product Management, High Impact Asia Department	The Global Fund
Casey Downey	Technical Officer at World Health Organization RSSH Focal Point	WHO
Caty Fall	Regional Manager, Central Africa Team	The Global Fund
Christine Perrier	Specialist Health Product Management, Central Africa Team	The Global Fund
Clarisse Mason	WHO, Global Fund Focal Point	WHO
Collins Acheampong	Audit Manager, OIG	The Global Fund
Corina Maxim	STC Specialist, EECA	The Global Fund

Name	Position	Organization
Dardane Arifaj	Manager, Health Product Management, High Impact Africa 2 Department	The Global Fund
Darren Dorkin	Senior Fund Portfolio Manager Ukraine, Eastern Europe and Central Asia Team	The Global Fund
Darwin Young	Specialist, Health Financing Data, Strategic Information	The Global Fund
David Bagonza	Specialist, Health Product Management, South East Asia Team	The Global Fund
David Traynor	Senior Technical Coordinator, Policy and Strategy Community Rights and Gender Department (CRG)	The Global Fund
Dianne Stewart	Head, Donor Relations, Donor Relations Department	The Global Fund
Dorcas Mapondera	External Relations Officer at UNAIDS	UNAIDS
Dorothee Davenet	Manager, Data and Analytics, DASH Team	The Global Fund
Dr Agnes Dzokoto	Senior Specialist, Public Health Monitoring & Evaluation, High Impact Asia Department	The Global Fund
Dr George Ayala	Executive Director, MPact Global Action for Gay Men's Health and Rights; Executive Officer of the Global Forum on MSM & HIV (MSMGF), UNAIDS steering committee	MPact Global Action for Gay Men's Health and Rights
Dr Mubashar Sheikh	Director, Strategic Partnerships & Cross Cutting Coordination, WHO Board Member Global Fund	WHO
Dr. Donald Kaberuka	Chair of Board of the Global Fund; Special Envoy of the African Union on Sustainable Financing for the Union and Funding for Peace in Africa	Global Fund Board
Dr. Obinna Onyekwena	Disease Advisor HIV, TAP Department	The Global Fund
Dr. Patricia Moser	Chair TRP	TRP
Elena Beselin	Team Leader Global Health Funds (GIZ) GIZ board focal point	Global Fund Board
Elin Bos	Fund Portfolio Manager, Lao PDR, South East Asia Team	
Eliud Wandwalo	Head of Tuberculosis, TAP Department	The Global Fund
Emily Hughes	CCM Hub Manager, CCM Hub Team	The Global Fund
Emina Rye- Florentz	Fund Portfolio Manager, Djibouti, MENA Team	The Global Fund
Enkhjin Bavuu	Senior Fund Portfolio Manager, Afghanistan, South East Asia Team	The Global Fund
Eric Fleutelot	Technical director Initiative 5 % – Health Department, major pandemics / 5% Initiative EXPERTISE FRANCE	5% Initiative EXPERTISE FRANCE
Filippo Larrera	Fund Portfolio Manager, Guyana, LAC Team	The Global Fund
Filiz Cengiz	Consultant SI PSM 1_1 Diagnosis and Planning	The Global Fund
Fortunate Mendlula	Project Manager, Strategic Initiatives, SI Coordinating Office	The Global Fund
Freddy Munyaburanga	Specialist Health Product Management, Central Africa Team	The Global Fund
George Korah	Senior Specialist, Health Financing, Strategic Information Department	The Global Fund
George Sakvarelidze	Senior Fund Portfolio Manager, Ethiopia, High Impact Africa 2 Department	The Global Fund
George Shakarishvili	Senior Technical Advisor HSS, TAP Department	The Global Fund

Name	Position	Organization
Gonzalo Penacoba-Fernandez	Sustainability and Transition Specialist, South East Asia team	The Global Fund
Hannah Grant	Senior Strategy and Policy Advisor, Strategy and Policy Hub	The Global Fund
Harinder Janjua	Manager, Strategy Implementation and Project Management, Strategy and Policy Hub	The Global Fund
Harley Feldbaum	Head, Strategy & Policy Hub, Strategy and Policy Hub	The Global Fund
Heather Doyle	Senior Technical Coordinator, CRG Investment Support, CRG Department	The Global Fund
Igor Oliynyk	Specialist, Partnerships & Technical Cooperation, TAP Department	The Global Fund
Iris Semini	Senior Advisor, Health Economics, UNAIDS	UNAIDS
Jack Macallister	Senior Technical Coordinator, Policy and Strategy, Community Rights and Gender Department	The Global Fund
Jacqueline Bataringaya	Senior Manager, Access to Funding and Strategic Initiatives, TRP and GAC Team	The Global Fund
Jacques Le Pape	Chief Financial Officer (Former)	The Global Fund
Janet Ginnard	Director, Strategy	UNITAID
Jessica Jones	Program Officer, Market Dynamics for RMNCH-N and Systems Innovations	The Bill and Melinda Gates Foundation
Jinkou Zhao	Senior Specialist, Monitoring & Evaluation, MECA	The Global Fund
Job Muriuki	Fund Portfolio Manager Iraq, (MENA)	The Global Fund
Joelle Ndikumasabo	Analyst, Financial Data & Management Reporting Financial Controlling Team	The Global Fund
Johannes Hunger	Head, Strategic Information Department, SI Department	The Global Fund
John Ocherro	Senior Fund Portfolio Manager Kenya, High Impact Africa 2 Department	The Global Fund
Joseph Chiu	Representing the Strategy Committee, Advisor to the SC Chair	The Global Fund
Joumana Al Atwani	Fund Portfolio Manager, Eritrea, MENA	The Global Fund
Joyce Witherspoon	Specialist, Data Quality and Use for Program Improvement, MECA Team	The Global Fund
Julia Martins	USAID	USAID
Kate Thomson	Head, Community Rights and Gender Department	The Global Fund
Kathryn Hodson	Head Investigations, Investigations Unit, OIG	The Global Fund
Katja Roll	Head of Health Sector Initiative at GIZ GIZ board focal point (Former)	Global Fund Board
Kevin Albuquerque	Process & User Support Specialist, Data Analytics Processes, and Tools	The Global Fund
Khoudia Diokhane	Specialist Health Product Management, Central Africa Team	The Global Fund
Lee Abdelfadil	Senior Disease Advisor HIV, TAP Department	The Global Fund
Lilian Pedrosa	Fund Portfolio Manager, Jamaica, LAC Team	The Global Fund
Lin Li	Senior Manager, Strategic Sourcing, Strategic Sourcing	The Global Fund
Linden Morrison	Head, High Impact Africa 2 Department, High Impact Africa 2 Department	The Global Fund
Lisa Luchsinger	Multilateral Team Leader at USAID	USAID
Louis Charpentier	Evaluation Adviser, Evaluation Office	UNFPA
Lucrecia Palacios	Fund Portfolio Manager, MENA	The Global Fund

Name	Position	Organization
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Marc Pechevis	Managing director for zeGOgroup, TSM/UNAIDS	UNAIDS
Maria Kirova	Head, High Impact Africa 1 department	The Global Fund
Marie Jn Baptiste	Specialist, Public Health and M&E, MENA	The Global Fund
Marijke Wijnroks	Chief of Staff, Office of the Executive Director	The Global Fund
Mark Edington	Head, Grant Management Division	The Global Fund
Martin Auton	Senior Manager, PR Services, PR Services	The Global Fund
Mathieu Courtois	Sourcing and Supply Chain Team	The Global Fund
Matthew MacGregor	Senior Manager, Sustainability, Transition and Co-Financing, Grant Management Division	The Global Fund
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Ousmane Bocoum	Specialist, Knowledge Management, Program Finance, Program Finance Team	The Global Fund
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Pamela Liyala	Specialist PHME, South East Asia Team	The Global Fund

Name	Position	Organization
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Pedro Alonso	Director of Global Malaria Programme (GMP), WHO	WHO
Peter Olumese	RBM RCSC Co-chair, WHO	WHO
Petra Forsstrom De Leon	Specialist, Ethics and Integrity, Ethics Office	The Global Fund
Philippe Creac'H	Senior Fund Portfolio Manager, Thailand, High Impact Asia Department	The Global Fund
Philippe Francois	Head, Supply Operations, SSC Division Front Office	The Global Fund
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Rahul Singhal	Chief Risk Officer, Risk Management Department	The Global Fund
Raj Long	Deputy Director - Integrated Development, Global Health	The Bill and Melinda Gates Foundation
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Robert Matiru	Director, Programmes, UNITAID	UNITAID
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Sarah Boulton	Global Health Funds Team Leader, Global Funds Department, Department for International Development (DFID), United Kingdom	DFID
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Silvio Martinelli	Head of Access to Funding Department	The Global Fund
Sonia Florisse	Senior Fund Portfolio Manager, Mali, High Impact Africa 1 Department	The Global Fund
Sophie Logez	Procurement and Supply Chain Management Specialist, Global Fund Partnership & Health	UNDP

Name	Position	Organization
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Stephanie Seydoux	Ambassador for Global Health, France and Board member for France	French Ministry for Europe and Foreign Affairs
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Sussann Nasr	Senior Disease Advisor, Malaria, TAP Department	The Global Fund
Tadashi Kanda	Associate Specialist, Financial Data & Management Reporting, Office of the Executive Director	The Global Fund
Tatiana Vinichenko	Senior Fund Portfolio Manager, Eastern Europe and Central Asia Team (EECA)	The Global Fund
The - Phong Nguyen	Senior Manager, Financial Controlling, Financial controlling team	The Global Fund
Thomas Stephen O'Connell	Adviser, Health System Governance, Policy and Aid Effectiveness (HGS) Health Systems Governance and Financing (HGF)	WHO
Tim Poletti	Health Adviser at Australian Agency for International Development	Australian Agency for International Development SC
Tracy Staines	Head Audit, Audit Unit, OIG	The Global Fund
Urban Weber	Head, High Impact Asia department	The Global Fund
Vincent Bretin	Director, Results, UNITAID	UNITAID
Vivian Mathieu	Manager, Performance Delivery Team, Office of the Executive Director	The Global Fund
Werner Buehler	Senior Fund Portfolio Manager, Pakistan, High Impact Asia Department	The Global Fund
Wilson Lo	Specialist PHME, High Impact Asia Department	The Global Fund

ANNEX 4: SUPPORTING MATERIAL FOR FINDINGS

ANNEX 4.I: PROGRESS TOWARDS SO1, AND ENABLING AND HINDERING FACTORS IMPACT (SRQs 1, 2, 3, 12)

This section supplements the main report by providing information on the assessment of progress towards impact (as reported through KPI 1), and progress in scaling up service coverage (as reported through KPI2) disaggregated by region and population group (responding to SRQs 1 and 3); and key enablers and barriers to further strategic progress (responding to SRQ 2 and partially SRQ 12).

PROGRESS AGAINST STRATEGIC OBJECTIVE 1

Overall impact (KPI 1)

Limitations of the Lives Saved as Indicator to Evaluate 2017-2022 Global Fund Strategy

The Global Fund estimates that 9.9 million lives were saved during 2017 and 2018 across Global Fund-supported countries and that the Global Fund and its partners are on track to meet the strategic targets of 29.0 (28.0-30.0) million lives saved between 2017 and 2022. The Global Fund Annual Report states that “The number of lives saved in a given country in a particular year is estimated by subtracting the actual number of deaths from the number of deaths that would have occurred in a scenario where key disease interventions did not take place”.¹ These estimates (both “actual” and what would have occurred – “counterfactual”) are computed by Global Fund strategic partners using different approaches for each disease. For HIV, this includes application of the Spectrum/Goals model for African countries, the AEM model for Asian countries, and Spectrum/AIM for other Global Fund supported countries. For TB, lives saved are derived by applying a standardized case fatality rate to the estimate of incident TB cases and subtracting it from the estimated TB deaths of the same year. Deaths saved from treatment of TB/HIV are removed to avoid double counting. For malaria, lives saved is derived by subtracting the observed number of deaths from malaria from a counterfactual which applies the malaria death rate in 2000 (i.e. before scale up of malaria key interventions) to the population at risk over subsequent years.² Use of Lives Saved to estimate the effectiveness of interventions was originally developed in response to challenges faced by many low- and middle-income countries to reliably estimate mortality.³

Recent publications have critiqued the Global Fund’s use of global progress to evaluate the effectiveness of investments in the Global Fund, and reference a lack of transparency in their methods.⁴ We were not able to examine the individual country-level models used to estimate the number of Lives Saved across Global Fund-supported countries. In this review, we highlight a number of potential issues related to the use of the Lives Saved model as a benchmark for evaluating the Global Fund 2017-2022 Strategy.

The current presentation of Lives Saved across the three diseases is not particularly helpful as a performance monitoring tool. The Lives Saved indicator combines information from HIV, TB and malaria to provide a single estimate across all Global Fund-supported countries. Although presentation of information in this way provides a strong statement as to the potential impact of the Global Fund and its partners on HIV, TB and malaria health outcomes, it has limited utility for the

¹ <https://www.theglobalfund.org/en/methodology/> Accessed 05 July 2020.

² KPI Definitions Methodology_SC06-AFC06.pdf

³ Stegmüller, A.R., Self, A., Litvin, K. *et al.* How is the Lives Saved Tool (LiST) used in the global health community? Results of a mixed-methods LiST user study. *BMC Public Health* **17**, 773 (2017). <https://doi.org/10.1186/s12889-017-4750-5>

⁴ Friebe R, Silverman R, Glassman A, Chalkidou K. On results reporting and evidentiary standards: spotlight on the Global Fund. *Lancet*. 2019;393(10184):2006-2008. doi:10.1016/S0140-6736(18)33055-1.

purposes of monitoring, evaluating grant implementation and improving allocation of resources. Presentation by individual disease within each country could enhance collaboration with disease-specific partners to improve allocation of resources and program implementation. For internal evaluation, the Global Fund provides information to Country Teams on the estimated incidence of each disease, as well as percent change from baseline and percent change needed to meet the Strategy target. Presentation in this format is much more useful to monitor and evaluate progress and to identify key areas for improvement. However, this level of information has not been presented to the Board, thus limiting the effect of this information on future strategic decisions.

There are a number of methodological issues which are likely to reduce the accuracy of estimations on Lives Saved:

Complete models have been developed for a limited number of countries. For each disease, complete GOALS, AEM and TIME models have been developed for only a limited number of countries.⁵ For other countries, either less advanced models have been developed (i.e. Spectrum/AIM for HIV) or the WHO has applied existing models to other countries. Where this is the case, it will be important to support the development of complete models in additional countries in order to more appropriately target and evaluate interventions in these additional countries.

Current models may not consider all appropriate interventions. For malaria, the default Spectrum/LiST model does not include all relevant interventions. For example, for malaria, only IRS, LLINs, case management and SMC are included as default interventions. The program does allow the user to add interventions, but if these are not added systematically in each country then the results will not be comparable across countries. In addition, countries have an incentive to invest in those interventions that are included in the model as these are the only ones that will be measured and lead to improvements in the number of Lives Saved.

Countries may not accurately estimate intervention coverage. For example, the estimates of effectiveness for bed nets assume 100% use of bed nets and no resistance. However, some countries translate this assumption into 100% *utilization* of bed nets where, in many countries, true utilization can be under 50%. In this case, the model would overestimate the use and therefore the effectiveness of the bed nets. It will be important to standardize application of models across countries.

Current models do not fully capture the effect of interventions within important sub-populations. For HIV, different models are used for different countries. The AEM model is used in Asian countries to estimate the effect of interventions in concentrated epidemics. These models require information by key populations and thus provide information on the effectiveness of interventions in these populations. The Spectrum/Goals and Spectrum/AIM models do allow estimation of lives saved within sub-populations, however, when estimating lives saved across an entire country, these models require that the user estimate the contribution toward coverage that each sub-population provides and then summing up (requires that the user add up) the contributions of each sub-population. This approach is computationally intensive and does not allow consideration of overlapping sub-populations. Further, estimation of the size of each key population and service coverage occurs only every few years in each country, may not be methodologically comparable, and often utilizes specific, regional data to extrapolate to the country as a whole. Thus, estimates for these sub-populations may be out-of-date in a given year and inappropriate as longitudinal, national estimates. Given these limitations and singular reliance on the limited, extrapolated data that do exist, the Spectrum/Goals and Spectrum/AIM models, may be too reliant on localized estimates whose limitations and caveats are not fully assessed. Given that key population members and their sex partners now represent the majority (62% in 2019) of new infections, including 28% of new infections in East and Southern Africa and 69% of new infections in West and Central Africa, it will be important to extend these models to include parameters for key populations and their sex partners

⁵https://www.theglobalfund.org/media/8049/corporate_expertpanelhealthimpactinvestmentsmeeting_report_en.pdf, accessed 23 August 2020.

in order to improve these models and allow estimation of the effect of interventions with key populations.

For TB, the Global Fund uses a single case mortality rate across all countries and settings to estimate the number of Lives Saved due to TB interventions. However, case mortality from TB varies across countries and is related to living in poverty, comorbidities (including HIV complicated with other infections), body mass index and undernutrition.⁶ It will be important to refine these estimates in order to better target and evaluate interventions by geography and population (i.e. minors and displaced persons).

Current models do not fully capture the variability in estimates of Lives Saved and may overstate the impact of Global Fund and partner investments. The models used to estimate Lives Saved include many different demographic, epidemiologic and programmatic parameters. Each parameter is measured with error, thus estimation of the number of lives saved also includes a substantial amount of variability. The current strategy target recognizes this variability, as do the models presented to the Board. However, information on this variability was not included in the recent Global Fund Annual Report. The recent Lancet letter noted this as a limitation of and potentially biased presentation of Global Fund results.⁷

Across all models, the effectiveness of each intervention is assumed to resemble efficacy estimates found in the scientific literature AND are assumed to be consistent in all populations, locations and settings. Wide variability has been observed in the adherence or fidelity to interventions, such as adherence to antiretroviral or TB therapy, uptake of prevention interventions. Any variation in effectiveness requires further specification of the model, which may not occur systematically in all countries. This variability introduces error into the Lives Saved estimate.

Estimates of mortality are now more readily available and should provide a more reliable estimation of impact. Finally, models to estimate Lives Saved were originally developed because countries did not have the ability to estimate mortality that made evaluation of interventions difficult. Since development of the initial Lives Saved Tool, other modelling groups have developed tools that estimate mortality from HIV, TB and malaria more directly (i.e. Goals, AEM). Additionally, since 2002 investment in improved HMIS systems has drastically risen, increasing the ability for countries to begin providing more accurate, localized data. It may be appropriate to move to these tools in order to monitor and evaluate the effectiveness of Global Fund investments.

Summary and conclusions. Estimation of Lives Saved is one approach to modelling the cumulative impact of Global Fund, national and partner investments, but is not useful for monitoring and evaluating the improvement of country programs. Limitations in some of the models used to estimate Lives Saved may limit standardization in methods across countries; consideration of all appropriate interventions; estimation of the effect of investments in key populations; and accurate representation of the variability in estimates of the number of Lives Saved. More recently developed models to estimate number of deaths from each disease may be more appropriate to monitor, evaluate and improve efforts to reduce mortality from HIV, TB and malaria in Global Fund supported countries. It will be important to support the development of the most state-of-the-art tools to estimate mortality and/or Lives Saved across all impact and focus countries in order to more appropriately evaluate the impact of Global Fund investments.

New Infections/Cases

The Global Fund estimates that the number of new cases of HIV, TB and malaria declined 7% from 2015 to 2018. This estimate assumes that all countries will meet their Performance Framework targets by 2022. The Global Fund estimates that country programs are at risk of not meeting the

⁶ Anurag Bhargava, Madhavi Bhargava, Tuberculosis deaths are predictable and preventable: Comprehensive assessment and clinical care is the key, *Journal of Clinical Tuberculosis and Other Mycobacterial Diseases*, Volume 19, 2020, 100155, ISSN 2405-5794, <https://doi.org/10.1016/j.jctube.2020.100155>.

⁷ Friebe R, Silverman R, Glassman A, Chalkidou K. On results reporting and evidentiary standards: spotlight on the Global Fund. *Lancet*. 2019;393(10184):2006-2008. doi:10.1016/S0140-6736(18)33055-1.

strategic target of 38% (28-47) 2015 and 2022. Using recent progress from 2015-2017 and drawing a straight line to 2022, new cases would decline by less than 19% between 2015 and 2022.

Methods: Using the approach describe above for change in mortality, we computed change in new cases between 2015 and 2017; estimated change in new cases by 2022 using this progress; and change in new cases between 2015 and 2022 needed to achieve 2022 targets. These estimates only use information for HIV, TB and/or malaria if the Global Fund supports services for that disease in each country.

Results: We estimate that between 2015 and 2017, new cases from HIV, TB and malaria declined 3%; new HIV case declined 41%; new TB case declined 14%; and new malaria cases declined 12% in Global Fund supported countries. Using these estimates, we would anticipate an overall decline in new cases of 12% between 2015 and 2022, a decline in new HIV cases of 41%, a decline in new TB cases of 14% and a decline in new malaria cases of 11%.

Summary and Conclusions: Based on current progress, the Global Fund and its partners are highly unlikely to meet the strategic target of 38% reduction in new cases of HIV, TB and malaria between 2015 and 2022. Current progress suggested that only around 50% of the target will be achieved.

Service coverage (KPI 2)

Box 1 presents a note on our methods used to derive findings in this section.

Box 1: Methods used for the assessment of progress towards KPI 2 targets

Our analysis of progress toward impact (KPI 1) and service coverage (KPI 2) targets compares:

- **Global Fund estimates of the ability to meet Global Fund Strategy targets based on:**
 - **Optimistic projection** is constructed from the PF targets assuming they will be met in all countries for the period for which a target is available. In the absence of a PF target, it is assumed that the PF target for the latest year or the latest results (if target is not available) will be maintained over the remaining period of strategy
 - **Conservative projection** is constructed based on actual results for years for which results are available, and PF targets adjusted for potential under-performance for the remaining years based on recent past grant performance. The low projection is not available for non-modelled indicators. For optimistic and conservative projections, the Global Fund rates progress as 'on track', 'at risk' or 'off track'.
- **Regression analysis of trends in service coverage within a specified cohort of countries**
 - For modelled indicators with a 2022 Strategy target (e.g. 23 million PLHIV on ART by 2022), we used repeated measures analysis to predict the mean and 95% confidence interval in 2022 across the specified cohort of countries. We then multiplied these values by the number of countries in the specified cohort to obtain the predicted value and 95% confidence interval in 2022.
 - For modeled indicators with a cumulative Strategy target (e.g. 22 million VMMC 2017-2022), we took the mean and 95% confidence intervals for the sum of values from 2017 and 2018. We then multiplied these values by the number of countries in the specified cohort and scaled them to correspond to the period of interest (2017-2022).
 - For non-modelled indicators, we used regression analysis to predict values in 2022 for each country. We then tallied the number of countries predicted to mean the target for each indicator, as well as the lower and higher variability bounds.
 - We used raw values for numeric values log transformations of proportions.
 - Where data were not available for all countries, we scaled data wherever possible to match the reported results for 2018.
- **Analysis of trends in service coverage across the entire Global Fund portfolio where data are available (trend projection):**
 - For modeled indicators with a 2022 Strategy target, we assessed progress toward Strategy targets by drawing a straight line between the baseline (2015) and most recent estimates (2018) reported by the Global Fund Secretariat to project progress by 2022. For indicators with cumulative Strategy targets (e.g. 22 million VMMC 2017-2022), we extrapolated Global Fund results from 2017 and 2018 to project progress by 2022.
 - For non-modeled indicators, we used available data for Global Fund-supported countries (UNAIDS for HIV; Global Fund for TB and malaria) to draw a straight line between baseline (2015 for HIV; 2017 for TB and malaria) and the most recent estimate for each country and then tallied the number of countries that met the current Strategy target. We used the same approach as the Global Fund to categorize progress (i.e. 'on track', 'at risk' or 'off track') in our analysis of trends within all Global Fund-supported countries for which data were available.
- **Progress toward 'global plan' targets based on publicly available data and analysis conducted by UNAIDS and WHO.** We used publicly available data and published estimates to assess progress toward global plan targets – i.e. Fast-Track strategy to end the AIDS epidemic by 2030; WHO End TB Strategy; and WHO Global Technical Strategy for Malaria (2016-2030). We assessed trends by drawing a straight line between baseline and most recent results. Because global plan targets do not have ranges, we assess progress as 'on track' if the point estimate met the global plan target and 'off track' if the point estimate did not meet the global plan target.

Actual progress in scaling up service coverage is slower than required to meet the current Global Fund Strategy targets for many indicators, and significantly below needs to end the epidemics by 2030/2035. Per Box 1, for each service coverage indicator included with KPI2, Table 1 presents:

- (1) Global Fund Strategy target;
- (2) Baseline indicator values within the Global Fund portfolio;
- (3) Current progress for the indicator within the Global Fund portfolio;

- (4) Global Fund optimistic projection assessment (i.e. Global Fund estimated ability to meet current Strategy targets based on the assumption that grant targets will be met in all countries);
- (5) Global Fund conservative projection assessment (i.e. Global Fund estimated ability to meet current Strategy targets based on current progress through 2020); and
- (6) SR2020 regression projection (i.e. SR2020 estimated ability to meet current Strategy targets based on trends in service coverage within specified Global Fund-support countries).
- (7) SR2020 trend projection (i.e. SR2020 estimated ability to meet current Strategy targets based on trends in service coverage in all Global Fund-supported countries for which data are available).

Table 1: Service Coverage: Global Fund targets, progress and projections

Disease	Indicator	Global Fund Target (2017-2022)	Global Fund Baseline (2015)	Global Fund Progress (2018)	Global Fund Optimistic Projection	Global Fund Conservative Projection	Regression Projection Global Fund Indicator Cohort	Trend Projection Global Fund Cohort
HIV	% PLHIV know	33/33 countries @ 80% (70-90%)	4 countries	15 countries			21/28 (17, 24)	43/59 countries
	# ART	23 M (22-25)	14 M	18.9 M			24.5 M (19.3, 29.7)	25.4 M
	% ART	78% (73-83)	47%	61.20%			84.1% (64.6, 100.0)	96.7%
	# VMMC	22 M (19-26)	0.5 M	8.1 M			24.3M (-5.5, 54.1)	24.3 M
	% PMTCT	96% (90-100)	77%	83.40%			97.5% (65.0, 100.0)	91.9%
	% ART retention	22/33 countries @ 90% (83-90%)	4 countries	4 countries			10/33 countries (10, 17)	20/64 countries
HIV/TB	% HIV+ IPT	35/35 countries @ 80% (70-90%)	0 countries	0 countries			4/35 countries (2, 5)	5/65 countries
	# HIV+TB on ART	2.7 M (2.4-3.0 M)	0.4 M	0.8 M			2.4 M (0.8, 4.0)	2.4 M
TB	# TB notified cases	33 M (28-39 M)	5 M	10.9 M			32.7 (7.4, 58.0)	32.7 M
	% TB	73% (62-85)	55%	64.4%			74.1% (51.7-100.0)	76.9%
	% TB TSR	99/99 countries @ 90% (88-90%)	18 countries	22 countries			38/76 countries	38/76 countries
	# MDR-TB	920 K (800-1,000 K)	86 M	213.8 K			634.3 K (136.4-1132.1)	641.4 K
	% MDR-TB TSR	33/33 countries @ 85% (75-90%)	1 country (2013)	2 countries			0/15 countries	0/15 countries
Malaria	# LLINS distributed	1350 M (1050-1750 M)	175 M	331.4 M			994.3M (478.4-1510.1)	1183.9 M (498.5, 1807.9)
	# IRS households	250 M (210-310 M)	17 M	19.1 M			191.0 M (30.0, 352.0)	191 M
	% malaria testing	80/80 countries @ 90% (85-100%)	44 countries (2014)	58 countries			35/52 countries	35/52 countries
	% IPTp3	36/36 countries @ 70% (60-80%)	0 countries	0 countries			4/24 countries	4/24 countries

In interpreting these analyses, it is important to note that Global Fund Strategy service coverage targets are lower than global plan targets as they are adjusted based on the expected availability of funding, whereas global plan targets are based on needs to end the epidemic for each of the diseases. For this reason, Global Fund Strategy targets are more likely to be met (and reported as 'on track') than global plan targets. However, Global Fund Strategy targets are also more likely to be reported as 'on track' in the optimistic projection due to the way in which the Secretariat rate progress – i.e. as 'on track', 'at risk' or 'off track' – not based on current actual progress, but an assumption that service coverage targets (which align to Global Fund Strategy targets) will be met for all grants in all countries. Based on historic achievement of Global Fund service coverage targets and most recent progress against current targets, our analysis suggests that this is unlikely.

Our analysis aligns broadly with the 'conservative' projection analysis conducted by the Secretariat. In addition, our analysis within specified Global Fund cohort countries aligns closely with our analyses conducted within the entire Global Fund portfolio. Thus, we have highlighted our

results from regression analyses throughout. Of note, for non-modeled indicators (those for which the Secretariat has not provided a ‘conservative’ projection), almost all are not on track to meet the optimistic Strategy targets, which are noted by the Secretariat as highly aspirational.

For HIV, progress towards service coverage targets is mixed. More specifically:⁸

- **People living with HIV (PLHIV) that know their status:** Globally, the proportion of PLHIV who know their status has risen each year from 71% in 2015 to 81% in 2019, which is not sufficient to meet the global plan target.⁹ The Global Fund Strategy target of 33 countries (100% of cohort) to achieve 80% knowledge of HIV status among PLHIV by 2022 is rated by the Global Fund optimistic projection as ‘at risk’. As of 2018, only 15 (45%) have achieved this. Our regression analyses suggests that 21 of 28 Global fund cohort countries (75%) with available data are on track to achieve – as such, the optimistic projection rating of ‘at risk’ appears appropriate and reflective of broader performance.
- **Treatment:** Globally, ART coverage has increased each year from 49% among PLHIV in 2015 to 67% in 2019 among PLHIV (82% of those who know their HIV status). This rate of progress is sufficient to meet the global plan target for number of PLHIV who know their status on ART but not for ART coverage. This difference is due increases in the number of PLHIV resulting from increases in life expectancy among PLHIV and increases in population in high impact settings. Within 33 Global Fund cohort countries, ART coverage has increased from 14 million PLHIV (47%) in 2015 to 18.9 million (61.2%) in 2018.¹⁰ This progress is ‘off track’ to meet Global Fund Strategy targets for number of PLHIV on ART and ART coverage according to the Global Fund conservative projection. In contrast, our regression analysis projects that within the 33 Global Fund cohort countries, 24.5 million PLHIV will be on ART and ART service coverage will be 84% by 2022. This difference may be due to the fact that the Global Fund conservative projection projects a plateau beyond current targets and thus may be overly conservative.
- **Voluntary medical male circumcisions (VMMC):** In 2017-2018, 8.1 million VMNCs were conducted both globally (15 countries) and in Global Fund cohort countries (14 countries).^{11,12} The Global Fund conservative projections rate this as ‘on track’ to meet the Global Fund Strategy target. Our regression analysis suggests that 24.3 million VMNCs will be conducted between 2017-2022 – as such, the both the optimistic and conservative projection ratings of ‘on track’ appear appropriate.
- **Prevention of mother-to-child transmission (PMTCT):** Globally, 82% of pregnant women with HIV received ART in 2018, while in Global Fund cohort countries this was 83%. The Global Fund optimistic projection rates the Key Performance Indicator 2 (KPI 2) target (96% coverage in 26 countries by 2022) as ‘at risk’ while the conservative projection rates progress as ‘off track’. In contrast, our regression analysis suggests that 97.5% of pregnant women will be on ART by 2022 – as such, even the optimistic projection rating of ‘at risk’ may be overly conservative.
- **ART retention:** Globally, 31 (33%) of 93 countries with available data reported 90% 12-month retention in 2018. The Global Fund optimistic projection rates the KPI 2 target (22 of 33 cohort countries to achieve 90% 12-month retention by 2022) as ‘at risk’. As of 2018,

⁸ Our analysis compares progress against Global Fund Strategy indicators using both the cohort of countries used to calculate KPI2 progress and UNAIDS cohort country data. Global Fund Board Strategy Committee report 2017-2022 Strategic KPI Framework: Proposed performance targets for KPIs 1, 2 & 8, Annex 1: Overview of models and methods for KPIs 1,2 and 8. https://www.theglobalfund.org/media/8057/sc02_er02_annexes_en.pdf, accessed 25 May 2020.

⁹ Currently, 15 (45%) of 33 Global Fund cohort countries and 34 (21%) of 177 UNAIDS cohort countries report achievement of 80% coverage in the number of people who know their HIV status. Information on number of countries reporting for each UNAIDS indicator available at <https://aidsinfo.unaids.org/>, accessed 25 May 2020.

¹⁰ The Global Fund does, however, rate the absolute number of people on ART as sufficient to meet the Global Fund Strategy target of 33 million people on ART by 2022.

¹¹ South Sudan is not included among Global Fund cohort countries and reported 1453 VMNCs in 2018.

¹² VMMC has been a major focus area of the Gates Foundation and PEPFAR, which is the predominant funder.

only 4 (12%) of 33 Global Fund cohort countries report achievement of 90% 12-month ART retention (which is the same as baseline). Our regression analysis projects that 10 of 33 (30%) Global Fund portfolio countries are on track to achieve 90% 12-month ART retention by 2022, suggesting that progress in this area across the portfolio is weaker than currently being reported through the optimistic projection.

- **Isoniazid preventive therapy (IPT):** Globally, 3 (5%) of 66 countries with available data reported 80% TB prophylaxis among HIV patients in care in 2018. The Global Fund optimistic projection rates the KPI 2 target (35 of 35 cohort countries to achieve 80% TB prophylaxis among new patients in HIV care by 2022) as 'off track'. As of 2018, no Global Fund cohort countries have achieved this (same as baseline). Our regression analysis projects that four (11%) of 35 Global Fund cohort countries are on track to achieve 80% TB prophylaxis among new patients in HIV care by 2022.¹³ As such, the rating of 'off track' appears to be appropriate.
- **Viral load:** Although the Global Fund does not currently have a target for suppression of viral load, it is an important indicator of the effectiveness of country-level HIV programs. Globally, the proportion of PLHIV who have suppressed viral load has increased from 41% (35-49) in 2015 to 59% (49-69) in 2019.

For TB, if all countries meet their grant targets (optimistic projection), then most Global Fund Strategy service coverage targets will be met. However, based on current trends (conservative projection and our regression analysis) this appears unlikely. More specifically:

- **Finding missing cases:** Globally, TB case notification has increased from <6 million annually in 2009-2012 to 6.4 million in 2017 and 7.0 million in 2018. However, this progress is still below the target set at the UN high-level meeting on TB to diagnose and treat 40 million cases between 2018 and 2022. The Global Fund Strategy target to increase the number of TB cases notified from 5 million (55% coverage) in 2015 to 33 million (73% coverage) by 2022 is rated by the Global Fund optimistic projection as 'on track'. As of 2018, the number of TB cases notified had risen to 10.9 million (64% coverage), which the Global Fund conservative projection considers 'on track'.¹⁴ This increase has been driven largely by more comprehensive reporting in two high burden countries (India and Indonesia) and significant numbers of missing cases remain in many countries. Our regression analysis projects that 32.7 million people (74.1% of estimated cases) in Global Fund cohort countries will be diagnosed and treated in 2022. This suggests that the rating of 'on track' is appropriate.
- **MDR/RR-TB.** Globally, 316,755 MDR/RR-TB cases were initiated on treatment in 2017-2018. The Global Fund Strategy target to increase the number of MDR/RR-TB cases on treatment from 86,000 in 2015 to 920,000 by 2022 is rated by the Global Fund optimistic projection as 'on track'. In 2017-2018, 214,000 MDR/RR-TB patients were initiated on treatment in Global Fund cohort countries, which is considered through the Global Fund conservative projection as 'off track'. Our regression analysis projects that 634,300 MDR/RR-TB patients will be initiated on treatment in Global Fund cohort countries in 2022, suggesting that the conservative projection rating of 'off track' is appropriate.¹⁵
- **HIV/TB:** Globally, 1.4 million HIV/TB patients were initiated on ART in 2017-2018. The Global Fund Strategy target to increase the number of HIV/TB patients on ART from 0.4 million in 2015 to 2.7 million by 2022 is rated by the Global Fund optimistic projection as 'on track'. In 2017-2018, 0.8 million HIV/TB patients were on ART in Global Fund cohort

¹³ Marsh K, Eaton JW, Mahy M, et al. Global, regional and country-level 90-90-90 estimates for 2018: assessing progress toward the 2020 target. *AIDS* 2019, 33 (Suppl 3): S213-S226.

¹⁴ WHO estimate: 69% treatment coverage in 2018.

¹⁵ WHO estimate is different: 316,755 MDR/RR-TB patients were initiated on treatment in 2017-2018. The Global Fund Strategy target is 920,000 MDR-RR-TB patients on treatment by 2022.

countries, which is considered through the Global Fund conservative projection as ‘at risk’. Our regression analysis projects that 2.4 million HIV/TB will be on ART in Global Fund countries by 2022.¹⁶ This suggests that the conservative projection rating of ‘at risk’ is appropriate.

- **Treatment success:**
 - **Drug-sensitive TB:** TSR is high (85% in 2017) across the 30 World Health Organization (WHO) high-impact countries. However, globally, only 41 (42%) of 197 countries with available data reported 90% treatment success among drug-sensitive TB patients initiated on treatment in 2017. The Global Fund Strategy target to increase TSR to 90% in 99 countries, from a baseline of 18 countries, by 2022 is rated by the Global Fund optimistic projection as ‘at risk’. As of 2018, 22 countries have achieved this. Our regression analysis projects that 38 of 76 Global Fund cohort countries with available data will achieve a TSR of 90% by 2022. This suggests that progress in this area is weaker than currently being reported through the optimistic projection.
 - **MDR/RR-TB:** Globally, overall TSR for MDR/RR-TB is much lower at 53%. Only 21 (14%) of 148 countries with available data have a TSR of 85% or higher among MDR/RR-TB patients who initiated treatment in 2016. The Global Fund Strategy target to increase MDR/RR-TB TSR to 85% in 33 of 33 cohort countries, from a baseline of one country in 2013, by 2022 is rated by the Global Fund optimistic projection as ‘at risk’. As of 2018, two countries have achieved this. Across the portfolio, our trend analysis suggests that none of the 15 cohort countries with available data will achieve the target by 2022. This suggests that progress in this area is weaker than currently being reported through the optimistic projection.¹⁷
- **TB preventative treatment:** Scale up of TB preventative treatment includes IPT for HIV-infected individuals and household contacts of people with TB, including children who comprise 96% of TB-related deaths due to untreated TB. Preventive treatment of household contacts under five years has increased four-fold between 2015 (87,242) and 2018 (349,487). This is not on track to meet the Declaration of the first-ever United Nations High-Level Meeting on TB target of 4 million in 2018-2022.¹⁸

For malaria, if all countries meet their grant targets, then most Global Fund Strategy service coverage targets will be met. However, based on current trends this appears unlikely. More specifically:

- **Insecticide treated nets (ITNs):** Since 2017, 402.9 million ITNs (mostly LLINs) have been delivered globally. The Global Fund Strategy target to increase the number of LLINs distributed from a baseline of 175 million in 2015 to 1.35 billion by 2022 in 63 cohort countries is rated by the Global Fund optimistic projection as ‘on track’. As of 2018, 331.4 million LLINs have been delivered in Global Fund cohort countries, which is considered through the Global Fund conservative projection as ‘at risk’. Our regression analysis projects that 994.3 million nets will be delivered between 2017-2022, suggesting that progress is somewhat weaker than what is currently being reported through the conservative projection. Further, ITN utilization (not captured through KPI 2) remains low and has plateaued at around 50%. However, ITN campaigns are cyclical in nature and many countries have scheduled campaigns for later in the grant cycle. Thus, it is possible that additional scale-up will occur in association with these campaigns.
- **Indoor Residual Spraying (IRS):** Globally, IRS coverage of the population at risk has declined from 180 million (5%) in 2010 to 93 million (2%) in 2018. The Global Fund Strategy target to

¹⁶ WHO estimate: 1.4 million. The Global Fund is on track to meet the strategic target of 2.7 million HIV/TB patients on ART in 2017-2022.

¹⁷ According to the most recent data, only 2 (6%) of 33 Global Fund cohort countries and 21 (11%) of 183 WHO cohort countries have met the Global strategy target of 85% treatment success among MDR/RR-TB patients.

¹⁸ World TB Report, 2019.

increase the number of IRS households covered from a baseline of 17 million in 2015 to 250 million by 2022 is rated by the Global Fund optimistic projection as 'on track'. As of 2018, 19.1 million households received IRS, which is considered through the Global Fund conservative projection as 'at risk'. Our regression analysis projects that 191 million households will receive IRS in 2017-2022, suggesting that progress is somewhat weaker than what is currently being reported through the conservative projection. IRS campaigns are however cyclical in nature and many countries have scheduled campaigns for later in the grant cycle. Thus, it is possible that additional scale-up will occur in association with these campaigns.

- **Intermittent prevention therapy in pregnancy (IPTp).** Globally, receipt of the recommended three doses of IPT has increased from 2% in 2010 to 31% in 2018. The Global Fund Strategy target to increase IPTp coverage to 70% in 36 of 36 cohort countries (from a baseline of 0) by 2022 is rated by the Global Fund optimistic projection as 'off track'. Our regression analysis across the portfolio projects that only 4 (17%) of 24 Global Fund portfolio countries with available data will achieve the target by 2022, suggesting that a rating of 'off track' is appropriate.
- **Malaria testing:** The percentage of patients suspected of having malaria who are seen in public health facilities and tested with either an RDT or microscopy, rose from 36% in 2010 to 84% in 2018. Globally, 51 (76%) of 67 with available data reported 90% or higher tested of malaria suspects in 2018. The Global Fund Strategy target to increase the number of countries testing 90% of malaria suspects from a baseline of 44 countries in 2014 to 80 countries by 2022 is rated by the Global Fund optimistic projection as 'at risk'. As of 2018, 58 countries have achieved this. Across the portfolio, our trend analysis suggests that 35 of 52 countries with available data will achieve the target by 2022. This suggests that progress in this area is weaker than currently being reported through the optimistic projection.
- **Seasonal malaria chemoprevention (SMC):** Although the Global Fund does not have a Strategy target for SMC, it is an effective prevention measure for children under 5-years old in areas of the Sahel sub-region in Africa where *P. falciparum* is sensitive to both antimalarial medications. As of 2018, 19 million children, out of the 31 million targeted had received SMC.¹⁹

Disaggregated progress: HIV

Progress by region

Progress toward HIV impact and service coverage targets differ substantially by region and sub-population. Globally, progress is stronger in settings with more resources (international and domestic), more generalized epidemics and fewer socio-political barriers to prevention, care and treatment.

- **East and Southern Africa (ESA).** International funding for HIV is prioritized to East and Southern Africa, the region with the highest proportion of PLHIV (54%) and the most generalized HIV epidemic (75% of cases in the general population). Since 2010, HIV-related deaths have declined 44%, new HIV cases have declined 28%, and the region has seen substantial progress toward Fast Track 90-90-90 targets (58% viral suppression in 2018).²⁰
- **West and Central Africa (WCA).** West and Central Africa, which have fewer international resources and both generalized (36% general population) and concentrated epidemics (13% key populations; 25% sex partners of key populations) have experienced a 29% decline in HIV-related deaths and a 13% decline in new HIV infections.

¹⁹ WHO World Malaria Report 2019

²⁰ 90-90-90 target is 73% of PLHIV with suppressed viral load.

- **Regions outside Sub-Saharan Africa.** Fewer international resources are targeted toward regions with primarily concentrated epidemics (except in the Caribbean) outside of sub-Saharan Africa. However, domestic resources have increased substantially in many countries. In these regions, HIV-related deaths have declined 20%, and new HIV cases have remained stable since 2010.
- **Eastern Europe and Central Asia (EECA), and Middle East and North Africa (MENA).** These regions continue to experience increases in HIV-related deaths and new HIV cases (9% and 5% increase in HIV-related deaths respectively; 10% and 29% increase in new HIV cases respectively). These regions are also far behind in achieving epidemic control and Fast Track 90-90-90 targets (29% and 27% viral suppression among PLHIV respectively).

Progress among populations

Pregnant women and children (0-14 years). Substantial progress has been made in reducing HIV-related deaths and new HIV cases among children, however they still lag behind in access to antiretroviral treatment. Since 2010, HIV-related deaths among children have declined 52% while new HIV infections have declined 41%. However, testing of infants within two months of birth (59%) and treatment of children 0-14 years (54%) lag behind diagnosis and treatment of adults.²¹ Intensive efforts in several countries in East and Southern Africa have improved treatment of pregnant women (91%) and children 0-14 years (61%). These improvements have not yet been achieved in West and Central Africa (treatment of pregnant women, 59%, and treatment of children, 27%)²². [iii]

Adolescent Girls and Young Women (AGYW)

- **Prevention.** Globally, significant progress has been made in preventing transmission of HIV to AGYW and in engaging HIV-infected AGYW in HIV testing, care and treatment. New HIV infections among AGYW have declined over time (25% from 2010 to 2018) but not as quickly as among older women. Current progress varies by region and is far behind the global target. *AGYW remain at substantially increased risk of HIV acquisition compared to their male peers.*
- **Knowledge of HIV status.** Knowledge of HIV status among women (data not available for AGYW) has increased over time and is approaching 90% due primarily to testing within PMTCT. However, this varies substantially by region and reflects disparities in implementation and social context.²³ ART prescription and subsequent viral suppression have not progressed as quickly and remain substantially below the international target of 90 percent across most Global Fund regions.
- **Investments in AGYW.** In contrast to observed progress in testing, care and treatment, overall investments in HIV prevention have decreased over time (except in the Middle East and North Africa), and Global Fund investments in HIV prevention have also decreased. Although investments in prevention specifically for adolescents make up an increasing proportion of overall investments in HIV prevention, the amount of Global Fund investment toward prevention of HIV among adolescents has not changed over time. Thus, because funding does not correlate with progress, it is not clear that Global Fund-supported prevention programs targeted to AGYW significantly contribute to observed progress.

Men

- **Knowledge of HIV status.** Disaggregated 90-90-90 targets, by male and female, show that targets set for men are less likely to be achieved (e.g. men are less likely than women to know their HIV status (75% vs 84%), receive HIV treatment (74% vs. 81%) or achieve viral

²¹ Knowledge of status = 79% and treatment = 62% in adults ≥ 15 years, UNAIDS 2019.

²² PEPFAR investments in PMTCT have decreased in the last few years, and relatively modest increases in support for pediatric treatment.

²³ UNAIDS We've Got Power, 2019

suppression (85% vs 87%). These differences also vary by region. Knowledge of HIV status among men is substantially lower than among women in EECA, the Caribbean, and WCA. In contrast, men are more likely to be on treatment in EECA and MENA. In LAC, testing, treatment and viral suppression were similar among men and women.²⁴

Key and Vulnerable Populations (KVPs)

- **HIV incidence and prevalence.** Globally, more than half of new infections are among members of key populations (men who have sex with men, people who inject drugs, prisoners, sex workers and transgender people) and their sexual partners. Members of key populations are 12 to over 22 times more likely to acquire HIV compared to the general population. Although it is difficult to track trends in HIV prevalence due to the infrequent nature of bio-behavioral surveys, HIV prevalence has remained relatively stable across all KPs since 2010 with a higher rate in east and southern Africa, highest among sex workers (34%).
- **Prevention Programs.** Prevention programs have been implemented in all regions among men who have sex with sex workers and men who have sex with men (MSM) and in some regions for people who inject drugs (PWID) and transgender persons. However, the comprehensiveness and coverage range widely (from 26% to 77% coverage, respectively) across regions and key populations.
- **Knowledge of HIV status.** Despite inconsistent implementation of prevention programs, knowledge of HIV status and treatment coverage has increased rapidly in many settings over the past few years. In 2018, knowledge of HIV status among KPs ranged between 62% among PWID to 72% among MSM and sex workers. Generally, knowledge of HIV status is lower in Asia and the Pacific and in ESA, except among sex workers.
- **Treatment Coverage.** Similarly, in 2018, treatment coverage ranged between 53% among transgender (TG) persons and 75% among MSM. Treatment coverage varies widely across countries and regions but is lower among PWID and higher among prisoners across regions.

Disaggregated progress: Tuberculosis

Progress by geographic area

Incidence & mortality. Incidence and mortality from TB vary dramatically across countries. Worldwide, 30 high impact countries represent 87% of annual TB cases and eight countries account for two thirds of the global burden of TB: India (27%), China (9%), Indonesia (8%), the Philippines (6%), Pakistan (6%), Nigeria (4%), Bangladesh (4%) and South Africa (3%).

- **Africa.** Africa has experienced declines in deaths from TB that approach 2030 elimination targets and declines in new infections that meet 2030 elimination targets.

All other regions have experienced less progress in reduction of deaths from TB and new TB cases and are not on track to meet 2030 elimination targets. Seven countries (Kenya, Lesotho, Myanmar, the Russian Federation, South Africa, Tanzania and Zimbabwe) are on track to meet both mortality and incidence targets.

- **Variable diagnosis and treatment progress by country and region.** Progress achieved on diagnosis and treatment of TB also varies across countries. Ten countries account for 80% of missing TB cases; India, Nigeria, Indonesia and the Philippines account for more than half. Worldwide, approximately 69% of estimated cases receive treatment each year. Countries in three regions have achieved treatment coverage of at least 75%. These include the Americas,

²⁴ Marsh K, Eaton JW, Mahy M, et al. Global, regional and country-level 90-90-90 estimates for 2018: assessing progress towards the 2020 target. *AIDS* 2019, 33:S213-S226.

Europe and the Western Pacific. Four countries have achieved treatment coverage of at least 80%: Brazil, China, Russia and Zimbabwe.

- **MDR/RR-TB.** The gap in appropriate diagnosis and treatment is substantially wider for MDR/RR-TB where only 32% of estimated cases are diagnosed and treated. Ten countries account for 75% of missing MDR/RR-TB cases. These include China, India, Indonesia, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, the Russian Federation and Vietnam.

Progress among populations

Gender, age differences. As diagnosis and treatment of TB improves worldwide, many regions are experiencing an aging of their TB epidemic (the highest number of estimated cases occur among adults over 65 years) including in Eastern Mediterranean, Southeast Asia and Western Pacific. In other regions, incidence is higher among adults aged 35-54 years. Worldwide, adult men are overrepresented in the number of new TB cases (57%) compared to women (32%) and children (11%). The male: female ratio varies widely across countries (range = 1.3-2.0). However, men do not appear to differ with respect to TB diagnosis (58%) or death from TB (55%) compared to women (34% and 31%, respectively). In contrast, although children do not appear to be at increased risk of acquiring TB (11% of new TB cases), they are less likely to be diagnosed (8% of diagnosed cases) and more likely to die (14% of all deaths from TB; 96% of deaths due to untreated TB) compared to adult TB patients.

HIV/TB. Among all new TB cases, 8.6% occur among PLHIV. Scale-up of diagnosis and treatment of HIV/TB co-infected individuals has been quite successful, particularly in Africa. In 2017, approximately 410,000 HIV/TB co-infected patients were on ART. The Global Fund rates this as on track to meet the 2017-2022 Global Fund strategy target of treating 2.7 million HIV/TB co-infected patients with ART.

Disaggregated progress: Malaria

Progress by region

High Impact Countries

- **Case detection.** There were about 155 million malaria cases in the 11-high burden to high impact (HBHI) countries in 2018, compared with 177 million in 2010, 12.4% difference. The Democratic Republic of the Congo and Nigeria accounted for 84 million (54%) of total cases. Of the 10 highest burden countries in Africa, Ghana and Nigeria reported the highest absolute increases in cases of malaria in 2018 compared with 2017. The burden in 2018 was similar to that of 2017 in all other countries, apart from in Uganda and India, where there were reported reductions of 1.5 and 2.6 million malaria cases, respectively, in 2018 compared with 2017.
- **Mortality.** Malaria deaths reduced from about 400,000 in 2010 to about 260,000 in 2018, the largest reduction being in Nigeria, from almost 153,000 deaths in 2010 to about 95,000 deaths in 2018.
- **LLINs.** By 2018, in all of the 11 HBHI countries, at least 40% of the population at risk were sleeping under long-lasting insecticidal nets (LLINs), the highest percentage being in Uganda (80%) and the lowest in Nigeria (40%). East and Southern Africa has experienced a greater positive change in coverage than West and Central Africa.
- **IPTp.** Only Burkina Faso and the United Republic of Tanzania were estimated as having more than half of pregnant women receiving three doses of intermittent preventive treatment in pregnancy (IPTp3) in 2018. In Cameroon, Nigeria and Uganda, the estimated coverage was 30% or less.

- **SMC.** The main gaps in SMC coverage in 2018 were in Nigeria (70%, 8.4 million), Chad (67%, 1.8 million), Ghana (66%, 0.7 million), Senegal (100%, 0.7 million) and Gambia (47%, 0.1 million). All targeted children received treatment in Cameroon, Guinea, Guinea-Bissau and Mali.
- **Pediatric Treatment.** The percentage of febrile children under 5 years who sought treatment varied from 58% in Mali to 82% in Uganda. In the Democratic Republic of the Congo and Mali, more than 40% of children were not brought for care at all. Testing was also worryingly low in children, with 30% or less being tested in Cameroon, the Democratic Republic of the Congo and Nigeria.

Elimination countries

Globally, the elimination net is widening, with more countries moving towards zero indigenous cases.

- In 2018, 49 countries reported fewer than 10,000 cases, up from 46 countries in 2017 and 40 countries in 2010. The number of countries with fewer than 100 indigenous cases – a strong indicator that elimination is within reach – increased from 17 countries in 2010, to 25 countries in 2017 and 27 countries in 2018.
- Paraguay and Uzbekistan were awarded WHO certifications of elimination in 2017, with Algeria and Argentina achieving certification in 2018. In 2018, China, El Salvador, Iran, Malaysia and Timor-Leste reported zero indigenous cases.^{25,26}

One of the key Global Technical Strategy milestones for 2020 is elimination of malaria in at least 10 countries that were malaria endemic in 2015. At the current rate of progress, it is likely that this milestone will be reached.²⁷

In the six countries of the Greater Mekong subregion (GMS) – Cambodia, China (Yunnan Province), Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam – the reported number of malaria cases fell by 76% between 2010 and 2018, and malaria deaths fell by 95% over the same period. In 2018, Cambodia reported no malaria related deaths for the first time in the country’s history.

Progress by specific population

Pregnant Women

In sub-Saharan Africa regions with moderate to high malaria transmission, prevalence of exposure to malaria infection during pregnancy was estimated as 29% in 2018. There were disparities in LLIN and ITN use among pregnant women across countries. While over 75% of pregnant women slept under ITNs in Mali, Benin and Mozambique, this value was below 50% in many countries. It was lowest in Angola (23%) and Zimbabwe (6%). As mentioned, IPTp3 coverage has increased from 2% in 2010 to 31% in 2018, with variations across countries.

Children under Five

²⁵ Global Fund Result Report, 2019.

²⁶ WHO grants a certification of malaria elimination when a country has proven, beyond reasonable doubt, that the chain of indigenous transmission has been interrupted nationwide for at least the previous 3 consecutive years. In addition, a national surveillance system capable of rapidly detecting and responding to any malaria cases must be operational, together with an appropriate programme to prevent re-establishment of transmission. <https://www.who.int/malaria/news/2018/uzbekistan-certified-malaria-free/en/>, accessed 25 May 2020.

²⁷ In 2016, WHO identified 21 countries with the potential to eliminate malaria by the year 2020. WHO is working with the governments in these countries – known as “E-2020 countries” – to support their elimination acceleration goals. Although 10 E-2020 countries remain on track to achieve their elimination goals, Comoros and Costa Rica reported increases in indigenous malaria cases in 2018 compared with 2017.

Children aged under 5 years are the most vulnerable group affected by malaria. From 2000 to 2017, malaria mortality in children under five has decreased significantly, although in 2018, it accounted for 67% (272,000) of all malaria deaths worldwide. Despite these alarming mortality figures, ITN coverage for children under five *increased* greatly in this period, although one in four children in sub-Saharan Africa are still living in a household without any protection from an ITN or from IRS.²⁸

Between 2015 and 2018, a median of 64% of febrile children globally were taken to a trained medical provider, of which 76% received a diagnostic test before antimalarial treatment in the public health sector – an increase from 38% in 2010. We notice, however, an important discrepancy in treatment coverage between facility-based and community health care workers: 47% of children taken to a public health care facility received antimalarial drugs compared to 59% who visited a community health worker suggesting a potential over-treatment of children by community health workers.

Barriers to progress against Strategic Objective 1

Drawing on the findings from the SR2020 cases studies conducted to date²⁹ as well as documents reviewed, we have identified enablers, challenges and approaches which factor into the disease response across the Global Fund portfolio. Continuing challenges include weak health systems, poor progress on human rights and gender discrimination, and resourcing. The continued presence of these barriers reflects negatively on progress made against Strategic Objectives 2, 3 and 4. Our assessment of progress against these Strategic Objectives is further elaborated in subsequent sections of this report.

We present our analysis of factors that enable and hinder progress on the three diseases by sub-categories of prevention, treatment and diagnosis followed by factors that are cross-cutting, related to health systems; socio-cultural, environmental and political; and resource mobilization and allocation.

HIV

Enablers and challenges in HIV prevention, treatment and diagnosis:

Prevention: Factors enabling progress include scale up in treatment for PLHIV which is useful in decreasing transmission; Scale up of “medicalized” prevention programs in some settings - PMTCT, harm reduction, PrEP, self-testing, and VMMC (with PEPFAR and BMGF funding). Micro targeting of priority KPs, increased use of differentiated prevention/service delivery approaches, including community-based approaches. Higher numbers of PWID and MSM are being reached, tested and served.

Hindering: KP prevention coverage still low (less than 50% of 195 UNAIDS reporting countries have prevention strategies in place for sex workers and their clients, MSM and AGYW), harm reduction package coverage very low, OST coverage low, [Consistent with global data - less than 50% of key populations are reached with combination HIV prevention services in more than half the countries that report it to UNAIDS in 2018.³⁰ Harm reduction package are provided at scale in only a few countries. Only 14% of all people who inject drugs have access to effective opioid substitution

²⁸ Alonso P. Recent changes in malaria epidemiology at the World Health Organization Malaria Vaccine Research and Development Consultation. Presentation at MALVAC, 15 – 16 July 2019. 20 Pryce J et al.

²⁹ As 5/11 case studies still remain to be completed due to covid19, this summary can be considered as illustrative but not yet comprehensively reflecting SR2020 case material

³⁰ UNAIDS (2019) Communities at the centre. Global AIDS update. 2019

therapy.^{31]} PrEP scale-up still limited - challenges include acceptability, continuation and delivery model as well as price, in the context of competing priorities³² (PrEP usually ends in PAAR). Low condom utilization and lower comprehensive knowledge on HIV prevention - relatively less money goes to the non-medical prevention programs safe sex education, communication on the HIV epidemic and condoms. Continuing infections among infants despite progress on PMTCT.

Weaknesses in the PMTCT cascade - pregnant women living with HIV are not diagnosed or not offered ART during pregnancy; mothers discontinuing treatment before delivering their babies or finishing breastfeeding; need to monitor pregnant woman's viral load to prevent transmission.

Treatment: Factors enabling progress in treatment include increasingly simple, less costly, better tolerated and more effective ARVs; generic manufacturing at the global level, enabled by license transfer from originators and WHO Pre-qualification to assure quality and competitive pricing; test and treat strategies which enable earlier treatment initiation and reduce LTFU; multi-month prescriptions which reduce load on health system and promote adherence; increased use of differentiated service delivery approaches, including community-based approaches; Integrated package of services, decentralization of HIV testing - ART TB and PMTCT services into Primary Care health facilities. Better integration of TB and HIV programs and improved information systems. Increase in PLHIV receiving IPT in some settings.

Hindering factors include adherence to daily life-long ART variable amongst population groups [globally, compliance is lower for some population groups including adolescents and pregnant and breastfeeding women³³. Up to one-third of people on ART interrupt ART³⁴.] Challenges to maintaining high level adherence includes stigma, travel, side effects, and health systems issues such as stock outs. Risk of opportunistic infections; limited access of children to ART and sub-optimal formulations; difficulty to buy pediatric ARVs if market is small. Challenges of country adoption and transition from older regimens; high cost of second- and third-line drugs, patent coverage for new products. Increased requirement for pharmacovigilance to monitor ADR as newer ARVs are introduced and scaled up.

Viral load monitoring enabling factors: large investments in molecular testing capacity and increased VL coverage; VL tests being procured more affordably due to the Global Fund and partnership work to make the market for viral load testing more competitive and transparent; point of care testing offering potential for increased access to underserved areas/groups, quicker turnaround time and reduced LTFU but at a higher price.

Hindering: In LMICs only ~ 30% globally of people on treatment have access to viral load tests³⁵; approaches for procurement of diagnostics including transparent and inclusive pricing had been problematic affecting VL scale up and maintenance budgets; utilization hampered by lack of investments in complementary assets; Testing and turnaround times for diagnostics challenged by sample delivery logistics challenges; limited coverage of infants and children; existing tools not adequately deployed, underutilization of multi disease tools.

Early infant diagnosis (EID) enabling: progress has been made in scaling-up access to EID in many countries. Hindering: countries such as Angola Burundi Chad the DRC and Nigeria continue to EID coverage rates below 15%.³⁶ Key challenges are the access to a timely result and timely linkage to treatment; infants can wait up to set several months to receive their results and this delays the

³¹ UNODC (United Nations Office on Drugs and Crime). Ending AIDs by 2030 for and with people who use drugs.

³² PrEP uptake is largest in Kenya, South Africa Zimbabwe and Uganda – see CHAI Market Report Issue 10 September 2019

³³ Bailey H et al (2018) HIV treatment in pregnancy. Lancet HIV

³⁴ People's COP19. Communities priorities. South Africa, 2019

³⁵ Although there is variation between countries - e.g. South Africa, Namibia, Kenya, and Uganda report VL testing among >75% of individuals on ART each year - see Lecher S, Ellenberger D, Kim AA, Fonjungo PN, Agolory S, Borget MY, et al. Scale-up of HIV Viral Load Monitoring—Seven Sub-Saharan African Countries. 2015

³⁶ Essajee et al. (2017) Scale-up of early infant HIV diagnosis and improving access to pediatric HIV care in global plan countries. JAIDS.

initiation of treatment; limitations of laboratory-based EID networks that rely on sample transport – many infants LTFU due to long turnaround times for test results.

HIV testing enabling: Increase in differentiated testing including provider-initiated testing, community- based testing, index testing and self-testing. HIV self-testing was introduced and scaled in 6 SSA countries. As of 2018, 77 countries reported having a national policy for HIV self-testing and 47 indicated policy was under development.³⁷ By 2018, 2.3 million HIV self-tests had been distributed in 6 SSA countries, reaching many young people and first-time testers.³⁸

Hindering: 21% of estimated people living with HIV are still unaware of their status³⁹; testing coverage remains even lower in key populations which account for nearly half of new HIV infections; testing rates remain low among men, adolescents and young people; HIV self-testing uptake is limited outside a few countries.

Other factors enabling and hindering the HIV response include factors at the health system level as well as factors external to the health system – environmental, social, and political and resourcing challenges:

Health systems: Hindering factors are siloed service delivery models, insufficient involvement of communities - reliance on facility based approaches not adequately addressing KP needs; lack of tailored response to high-risk groups, Inadequate data and size estimates on recognized key populations; suboptimal use and flow of data and information for adequate monitoring and strategic targeting, Slow shift from blanket approach to better stratification and targeting of investments and strategies to KP groups and geographies; Reaching potential of polyvalent diagnostic tools for multi disease targets enabled by improved health system integration; sample transport logistical challenges; human resource constraints. Stock outs of ARVs, and diagnostic supplies. General health system and capacity weaknesses affecting service coverage, quality and use of service among regions, socioeconomic groups, age groups and sexes.

Structural: Enabling: Multi-sectoral responses. Introduction of reforms to improve the human rights environment.

Hindering: Conflict and deteriorating security situation, large number of refugees result in restricted access to conflict areas and hazardous conditions for healthcare providers, limited services; Cultural denial of existence of some KPs and of their vulnerability to HIV; stigma discrimination and violence (highest in WCA and MENA); human rights violations; criminalization of sex work and same sex acts (varies across countries, some with 14 years to life imprisonment and some with death penalty); legal barriers to care; limited mechanisms to promote justice for KPs (e.g. legal aid, rights training for KPs, health workers and police training on human rights and discrimination).

Resource mobilization and allocation: enabling: Government commitment to the HIV response. Sustained financial investment from partners. Increased government domestic funding. Co-ordination between PEPFAR and Global Fund programs to ensure efficient geographic coverage and service synergy. Elimination of user fees for HIV-positive patients.

Hindering: As noted above, the majority of new HIV cases occur worldwide and in almost all regions occur among key populations and their sex partners however allocation of resources for prevention, diagnosis and treatment does not currently reflect the distribution of burden of disease -in 2019, key population interventions comprise 7.2% of Global Fund budgets. Other hindering factors with regard to resources include: failure of government to fulfil co-financing commitment resulting in ARV stock-

³⁷ Unitaaid and WHO (2019) Market and technology landscape. HIV and HCV rapid diagnostic test for self-testing, 5th edition.

³⁸ Ingold et al. (2019). The Self-testing Africa (STAR) initiative: accelerating global access and scale-up of HIV self-testing. JIAS 2019 Mar;22

³⁹ WHO (2015) Consolidated guidelines on HIV testing services. <https://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>

outs; insufficient domestic investment at a time when interventions to control or end epidemics are increasingly expensive. Competing priorities for limited funds.

Table 2: Selected SR2020 case study factors enabling and hindering progress HIV disease impact

<p>Eswatini is on track to achieve the fast-track targets (even super-fast track 95-95-95) with All age cascade data of 92/93/94⁴⁰. However, achieving the targets will not end the epidemic as there is a need to reach the last 15% for testing. Moreover, there is inequity in coverage of HIV services among populations (key pops in particular – MSM and FSW).</p>	
<p>Factors enabling success: Policy: Large scale expansion of HIV testing and ART services can help explain programmatic achievements. Multi-sectoral response is led and coordinated by NERCHA; Integrated package of services, local responses to micro-target priority and key pops, using data for local response; good coordination at local level, hold stakeholders accountable; Provider initiated testing, community based testing and index testing, self-testing (STAR initiative) 72,000 kits by 2020; test and treat policy in October 2016 & community ART in June 2016; decentralization of HIV testing, ART, TB and PMTCT services into Primary Health care facilities in all the regions; Government commitment to the HIV response has been long sustained and is embedded in domestic financial planning; Significant and sustained financial investment/commitment to the diseases by Global Fund and PEPFAR; Strong NSF; PEPFAR & Global Fund aligning and consolidating approaches to achieve epidemic control; active community-led outreach, albeit with opportunities to improve efficiencies, hot spot mapping and targeting.</p>	<p>Challenges: Men, youth and key populations (sex workers and MSM) still lag behind; 71 percent of MSM were unaware of their HIV status; difficulties with client retention, with marked differences between regions; VMMC program reached only 50% of the target; less than 50% in the 15-29 year olds; High levels of GBV and women need a man's permission to access SRHR services – 35% of women are HIV+; some activities slowed due to need to co-ordinate with PEPFAR; 17 facilities had a stock-out of at least one ARV in the preceding 12 months against a target of 0; only 30% of pregnant women know their status; need to scale up VL testing; need to strengthen PMTCT interventions; due to the small scale of pediatric ARVs required, the country was unable to fulfil its purchasing commitment and relied on PEPFAR mechanisms. Linkage of HIV negative women to prevention services has not been fully optimized resulting in missed opportunities; supervision is majorly received from partners with more attention on ART, viral load and data and less on the maternal health; no clear understanding of integration, the models to be used and how effectiveness of integration can be measured for the program; HR/gender - Negative attitudes, practices and environment against KVPs; a dichotomy between bio-medical and non-biomedical response has emerged and overshadowed the multi sectorality of the response; low condom utilization and low comprehensive knowledge on HIV prevention; inequity in service coverage among age groups, and the sexes; inadequate data on recognized key populations (FSWs, MSM); Structural barriers (i.e. cultural, political): Lack of access to services for some KPs reflecting discrimination and deprivation of basic human rights.</p>
<p>Kenya HIV prevalence is 4.9% in adults, .07 children (0-14) living with HIV, and about 36,000 new infections (or an incidence rate of .14%) / year. All age cascade data: 89/77/third 90 not available.⁴¹ Pockets of very high transmission, and the epidemic is much worse in younger females (prevalence in females 15 – 49 is 6.2% and in males of same age only 2.7%).</p>	
<p>Factors enabling success: Global Fund and PEPFAR has contributed significantly to the treatment program through a number of experiments in how to speed up the test to treat process, how to find more cases (through index case testing), and interventions to improve retention; capacity and quality of work by NASCOP and NAAC high, despite some rivalries between organizations; Viral load testing appears to be working extremely well for those on treatment; Improvements in supply chain management and monitoring, evaluation and surveillance are all taking hold, but have weaknesses still. Prevention: Some KP programs have been successful – PWID and MSM are being reached, tested and served in much higher numbers; more consistently than before; Other KPs are being included in NSP: transgender for the first time, despite cultural and political sensitivities; the “Medicalized” prevention programs e.g. PMTCT, harm</p>	<p>Challenges: Many estimated PLHIV who do not know their status; regional variation is considerable with prevalence ranging from 19.6% in Homa Bay, to under 1% in Wajir and Mandera; Long term retention remains an area that needs more work; Prevention outreach to FSW is not working as well: this may reflect the lower investment by the Global Fund grant or less effective representation at national level (by FSWs); fairly low performance on the human rights-related barriers; but relatively little \$ goes to the non-medical prevention programs: condom distribution, safe sex ed and communication on the HIV epidemic (and TB and Malaria).</p>

⁴⁰ UNAIDS 2019

⁴¹ UNAIDS 2019

reduction, PrEP, self-testing, VMMC interventions have being/are being scaled up.	
Cameroon has the 4th highest HIV prevalence in WCA. HIV incidence and mortality dropping, concentrated epidemic. All age cascade data: 74/71/third 90 not available ⁴² . PMTCT coverage was 77% (2017). Among children, ART coverage is 25% while among adult females was 56% and 43% among male adults (2017).	
<p>Factors enabling success: Prevalence in KPs is decreasing – not clear whether this is due to a decrease in incidence or to high mortality rates. Prevention focuses mainly on key and vulnerable populations through peer-education and the distribution of condoms and STI treatment kits; the treatment component of the program focuses on ART provision, including treatment for seropositive pregnant women, counselling and testing, treatment of opportunistic infections (OIs), better integration of the TB and HIV programs and improved information systems; The PEPFAR and Global Fund programs complement one another with minimal overlapping of geographical coverage and offer a synergy of services where there is a geographical overlap; In January 2020, the government announced the elimination of user fees for HIV positive patients. According to KIIs, this was largely a result of intensive lobbying by the USG / USAID / PEPFAR (KIIs). Patient cards, consultations, HIV testing, viral load screening, treatment and prevention for PLHIV are free; A tracking mechanism has been established for co-financing, including a dedicated bank account and traceable targeted interventions including; The PC FR 2017 emphasizes joint TB and HIV interventions designed to significantly boost the results expected for TB screening among PLHIV at health care facilities, for ART in co-infected patients, and for the number of PLHIV receiving IPT.</p>	<p>Challenges: National PMTCT cascade for mothers shows shortfalls throughout the system: 17% of the expected number of pregnant women were not seen in an ANC, 12% of those who were seen were not tested for HIV, and 13% of pregnant women who were seen and tested do not know their HIV status. Among those who are HIV-positive, 25 percent are not receiving ARVs. Among new pregnant women enrolled on ART, only 55 percent are still being monitored after 12 months. HIV prevalence among SW decreased from 37% in 2009 to 24.3% in 2016. HIV prevalence remains high among MSM, although a decrease was observed nationally, from 37% in 2011 to 20.6% in 2016. Yet, increased prevalence in Yaoundé (from 44.3 to 45.1 percent) and Douala (from 24.2 to 25.7 percent) in the same surveys. Long-term conflict, deteriorating security situation 2018; 530,000 IDPs; persistent security risks in North and Extreme North due to Boko Haram; and large number of refugees in eastern and northern Cameroon due to political crisis in CAR. These conflicts have resulted in restricted access to conflict areas and hazardous conditions for health care service providers, and have therefore hampered program implementation; Cameroon's public spending on health went down from 16 dollars per capita in 2011 to 8.5 dollars in 2016; government commitment for HIV did not materialize and there was therefore a gap in ARVs. The CT and CNLS therefore revised the HIV grant, and increased the ARVs procured by the Global Fund to cover the 2020 patient targets, but without a buffer stock due to the budgetary constraints. Finances needed to mitigate active conflict / terrorist activity in the country detract from the ability to allocate adequate resources to health.</p>
Ethiopia is on track to achieve the fast-track targets. All age cascade data 79/83 – third 90 not available. ⁴³ But achieving the targets will not end the epidemic as Ethiopia lags in achieving targets for reductions in new HIV infections, discriminatory attitudes, and HIV prevention efforts. Moreover, there is inequity in coverage of HIV services among populations and locations	
<p>Factors enabling success: HIV incidence has declined significantly since 1995 although 2015 saw annual number of new HIV infections increase for the first time in more than 20 years; AIDS related deaths have declined by more than 80% between 2003 and 2016; large scale expansion of HIV testing and ART services can explain marked drop in HIV-related deaths between 2011 and 2016. GoE/MoH has shown strong leadership, vision and commitment; low levels of corruption in the health has given development partners confidence to invest; consistent sustained policy, planning and partnership environment using joint coordination platforms; significant, sustained and coordinated investment in the health system and particularly primary health care; expansion of health infrastructure, health workforce, and integrated primary services; contribution of sustained external funding - particularly Global Fund , GAVI and USG - in supporting high impact interventions and scale up of disease specific which has brought about dramatic changes in program outcomes for the three diseases, as well</p>	<p>Challenges with continuing momentum on tackling incidence; difficulty in moving from blanket approach to targeted approach due to challenges in finding KPs; cultural denial of existence of some globally recognized KPs (PWIDs and MSM) and of their vulnerability to HIV, and lack of access to services for these populations is seen as a public health strategic flaw in the epidemiological context of Ethiopia; declining external funding/technical assistance: which affects coverage of essential services through the treatment cascade (e.g. of HIV prevention services); no evidence of significant domestic investment at a time when interventions to control or end the epidemics is increasingly expensive; slow/late shift in approach: from 'equity' ('blanket' approach) to better stratification/targeting of investments and strategies to (expanded) KP groups and geographies for disease responses (all diseases); facility-based approach to services will not adequately address KPs; health system and capacity weaknesses affecting equity of service</p>

⁴² UNAIDS 2019⁴³ UNAIDS 2019

as ensuring the availability of essential PHC services; growth in total health expenditure; Since 2018, the political and human rights landscape is changing after years of widespread restrictive government policies, and security force repression. Introduction of numerous other reforms is paving the way for an improved human rights environment; New Organization of Civil Societies Proclamation was passed in March 2019 and is seen as less restrictive than the 2009 legislation it replaces. It allows NGOs more scope for activities.

coverage quality and use of services among regions, socioeconomic status groups, age groups and sexes; inadequate data and size estimates for recognized KPs (FSWs, long-distance truck drivers, youth) and dearth of data for PWIDs and MSM; DHIS2 critical reform but transition has been difficult.

Tuberculosis

Enablers and challenges in TB prevention, diagnosis and treatment:

There is a lack of uptake of current preventive therapies, although it is better for PLHIV than for eligible children. Although recent data have shown an increase in the number of people receiving preventive therapy for LTBI, primarily isoniazid preventive treatment (IPT), the coverage and completion of treatment have been disappointing, except for in a few countries.⁴⁴ The pill burden, treatment duration and cost have influenced this poor result. There are differentials between groups, with children having worse access to TPT - only 27% of estimated eligible children receive the treatment - whereas coverage has increased more significantly among PLHIV.⁴⁵ This differential may be due to relatively constrained TB budgets and embryonic case finding interventions, among other factors. A hopeful enabler to progress: WHO has recommended several shorter preventive treatment options besides IPT,⁴⁶ which significantly reduce pill burden and treatment duration, and in late 2019 the Global Fund and UNITAID negotiated a price discount for 3HP with Sanofi.

There has been a substantial investment in molecular testing but their contribution to case finding varies across countries. Diagnostic strengthening is key to finding missing cases, and treatment initiation and management, under all forms of presentation - sensitive, resistant and latent TB. There is a need for better access to diagnostic tools to decrease the large gap between the 7 million new TB cases reported vs the 10 million estimated number of cases in 2018. Effective diagnosis and reporting including from the private sector is essential to reaching 3 million missing cases and curbing the epidemic; India Indonesia, Bangladesh Pakistan and others have well developed PPM models contributing significantly to the TB response, though not without challenges as discussed elsewhere in SR2020. Access to molecular testing is an issue in MDRTB as well; over 60% of all people estimated to have MDRTB were not detected in 2018 and only 32% received treatment. Even among people with a diagnosis of MDRTB the coverage of drug susceptibility testing to guide treatment was only 51% with drug susceptibility testing access much lower in some settings.⁴⁷ In SR2020 case study countries, lack of funds forced a hold on plans for Nextgen sequencing for DR surveillance.

The treatment success rate for drug sensitive TB is high globally, whereas for MDRTB, treatment adherence and success rates have historically been hampered by lengthy, toxic expensive TB drug regimens. New regimens are available, but uptake is slow. The Global Drug Facility enables global access to quality DSTB fixed dose combination FLDs at competitive prices. Hindering factors include anti TB drugs being sold in the private market as single drugs of unknown quality, emergence of fluoroquinolone resistance in some countries. Progress in MDR TB has been hindered by use of old technologies to diagnose and treat. For MDR TB (first time in 40 years) there are new TB drugs - bedaquiline, delamanid, BPaL. The March 2019 WHO updated guidelines on MDR TB prioritized all

⁴⁴ WHO TB Report, 2019.

⁴⁵ Global TB Report 2019

⁴⁶ Latent tuberculosis infection: Updated and consolidated guidelines for programmatic management. WHO 2019

⁴⁷ WHO Global TB Report 2019

oral regimens that include bedaquiline as a key drug, recommending limited use of injectables (major opportunities for improved adherence, improved efficacy and health systems savings). However; between 2016 and 2019, new DRTB medicines, launched in 2012, were only being used by approximately 20% of patients who needed them.⁴⁸

Other factors enabling and hindering the TB response include factors at the health system level as well as factors external to the health system – environmental, social, and political and resourcing challenges:

Health systems factors that are enabling and hindering the TB response include: enabling: Contribution of NGOs within effective TB PPM models; introduction of mandatory case notifications from a private sector in some countries; effective use of community systems and responses in some settings for case detection and investigation of household contacts as well as for following up patients; use/scale up of digital technologies for patient registration, tracking, adherence support and digital funds transfer; savings from more efficient TB care models (e.g. reducing hospitalization and increasing ambulatory care); increased co-testing between of HIV and TB patients; integration of TB services with other services such as the diabetes; innovative solutions for sputum transport, including with private sector; massive scale up of GeneXperts.

Hindering factors include: massive expert scale up yet low utilization (e.g. due to maintenance issues, lack of budget for cartridges, and short working hours of public facilities); Weak sample transport systems that do not stretch to the PHC level; challenge of clinical rather than bacteriological diagnosis in the private sector as well as poor quality case management and lack of integrated reporting with the public sector - the need to improve quality efficiency and equity of services provided in the private sector; and information management systems that enable improved case notification as well as data to support geographic and population targeting. There is a need to bring diagnostic access closer the lowest health care facilities' level, where patients first present with symptoms. This can only be achieved by optimizing placement of functioning of diagnostic technologies alongside efficient sample transport systems and improving linkages and integration with other disease programs (e.g. to reach diabetics, smokers and PLHIV) and with the private sector. In addition, there are challenges with substandard products in countries procuring domestically and weak quality control measures as well as national procurement and supply system leading to shortages in supply of expert cartridges and anti-tb drugs; weak health system infrastructure including related to supply chains; weak human resource capacities; expensive patient care support packages; weak analysis of drivers of DRTB resistance (e.g. poor treatment adherence, management of patients through hospitalization, societal barriers to access treatment). SR2020 country case studies also revealed that contact investigation is hampered by unclear algorithms, weak SOPs and that LTBI similarly hampered; Weak national coordination of the National TB response in the context of devolved services to provinces; Weak recognition of NTP strategies and policies at the provincial level; low participation of CSOs in TB case finding.

Structural: Outside the health system, TB progress is enabled by Strong political will and Country leadership; TB related programs to reduce human rights related barriers.

Hindering factors include: social unrest and complex humanitarian disasters affecting service delivery and diverting government attention and finances; increase of lifestyle risk factors smoking and diabetes; structural barriers affecting service access of vulnerable and hard-to-reach groups such as mobile or migrant populations, PLHIV, miners and prisoners; Weak development of civil society capacity for reducing rights barrier to TB services; in devolved settings, local leaders may not favor

⁴⁸ Global Use of Bedaquiline, Delamanid, and Fully Oral Treatment Regimens for Drug Resistant Tuberculosis. DR-TB STAT presentation, October 2019.

<http://drtb-stat.org/wp-content/uploads/2019/10/DR-TB-STAT-Union-slide-deck-2019-final.pdf>

financing activities for stigmatized populations; gender is generally overlooked in TB programming. Mitigation measures are required to prevent catastrophic cost.

Resource mobilization and allocation: enabling factors include: integration of TB services within the National Health Insurance; government intention to contribute by financing TB first line drugs; savings on procurement by transferring functions to international procurement agent; sustained domestic sources of income; 87% of funding for tuberculosis programs comes from domestic resources, however the majority of these funds come from six countries: Brazil, Russian Federation, India China and South Africa.

Hindering factors: Current (2019) international and domestic resources meet only 6.8 billion of the estimated 10.1 billion need to prevent, diagnose and treat TB worldwide. Global fund investment in TB is projected to decline in all regions except west and central Africa in 2012-2020 (Global Fund data). Several case study countries identified challenges resulting from government failure to meet their commitment for financing the TB response. TB service often not covered in social health insurance schemes; provincial funding commitments not being honored

Table 3: Selected SR2020 case study factors enabling and hindering progress TB disease impact

<p>Pakistan is in 5th position among countries with the highest TB burden in the world and 4th position among countries with the highest burden of MDR TB in the world. Treatment coverage (2017) for DSTB is 68% (vs 90% target) and for DRTB 12% (vs 50% target). Annual fall in incidence of 2% vs 10% required to meet and global TB targets.</p>	
<p>Factors enabling success: Important contribution of leading NGOs in TB PPM (Global Fund PRs) models, notifying 31% of total TB cases. The DS-TB treatment success rate has been above 90% since 2013 onwards.</p>	<p>Challenges: Provision of health services devolved to provinces - concern in relation to national coordination of the national TB response - NTP effectively functioning (and funded) to serve the Global Fund TB grant. Little commitment to increase domestic finance for TB. TB services not covered by social health insurance. Provincial funding commitments not being honored; Anti TB drugs sold in the private market in Pakistan as single drugs of unknown quality; High fluoroquinolone resistance and emerging signs of resistance to bedaquiline; contact investigation included in in NSP but implementation hampered by unclear algorithms, weak SOPs; latent TB infection management included in NSP but similarly hampered; NextGen sequencing for DR surveillance and transmission analysis planned but on hold due to lack of funding; need to better engage communities in TB responses including Lady Health Workers, inadequately addressing TB in high risk populations – PLHIV, prisoners, migrant/mobile populations, diabetics and smokers; massive Global Fund-funded Xpert scale up between 2011 and 2019, yet 1 microscopy laboratory for 135000 population and low utilization due to maintenance issues and short working hours of public facilities; weak sample transport system that does not stretch to the PHC facility level; private primary care providers account for 80% of initial care seeking less than 5% of them are effectively engaged.</p>
<p>Ukraine has as high MDR TB burden ranking 5th worldwide in infection rates per capita. Estimated MDR prevalence of new cases is 29% and among previously treated cases 46%. Cure rates are among the worst in Europe at 76% of new cases and 49% of MDR cases. Poor treatment outcomes for all TB patients, particularly drug-resistant TB. Tuberculosis remains the main aids-related cause of death among PLHIV 51%</p>	
<p>State budget is covering TB drug needs; 100% transitioned to new WHO recommended regimens with delamanid and bedaquiline;</p>	<p>Challenges include: weak TB HIV service integration; political uncertainty; no potential to increase total</p>

<p>about 40% of the state budget was saved due to the transfer of functions to an international procurement agent; Ukraine is one of countries with the TB Regional EECA Project (TB-REP) - health system strengthening for effective TB aiming to reduce hospitalization and increase ambulatory care - efficiency gains achieved from optimization of beds from 22K in 2012 to 12K in 2018, while introducing outpatient treatment model for TB patients allowed a further reduction in beds by 12%; there is strong political will country leadership and commitment for health sector reform and sustaining the HIV and TB programs; legally binding and fully financed transition plan; TB related programs to reduce human rights related barriers show progress and improvement.</p>	<p>government expenditure in the short-term; despite positive increases in TB and HIV spending, previous co-financing commitments have not yet fully materialized; limited human resource as well as technical capacity in public health center and central procurement agency to implement the planned activities; the strategy on HIV tuberculosis and viral hepatitis includes commitments to remove political legal and cultural barriers that restrict access or cause stigmatization (e.g. KPs and prisoners) however TB-related programs to reduce human rights-related barriers in Ukraine lag far behind programs for HIV and civil society capacity for reducing rights barriers to TB services is insufficient; devolution - not popular to finance activities for stigmatized populations; limited health and social sector collaboration and harmonization.</p>
<p>Vietnam has the goal to eliminate TB by 2025. Drop-in incidence rate reported at 3.1% (2019) Out of existing cases estimated over 100,000, only 58% have been found and notified. DSTB treatment success rate remains above 90% on average (various sub nationally) so the main challenge continues to be case-finding.</p>	
<p>Factors enabling success: Recent top-level attention to TB via the prime minister's office with convening of a national committee for TB; strong treatment program for those that are found in 92% treatment success for DSTB; government intention to contribute to response by taking over financing of TB FLDs (positive in theory)</p>	<p>Challenges: Some question of the strength of the NTP strategies at all provincial levels; insufficient use of existing data to understand patterns at sub national level; ongoing issues with data storage and management; plans to increase Xpert access under the new grant but unclear comparable push for new case finding through outreach; civil society participation is lower in TB than in HIV; social health insurance to take on prevention services, though not covering Xpert diagnosis; around 60% of patients first approach care in the private sector - private sector linkage for TB continues to be weak and inadequate for reporting or for case-finding, this combined with low participation of CSOs in TB case finding will almost certainly translate into lower effectiveness in finding missing cases; TB reflecting a mixed concentrated and generalized epidemic - needs more flexibility and innovation in their strategies for reaching these mixed populations, both the hard-to-reach and the large affected demographic groups such as the elderly men with TB.</p>
<p>Philippines was one of eight countries that accounted for two-thirds of the global TB burden and 6% of all TB cases worldwide. Increased treatment coverage from 52% in 2017 to 70% in 2019. Treatment success was 91% for DS new and relapse TB cases in the 2017 TB treatment cohort, 82% for previously treated cases, and 83% for people living with HIV. Gaps: finding missing MDR-TB cases and MDR-TB treatment success as well as the low numbers of TB notifications and missing treatment outcomes from the private sector.</p>	
<p>Factors enabling success: Embracing innovation - adoption of digital systems to improve the continuum of care and all-oral short treatment regimens for DR-TB, newer preventive therapy regimens, and local sputum transport networks, expansion of rapid molecular diagnostic capability; 2017 TB prevalence survey and subsequent political commitment to meet the targets of the 2018 United Nations High-Level Meeting on TB; implementation of active case finding in high-risk groups (e.g., prisons, poor populations); intensified case finding through facility-based activities; recently instituted mandatory TB case notifications from the private sector; ART initiated in 91% of the HIV-TB co-infected cases; sustained domestic sources of income for increased health program expenditure; integration of TB services within the national health insurance, as part of the national adoption of UHC (provides increased opportunities for</p>	<p>Challenges: Knowledge of risk groups (type-2 diabetes, poverty, prisoners) without knowledge of resistance drivers; challenges in the national procurement and supply system, leading to shortages in supply of Xpert cartridges and anti-TB drugs; extensive private sector but only 17% of TB patients reported by private health facilities – no knowledge of quality - 95% of TB cases in the private sector diagnosed clinically, (molecular diagnostic tests not widely used); gender is generally overlooked in TB programming; TB patient and community groups need strengthening; mitigation measures required to prevent catastrophic cost; Among children under 5, less than 10,000 contacts of TB cases initiated TPT.</p>

integration of TB services with other services (such as the diabetes services)	
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Malaria

Prevention

Vector control: LLINs: Factors enabling progress include sustained coverage of vector control interventions; appropriate malaria stratification, informing a risk-based vector control strategy. LLINs are aligned with user preferences, are used, and are aligned with pyrethroid resistance patterns to ensure impact. LLINs made available through mass campaign and continuous distribution. **IRS:** Universal coverage with IRS funded with country resources and adopting housing improvements including eaves on doors and windows to compliment the IRS; IRS is appropriately deployed.

Hindering: Factors limiting further progress with vector control include resource limitations, variable coverage and use, insecticide resistance, need for improved data to enable stratification, and need for new malaria control tools. While there has been sustained LLIN coverage, still only half of people at risk of malaria in sub-Saharan Africa are sleeping under an ITN; in 2018, 50% of the population were protected by this intervention. This is an increase from 29% in 2010 but coverage has improved only marginally since 2015 and has been at a standstill since 2016⁴⁹. Also, coverage of insecticide-treated nets varies considerably between countries, and within countries by geographic area, specific populations, and socio-economic status. Houses with many residents, poorer households, and school-aged children have been shown to have lower LLIN coverage.⁵⁰ Some countries are finding great variability to net ownership and coverage over time periods as well, highlighting issues of net attrition, distribution/access via campaign or routine delivery. For example, a 2018 study in Uganda found that only 65.0% of households owned at least one LLIN (down from 94% in 2014) and only 39.5% of residents used a LLIN the previous night.⁵¹ Even where nets are deployed routinely and used correctly, the protection is only partial due to growing pyrethroid resistance. There is resistance to all four classes of insecticides used for public health; insecticide resistance management is complex and still developing within countries. Innovative products with a synergist – PBO nets - have been WHO recommended however there is a slow uptake for these due to their higher price, lack of impact data and limited funding that is often already insufficient to maintain or high coverage with existing vector control tools. There are needs to develop better data and surveillance to enable better stratification and targeting of interventions, particularly as the vector control tool options are now growing. Indoor residual spraying is very popular (FRs often include it), very cost-effective but very costly. The insecticide price has reduced but it is still expensive to implement and requires regular and repeated campaigns. Some SR2020 case study countries are using insecticides with known resistance and/or relying on insecticides with a shorter residual efficacy when sprayed on mud walls. In settings where outdoor biting is predominant, there are a dearth of vector control tools.

Chemoprevention IPTp: enabling: Coverage with IPTp3 has increased but is highly variable between countries. **SMC:** enabling: significant and continuing scale of SMC. The Global Fund worked closely with UNITAID to scale this intervention in 2017, with significant progress however only 15.7 billion out of 29.3 million eligible children had received SMC, mainly due to lack of funding. The initiative was able to demonstrate the impact of effective chemoprevention, and SMC has continued to scale, with 17 million children, out of the 26 million targeted receiving SMC in 2018.

⁴⁹ World Malaria report 2019

⁵⁰ <https://malariajournal.biomedcentral.com/articles/10.1186/s12936-019-2838-3>

⁵¹ <https://malariajournal.biomedcentral.com/articles/10.1186/s12936-018-2571-3>

Hindering: factors which inhibit further scale up of malaria chemoprevention interventions include low demand and adoption, poor quality and stock-outs of SP, and resource limitations.

Although SMC was scaled significantly in 2017, coverage was limited due to resource constraints as well as caregivers' having negative perceptions of SMC. IPTp3 uptake is hindered by negative perceptions of drug use in pregnancy as well as ongoing perceptions of SP resistance despite demonstrated efficacy of SP when used for chemoprevention and not for first-line treatment. SP is also often funded as part of the government commitment and there are often stock outs.

Case Management

Enabling There are effective malarial treatments, available in adult and pediatric formulations, produced by generic firms at competitive prices and quality-assured through the WHO Pre-qualification program. Malaria RDTs are now readily available and there is an increase in cases are confirmed using parasitological-based diagnosis. Some countries have a test treat and track policy through engagement of community health extension workers.

Hindering factors: over-treatment with ACTs; limited uptake of tools for severe malaria management; limited tools to manage biological threats; substandard and falsified products. The current demand for ACT treatments in the African region would be reduced by more than half if only malaria cases confirmed with diagnostic testing were treated with ACTs.⁵² This speaks to the need for better targeting of ACTs at confirmed malaria cases alongside expanded RDT scale up efforts. While progress has been made in scaling up recommended treatments for severe malaria - including injectable artesunate and rectal artesunate suppositories as pre referral treatment - coverage with these interventions remains low. Partial resistance to artemisinin which has been identified in the Greater Mekong region; the emergence of *P. falciparum* strains that cannot be detected with the most common RDTs used in primary care settings. There are limitations to use of microscopy in field settings and limitations of RDTs quality and pricing; limitations of current tools to manage *P. vivax* cases, which represent 70% of cases in countries approaching elimination.

Health systems and structural barriers

Other enablers and challenges to the malaria response can be divided into those at the health system level and those external to the health system – environmental, social, political and resourcing challenges – which can affect the malaria epidemic and access to care.

Health system enablers: malaria case management is integrated into primary and secondary level health care at public health facilities; integrated disease surveillance system including web based platforms; CSOs supporting to reach “hard-to-reach” communities such as seasonal agricultural laborers; military; forest workers in the formal sector and informal sectors. Continuous distribution channels being effectively supplied and used; culture/habit (of regular data collection) and the effectiveness of data use in malaria; reactive surveillance; active case detection; outbreak monitoring and response.

Health system challenges include variable implementation of IMCI and iCCM across settings; IPTp3 affected by recording and reporting, stock-outs and contention between repro health and malaria programs (who “owns” the IPTp3 programs); 2/3 of patients with febrile illness do not access PHC; challenge of substandard and falsified products and weak quality control measures; poor quality case management in the private sector; limited granular level sub-national data - lack of robust data for decision-making to deploy new tools; weak health system infrastructure including those related to

⁵² World Health Organization. World Malaria Report 2018. Geneva: World Health Organization; 2018.

supply chains; regulation of the private sector; and weak human resource capacities. Cross-border transmission and ability to set up adequate surveillance.

Outside the health system, malaria progress can be affected by social unrest; complex humanitarian disasters; food insecurity which leaves malnourished, immunocompromised patients more vulnerable to malaria; climate and environmental change which has an influence on malaria distribution and transmission; population growth which increases resources needed for coverage; within endemic populations, limited analysis of access barriers and needs of refugees and migrants, and other vulnerable and hard-to-reach groups; lack of specific targeting of some recognized KPs including children and pregnant women; conflict areas which make Global Fund programs mostly inoperative impacting services; challenges posed by devolution

Resourcing: A final important factor is the overall resourcing into the sector. Enabling factors are the sustained international funding, increased domestic spending for health, high government contribution to the malaria program. [Except for India, direct domestic investment remains very low relative to international funding in the HBHI countries.] Section xx also explains the interplay between resource scarcity and limited prioritization guidance, which has been a key factor inhibiting progress under the current Global Fund strategy.

Table 4: Selected SR2020 case study factors enabling and hindering progress malaria disease impact

eSwatini is making great progress towards eliminating malaria transmission - with confirmed cases decreasing by 47%, and local cases by 75% and a significant cases decline of 62% over 2017 – and single digit malaria deaths over the past three years.	
Factors which have enabled this progress include: all cases are confirmed using parasitological-based diagnosis (100% achieved in 2015/2016) and all confirmed cases are treated with artemisinin-based combination therapies (100% achieved in 2015/2016); no LLINs are used but vector control has reached universal coverage with IRS coverage being 96% in 2015/16 period and the country adopting housing improvements that will see the installation of eaves on doors and windows to complement the IRS; reactive surveillance (94% investigation rate in 2015/2016) and active case detection (80% of people targeted in 2015/2016); outbreak monitoring and response. Eswatini also has the highest domestic spending for health in Southern Africa and the government has a high share contribution to the malaria program. The government has shown commitment over past two decades and The King started a Malaria Fund to ensure that Eswatini achieves elimination.	The key challenge facing the program is cross border transmission and ability to set up adequate surveillance.
Ethiopia has made notable progress through reductions in incidence of malaria and number of malaria-attributed deaths. Now heading for elimination in all regions.	
Factors which have enabled this progress include: effective LLINs are utilized (LLINs are aligned with user preferences and are used. Type of LLIN is aligned with pyrethroid resistance patterns to ensure impact). IRS is appropriately deployed. A PHC approach and HEW program which is providing integrated services (i.e. of the 18 health packages of training that a level 4 HEW receives, only 3 relate to TB/HIV and malaria) and aims to improve skill, quality of care, address HEW motivation and retention; training in DHIS2 which benefits all health programs; growth in total health expenditure, much of it spent at PHC level where HIV, TB and malaria services are delivered; Overall, progress can be attributed to sustained coverage of core vector control interventions, malaria stratification and risk-based vector control strategy and implementation of 'test, treat and track'	Current challenges affecting the program include: limited 'granular' level sub-national data and analysis on the burden in refugees and migrants and lack of specific targeting of some recognized KPs including children and pregnant women; continued high use of carbamates for indoor residual spraying (IRS) in the face of confirmed resistance and questionable reliance on bendiocarb which has shorter residual efficacy when sprayed on mud walls; high program management costs; consensus that funding for Malaria is insufficient for needs given reductions in external funding and stage of epidemic (requiring scale up of differentiated and more expensive interventions to get to end point).

policy through engagement of community health extension workers.	
In Cameroon, malaria the number of cases and deaths have dropped, however, Cameroon is still not meeting its impact indicators for Malaria.	
Factors enabling success include: a 2015-2016 LLIN mass campaign; the 2016 seasonal malaria chemoprevention (SMC) campaign which provided 85.6 percent coverage for children aged three to 59 months in the target areas (North and Far North) and helped to reduce morbidity among children by 58 percent; coverage of Intermittent Preventive Treatment (IPT3) which increased from 28 percent to 32.8 percent between 2014 and 2016; Global Fund support to a harmonized remuneration and set of activities for 4,400 CHWs delivering essential health packages, although the services these CHWs provide appear to be overwhelmingly malaria-focused.	Challenges for the program include: conflict areas in Cameroon, which has made Global Fund programs mostly inoperative in affected regions - the National Malaria Program reported that the conflicts have disrupted distribution of LLINs; both access to and utilization of LLINs fell between 2015 and 2019 - access and use were 77% and 58% respectively in 2015 and access and use were 57% and 50% respectively in 2019. The reasons are unclear, but may be associated with increased conflict and decreased access to conflict zones.
In Kenya, there has been a steady decline in malaria incidence over the last 10 years, but recent epidemics in highland or non-endemic areas as well as increases in some endemic areas are worrying.	
Factors enabling impact: The NMCP runs a very targeted and focused program based on epidemiological data and zoning for malaria endemicity. This data drives the prevention interventions – LLIN and IRS. Programmed reacting fast to sub-national regional outbreaks/mini-epidemics outside normal zone of operation.	Factors hindering progress: Finding resources for enough LLINs to continuous support the prevention of malaria is challenging. Also a relatively low rate of LLIN ownership in targeted (endemic, highland epidemic and other high-risk) areas and only 48% of the general population is sleeping under LLINs. Socio-economic variation in LLINs ownership as only 26.2% of households in the lowest income quintile compared to 42.6% in the highest quintile, had at least one net (KMIS 2015, prior to the 2017 mass campaign). All diseases' impact could be threatened by the challenges of devolution; periodic procurement challenges; climate change concerns - noted spikes in malaria outbreaks are already being "handled" and will likely worsen with more unreliable rains and high population movement and growth. Little planning appears to have taken place yet, despite many stakeholders commenting on this vulnerability.

Cross-cutting factors enabling and hindering disease impact

The table below provides a summary of the cross-cutting factors enabling and hindering progress across the three diseases, including health system; socio-cultural, environmental and political; and resourcing. Some of the factors appear in more than one disease area and absence of a factor only means that it has not featured in SR2020 case studies to date.

Table 5: Hindering and enabling factors

	Hindering	Enabling
Health Systems		
HIV	<ul style="list-style-type: none"> • Siloed services • Reliance on facility-based services • Insufficient community involvement • Lack of tailored response to high risk pops • Lack of KP size estimates & data • Lack of stratification & targeting • Weak sample transport • Weak use of diagnostics across diseases • HRH capacity weaknesses • Health care worker strikes 	<ul style="list-style-type: none"> • Micro-targeting and differentiated services (provider-initiated testing, community based testing, index testing and self-testing) • Reaching KPs through web-based platforms and networks • Effective engagement of CSOs to reach KPs • Test and treat policies • Multi-month prescriptions • Integrated package of services • Decentralization of testing

	Hindering	Enabling
	<ul style="list-style-type: none"> • Stock outs • Challenges caused by decentralization on health systems (procurement, data systems, treatment, supervision and health worker shortage) 	<ul style="list-style-type: none"> • TB/HIV integration • Transition to new WHO recommended technologies
TB	<ul style="list-style-type: none"> • Low utilization of Xperts • Weak sample transport • Private sector quality and reporting issues • Weak data to support targeting • Weak info mgmt. to support case notification • Diagnostics too centralized • PHC level not engaged • Poor linkage with other disease programs • Poor linkage with private sector • Sub-standard drugs/weak QC • Weak procurement (stock-outs) • Weak supply chain (stock-outs) • HRH • Poor mgmt. of (expensive) patient care support packages • Weak analysis of resistance drivers Unclear algorithms & weak SOPs (e.g. in relation to contact tracing & LTBI) • Weak national co-ordination in devolved settings • Weak recognition of NTP strategies at provincial level • Low CSO participation in case finding • Slow transition to newer WHO recommended technologies 	<ul style="list-style-type: none"> • TB PPM contributions • Mandatory case notifications • Use of CSR (case detection and patient f/u) Digital tech use (registration, tracking, adherence support, funds transfer) • Increase ambulatory care while reducing hospitalization • Co-testing HIV/TB • TB integrated with other services (diabetes) Sputum transport innovations (incl. private) GeneXpert scale-up
Mal	<ul style="list-style-type: none"> • Variable implementation of IMCI and iCCM • Sub-standard & falsified products in context of weak QC capacity • Poor quality case mgmt. in private sector • Limited granular sub-national data • Weak supply chains (stock-outs) • Vertical supply chains linked to funding source • Regulation of private sector • HRH • Cross-border transmission – need for surveillance 	<ul style="list-style-type: none"> • Case mgmt. integrated into PHC • Engagement of CHWs • Integrated disease surveillance, incl web based strengthened microscopy services also contributing to other diseases • CSOs reaching seasonal laborers, military, forest workers etc. • Continuous distribution channels • Regular data collection/use • Appropriate stratification • Reactive surveillance • Active case detection • Outbreak monitoring and response
Socio-cultural, environmental, political		
HIV	<ul style="list-style-type: none"> • Services affected by conflict/disasters/humanitarian crises • Cultural denial of KPs • Stigma discrimination violence • Criminalization • Legal barriers to care • Limited mechanisms to promote justice for KPs • KPs not recognized in NSPs • Travel/distance to reach services • Challenges posed by devolution 	<ul style="list-style-type: none"> • Political will • Country leadership • Multi-sectoral response • HRG reforms
TB	<ul style="list-style-type: none"> • Increased lifestyle risk factors (smoking, diabetes) 	<ul style="list-style-type: none"> • Political will • Country leadership

	Hindering	Enabling
	<ul style="list-style-type: none"> Structural barriers affecting migrants, refugees, miners, prisoners, PLHIV Weak civil society capacity in TB Local leaders avoiding financing services for stigmatized pops Gender overlooked in TB Catastrophic costs Challenges posed by devolution 	<ul style="list-style-type: none"> TB related programs to reduce human right barriers Regional grants to address structural service inefficiencies: (TB-REP to shift from hospitalization and increase ambulatory care for TB)
Mal	<ul style="list-style-type: none"> Food insecurity – malnutrition increases malaria vulnerability Climate change – malaria distribution & transmission (relationship with la nina and el nino - more rain = more malaria, less rain = less malaria) Population growth – increased resource need Limited analysis of needs of refugees, migrants & hard to reach groups Lack of strategic targeting to KPs (e.g. women, children) Challenges posed by devolution 	<ul style="list-style-type: none"> Political will Country leadership
Resource mobilization and allocation		
HIV	<ul style="list-style-type: none"> Misalignment between resource allocation and KP BoD Government failure to keep co-financing commitment (stock-outs) Insufficient government investment Insufficient partner investment 	<ul style="list-style-type: none"> Government commits funds Sustained partner funding Partner co-ordination/synergy Elimination of user fees for PLHIV
TB	<ul style="list-style-type: none"> International & domestic resources only 7/10ths of need 	<ul style="list-style-type: none"> Integration of TB services within national health insurance Government commitment to finance TB FLDs Procurement savings through international procurement platform Sustained domestic contribution to TB
Mal	<ul style="list-style-type: none"> Insufficient resources to enable full VC coverage Interplay between resource scarcity and limited prioritization guidance 	<ul style="list-style-type: none"> Sustained international funding Increase domestic spending for health

ANNEX 4.II: PROGRESS TOWARDS SOs 2, 3 AND 4

This annex presents a summary of progress towards strategic Objectives 2, 3 and 4 based on the available quantitative data. This was used to inform our overall assessments of progress which are presented in the main report.

Strategic Objective 2: Build Resilient and Sustainable Systems for Health (RSSH)

Under the Global Fund Strategic Objective 2: 'Build Resilient and Sustainable Systems for Health,' there are seven operational objectives. They include a. Strengthen community responses and systems b. Support reproductive, women's, children's and adolescent health, and platforms for integrated service delivery c. Strengthen global and in-country procurement and supply chain systems d. Leverage critical investments in human resources for health e. Strengthen data systems for health and countries' capacities for analysis and use f. Strengthen and align to robust national health strategies and national disease-specific strategic plans g. Strengthen financial management and oversight. Investments under these sub-objectives are guided by the Modular Framework handbook that has seven equivalent RSSH modules:

1. Procurement and supply chain management systems (PSM)
2. Health management information system and monitoring and evaluation (HMIS)
3. Human resources for health, including community health workers (HRH)
4. Integrated service delivery and quality improvement (ISD)
5. Financial management systems (FMS)
6. National health strategies (NHS); and
7. Community responses and systems (CRS)

Allocation of funding toward building RSSH has declined during the current grant period. The allocation of resources directly toward RSSH was 7.4% of overall Global Fund investments during 2015-2017 and 6.3% of overall Global Fund investments during 2018-2020. Prioritization of RSSH as a Strategic Objective is not reflected in the investments made in this area.

The utilization and absorption of RSSH grants trails that of disease-specific and multi-component grants. Allocation utilization for RSSH grants trails allocation utilization for all other grant types. All grant types have an allocation utilization above 90% except for RSSH, which had an average allocation utilization of 61%. Absorption of RSSH funds also trails disease modules. Almost all RSSH modules report absorption below the 75% Global Fund target.

SO2a: Strengthen community responses and systems

Allocation to community responses and systems has declined over time, allocation is highly variable, and it is difficult to link investment to outputs, outcomes and burden of disease.

Community systems are a vital component to target interventions that best respond to disease by providing localized sensitivity, knowledge, and capacity. In general, the proportion of RSSH funds budgeted for community systems has declined across components (HIV, TB, malaria, RSSH) and regions from 2016 to 2019. However, the proportion of resources allocated to RSSH has increased for HIV grants in LAC and SEA and for TB/HIV grants in Asia, EECA and WCA. Between 2016 and 2019, absorption has been high variability across components and over time, steady improvement observed only in RSSH grants (and not in the community response components of disease-specific grants). We do not have access to information on the outputs and outcomes of community-based responses and systems. Outputs and outcomes of community-based responses and systems are generally aggregated up to country-level reporting. As such, it is difficult to assess output level indicators from community systems. These data suggest that although community-based response is a key priority for Global Fund, investment does not match the aspiration.

SO2b: Support reproductive, women's, children's, and adolescent health, and platforms for integrated service delivery

Countries have made great progress in integrating HIV into more general care services in the past decade, however gaps remain. To date, integration of services has focused on HIV especially PMTCT. TB services are largely integrated through HIV as 92% of countries at least partially integrate TB screening into HIV. Malaria has much less information on integrated services, but most Global Fund expenditures in Malaria integrated service delivery go to supporting policy and programmatic environment and service delivery infrastructure.

Integration of HIV into reproductive health programs, PMTCT, has been one of the greatest success stories of the HIV epidemic, greatly reducing vertical transmission of disease. Over 60% of countries have fully integrated PMTCT and a further 30% have at least partially integrated. Even with this integration, low coverage of PMTCT services persist. Only 38% of pregnant women in Asia on ART and similarly low numbers exist in some countries across all regions. In 2017, only 43% of infants exposed to HIV in pregnancy were tested within two months of being born, and AIDS-related complications remain the highest reason for mortality among children infected with HIV. In addition, only 25% of countries integrate HIV testing in child health services and a fewer 16% integrate HIV treatment.

Malaria has much less information on integrated services, but most Global Fund expenditures in malaria integrated service delivery go to supporting policy and programmatic environment and service delivery infrastructure. Very little money has been allocated for integration in Malaria vector control, having only had one year where money was allocated anywhere in the portfolio (2018). Integration allows for more efficient delivery of healthcare and improves access to treatment and care, especially when based in the community. However, Integrated community case management (ICCM) has received little to no money over the past 2 grant cycles.

Conversely, several services that directly target women's health have not been widely integrated. Looking at violence screening and mitigation, only 12% of countries fully integrate screening into HIV care. A similar proportion can be observed in cervical screening integrated into HIV care. Much more is required to integrate the full breadth of sexual and reproductive health needs where women, children, and adolescent can receive the appropriate, cohesive, and comprehensive services they require.

SO2c: Strengthen global and in-country procurement and supply chain systems

Supply chain targets have been met or are close to being met in target high impact and Core countries. However, only 15 countries have been targeted to date. In these countries, the Global Fund target of 15% reduction in the non-availability for diagnostics and tracer medicines has been met for HIV and TB and is close to being met for Malaria. However, individual country results vary significantly.

SO2d: Leverage critical investments in human resources for health

Allocation of funding toward human resources has remained relatively stable, while absorption remains below target. Many countries in the Global Fund portfolio have a paucity of healthcare workers and regional deficiencies to adequately serve rural populations. Overall, the proportion of RSSH expenditures going to human resources for health have remained somewhat constant globally across disease components from 2016 to 2019. However, when looking by region, we can see that

there has actually be an increase in these funds across components for most regions. Decreases were seen in HIV for MENA and WCA. Additionally, MENA saw decreases in malaria grants, TB/HIV grants, and RSSH-specific grants. Absorption of funding toward human resources for health has been variable, with only RSSH and TB HRH modules being above 80% in 2018. During the first semester of 2019, only the RSSH grant achieved above 80% absorption.

SO2e: Strengthen data systems for health and countries' capacities for analysis and use

The majority of Global Fund resources toward RSSH support health information infrastructure for data systems. In 2019, over 70% of TB RSSH funds went to strengthening data systems. In addition, Malaria, HIV, and TB/HIV grants all spend over 60% of their RSSH funds on this category. There has been improvement in absorption of resources in the area of data systems each year between 2016 and 2019. However, absorption of funds towards data systems remains low at of 52.3% in 2019. This suggests that most grants are well planned and executed in this arena.

The Global Fund reports high achievement in development and implementation of country-level data systems, though only half of countries are included in these assessments. The Global Fund completes desk reviews to identify whether countries data systems include 80% of all appropriate elements, are installed in 80% of health facilities, whether 80% of health facilities report data, and whether these data are submitted on time by 80% of health facilities. The Global Fund has targeted 54 countries for inclusion in this indicator. To date (end 2018), 25% of Global Fund cohort countries have achieved 80% across all four data system components, and 59% of Global Fund cohort countries have achieved 80% across 2-3 data system components. It will be important to assess data system development and implementation across the entire Global Fund portfolio in order to truly assess progress in this area.

Development of and international repository would facilitate monitoring and evaluation of country-level programs. Many countries use global data, rather than their own country-level systems to understand longitudinal trends. In our analysis, we have found that many global (i.e. UNAIDS, WHO) systems are antiquated, not standardized, fail to provide important background information, and omit key indicators that would be important to consider. Additionally, many data are expunged from the public record after a year and are not readily available. For example, the Global TB Report is a gold standard for providing metrics on TB across the globe. While previous reports are available, no appended data are included, making longitudinal analysis for countries cumbersome.

SO2f: Strengthen and align to robust national health strategies and national disease specific strategic plans

TRP members rate grants as strongly aligned with national strategic plans, however, we observed substantial variation across disease and aspects of national strategic plans. The Global Fund assesses alignment with national strategic plans by asking TRP members their subjective opinion of alignment for each grant with respect to deployment, disease reporting, completeness and timeliness. Overall, 98% of grants are rated as 'agree' or 'strongly agree' by TRP members. However, these ratings are highly variable across diseases and components of the indicator. Across diseases, data reporting is less well aligned with Global Fund grants the completeness of plans is the most highly aligned aspect of Global Fund grants. In general, Core countries slightly underperformed across aspects of alignment compared to Focused and High Impact countries.

HIV: For HIV, disease reporting is the weakest performing indicator, with the average alignment at 66.7% for High Impact countries and 53.8% for Core countries. Second is timeliness, where 73.2% of High Impact and 53.7% of Core countries are aligned. Completeness has the largest gap between

Core countries and High Impact (78.0% and 90.8% respectively). Lastly, deployment is the best performing indicator with 83.6% of Core countries and 94.3% of High Impact countries aligned.

TB: Like HIV, disease reporting is the weakest, with 46.2% of core countries and 52.0% of hi impact countries aligned. Timeliness is assessed to be aligned in 62.2% and 79.0% of core and hi impact countries, respectively. Both deployment and completeness score below 90% in core countries, and 97.2% and 90% respectively for hi impact countries.

Malaria: Disease reporting for Malaria is the only instance where core countries outperform high impact countries (75.0% to 69.6%), though the average is also the lowest among the 4 categories as with HIV an TB. Timeliness is 62.3% for core countries and 82.0% for high impact. Completeness measures at 79.7% in core countries and 90.4% in high impact, and deployment performs the best at 85.8% and 93.2% respectively.

As noted above, alignment of Global Fund grants with national strategic plans is assessed through subjective assessment by TRP members on a limited number of aspects of alignment. The KPI for this sub-objective includes only a summary measure of this indicator. More rigorous objective assessment, which includes consideration of differences in epidemiology and implementation by geography and population, will be essential in order to ensure that country implementation is appropriately targeted.

SO2g: Strengthen financial management and oversight

Investment in financial management systems has increased, but they still makes up a very small portion of Global Fund investments. Historically, the Global Fund has invested very little in financial management systems, accounting for between <1.0%-7.3% of RSSH funds across all components in 2016. However, investments in financial management systems have increased across most grants from 2016 to 2019. The only decreases in the proportion of RSSH funds going to financial management systems were seen in MENA and WCA for HIV, MENA for TB, ESA for malaria and WCA for the multi-component grant(s).

The Global Fund has strengthened financial management systems in relatively few countries. The Global Fund measure progress in financial management as the number of high priority countries that transition to in-country financial management systems, as well as the number of countries with financial management systems that meet defined standards for optimal absorption and portfolio management (80% implementation of agreed action plans). As of the end of 2018, three (target: 3 in 2018) high impact countries had completed transitioned to in-country financial management systems. The Global Fund rates this as 'on target' to meet the strategy target for this KPI. Thirteen (target: 16 in 2018) countries have implemented required actions to meet defined financial management systems standards for optimal absorption & portfolio mgmt. To date, only 26 countries have reported data for this indicator. The Global Fund plans to grow the number of reporting countries from 26 to 46 in the next 3 years. This will provide a more comprehensive assessment of strengthening in this area.

Progress in strengthening financial management systems was greater for HIV and less for malaria. Many countries manage disease programs separately. We observed differences in the strength of financial systems, which correspond to the overall availability of funding of these programs. For HIV, 2 (of 15) countries reported performance below 2 countries reported performance between 80-90% and 11 countries reported achievement above 90%. For TB, 3 (of 14) countries reported performance below 70%, 5 reported performance between 80-90% and 6 reported performance above 90%. For

malaria, we observed considerably more variability than for HIV and TB. One (of 15) country reported achievement below 50% and only four countries reported achievement above 90%.

Secondary study into progress against SO2

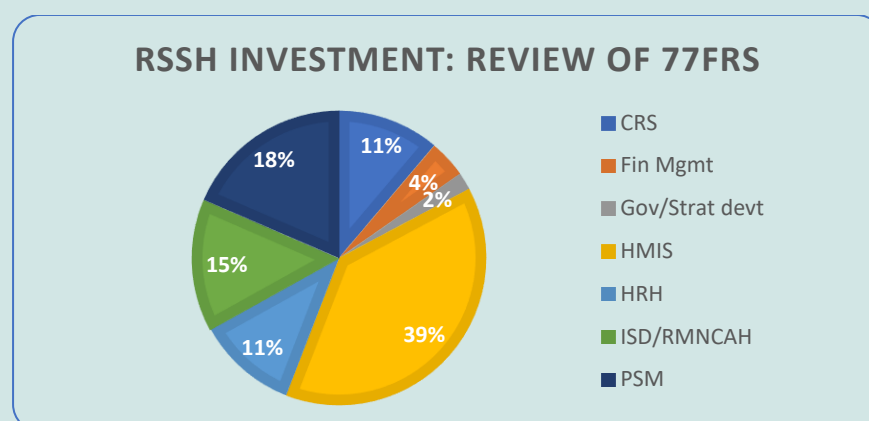
Introduction

Under the SR2020, a review was undertaken of the overall RSSH investments as well as a review by the SO2 sub-objectives. Sources of the data were the 2017-2019 FR budget reviews of RSSH modules during TRP/RSSH (2018), TERG/RSSH (2018), TERG/STC (2019), and TERG/SR2020 (2020) reviews; a total of 77 FRs.

Findings

The 77 FRs represented a total FR budget request of \$ 3,969,343,471 of which \$ 605,999,787 for RSSH investments, approximately 15%. This is higher than the overall review of RSSH investments during the 2017-2019 allocation period, where only 8% of the direct investment was for RSSH; the discrepancy is explained because the nature of the reviews undertaken was focused on RSSH- 'heavy' countries. However, the ratios of support to the different RSSH modules as shown in Figure 1 below is comparable: with a total 883 Mio investment for RSSH: investments were in HMIS: 40%, PSM: 17%, HRH: 18%, ISD: 12%, CRS: 6%, NHS: 3%, and FM: 4%.

Figure 1: RSSH Investment by RSSH modules/Sub-Objectives for 77 Funding Requests during 2017-2019



Nature of the RSSH investments

Supporting health systems

RSSH investments account for 65% supporting health systems⁵³, indicating inputs to keep systems going, improving outcomes, i.e., payment for recurrent costs of the MoH, the PR/SRs, and the operations of the disease programs: i.e., for salaries, support supervision, meetings, travel, TA from technical partners. If program management costs to support the implementation of disease programs and also considered an 'RSSH' investment were included, an additional 16% would be added, bringing the total for purely supporting the implementation of the Global Fund programs to over 80%.

Strengthening health systems

The remainder of the investments under the RSSH modules was to support the strengthening of health systems⁵⁴ (the main intention of the SO2), i.e., the implementation of systems that address changes in policies and regulations, organizational structures, and relationships across the health system to motivate behavior change and allow more effective use of resources to improve multiple health services and programs. Quite often, investments in the strengthening of systems were of a pilot nature and only possible if significant funding became available through portfolio optimization as a considerable amount of RSSH funding was requested for in PAARs. Also, strengthening health systems are often long-term processes that usually stretches beyond the Global Fund grant period.

Investments by RSSH Sub-objectives

From Figure 1 above, it can be seen that Global Fund has substantially invested in HMIS, PSM, and HRH, covering almost 75% of the RSSH investments. This has led to i) substantial improvements of information systems, particularly through the expansion of DHIS2 as an interoperable information system platform for the integration of the different disease information systems; ii) expansion of medicines and commodity distribution systems to 'last mile' facilities; and iii) adding workforce to support the implementation of the disease programs, both at national, local and community levels, primarily through salary support. A particular case is the financing for Community Health Workers that feature prominently in most of the NSPs. These posts are sometimes disease-specific (e.g., not integrated into broader services delivery). However, in general, plans for supervision, absorption, and future funding of positions are not well specified. While salary support is not necessarily wrong, it may prohibit addressing the strengthening of systems, and even future sustainability of the disease outcomes.

There was less investment in Integrated service delivery, improvement of financial systems and national governance, and inclusion of community systems to support disease program implementation. The latter was more often than not, through the establishment of CHW schemes, rather than looking at a more comprehensive community systems approach, e.g., using community mechanisms and structures to mobilize, advocate, support, and monitor key and affected populations.

Weak financial systems that include budgeting, accounting, auditing, contracting, and oversight mechanisms continue to hinder the effective and efficient implementation of Global Fund supported programs. However, most of these lie beyond the sphere of influence of the Global Fund with the Ministry of finance or the auditor general in a country or are affected by decentralization or fiscal devolution of health services. So, the FM support is mostly to ensure appropriate accountability of the Global Fund grant rather than supporting the broader financial systems.

Despite countries' desire to move towards UHC, requiring a more integrated approach of the provision of health services, Global Fund investment rarely moves beyond TB/HIV program integration through attention to co-infected clients, i.e., testing and medicines provision. There are a few countries where there have been attempts to integrate with other diseases such as Hepatitis C or dengue or have integration of services through the provision of a national health insurance service delivery package. There was a substantial investment in laboratory services under the ISD modules⁵³, where several countries attempted the integration of diagnostics (using GeneXpert for TB and Viral load testing), integrated specimen collection for lab investigations and integrated supportive supervision for IMCI and adult integrated health services (e.g., check for blood pressure, diabetes, and cholesterol).

While there is significant Global Fund support for the development of NSPs and broad engagement in program formulation and monitoring through CCMs, Global Fund governance support also here rarely ventures beyond the Global Fund supported programs. NSPs do not

⁵³Expanded from an international recognized differentiation methodology initially described in: G. Chee, N. Pielemeier, A. Lion, and C. Connor. 2013. "Why differentiating between health system support and health system strengthening is needed." *International Journal of Health Planning and Management* 28(1):85-94. "Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs. Examples of FRs that were health systems support oriented included requests for cars, computers, phones, travel costs for routine monitoring, furniture and office equipment, payments for fuels and maintenance of vehicles, cost for regular training or overseas training, software among, reimbursement for importation, among others.

⁵⁴ Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services". Examples of FRs that were more health systems strengthening oriented included requests for upscaling of volunteer network, develop protocols for data quality monitoring, develop SoPs for quality control in laboratories; transfer of the procurement system of Global Fund into the national procurement systems; digitize HMIS data, development of strategies to engage with the private sector, TA for DHIS2 roll-out, TA for improving PSM procedures including e-LMIS, establishing medicine regulatory authority, among others.

⁵⁵ Hence RSSH for Lab Systems has become a separate RSSH module in the 2020-2022 allocation period

always align with national health sector strategic plans, and Global Fund governance support is rarely sufficient to support the countries' decentralization and governance structures, which are usually processes that go beyond the three years of Global Fund support.

Examples of health systems strengthening through the different RSSH modules/sub-objectives

While supporting health systems for all the RSSH modules reflects common inputs, such as salaries, travel costs, meetings, supervision, utilities, and other recurrent costs, Table 6 below shows examples of strengthening efforts under the different RSSH sub-objectives. These represent activities that have an impact across health services and outcomes identified constraints, address revise policies, and institutional relationships to change behaviors and resource use to address and maybe sustained after Global Fund support ceases.

Table 6: Examples of Global Fund supported Health systems strengthening under the different RSSH sub-objectives

RSSH Module/Sub Objective	Examples of Global Fund supported Health systems strengthening
Procurement and supply chain management systems (PSM)	<ul style="list-style-type: none"> • Deploy a national eLMIS system • PSM training, Refresher training on SOP/tools for Labs • Transfer of procurement function from PR to the national system • Establish medicines regulatory authority; medicine steering committees; Update NLED • Improve storage, distribution, and management re PSM. Improve stock handling, equip some facilities. • improve/expand an electronic dispensing tool
Health management information system and monitoring and evaluation (HMIS)	<ul style="list-style-type: none"> • Analysis of expenditure on HIV prevention and care • Develop SOPs and protocols for routine monitoring of quality based on data • DHIS2 scale up with workshops at every level • Develop cascade analysis for routine data and develop dashboards and implement DQA • Development of HIV dashboards and tracking systems • Establishing systems for monitoring of human rights and quality of services; • Digitization and establishment of DHIS2 compatible hospital register; implementation of SMS data entry into DHIS2; and development of an interface between other data collection systems and DHIS2 • Selected surveys on Socio-cultural determinants limiting access to services; mini-DRS in provinces that are high prevalence for anti-tuberculosis drug resistance; Intensive Case Finding (ICF) among vulnerable groups; catastrophic costs of TB in households; TB-HIV co-infection, determinants of early diagnosis, comorbidities, and Pharmaco-resistance.
Human resources for health, including community health workers (HRH)	<ul style="list-style-type: none"> • Stigma Sensitivity orientation training • Continuous In-service training for medical staff at ART sites • Training of social health counselors • Basic and in-service capacity development of HWs • Develop manual for Community-based services, train CB staff • Establishment of health professional councils; • Establish HW database • HW medical ethics training: • Training of CHOs to supervise CH volunteers
Integrated service delivery and quality improvement (ISD)	<ul style="list-style-type: none"> • Expand and strengthen lab system, network, electronic labs systems • Integrated screening using mobile technology, support mobile team • Harmonize standards and enforce support supervision; Establish joint support supervision systems and monitoring • Integration of LIS with CMIS • Involve nutritionist in TB screening • Update of national standards of STI care, biosafety, and Universal Protection • Develop SOPs for QC in labs for the three diseases

	<ul style="list-style-type: none"> TOT on infection control mgmt.; Training on IP and waste management for lab personnel Establish cervical cancer screening as part of the HIV program
Financial management systems (FMS)	<ul style="list-style-type: none"> Health Equity Fund contribution for HIV services and transport Strengthen Audit systems; reinforce control structure in decentralized health systems, monitor compliance, and strengthen financial data management systems. Development of mechanisms for performance payment schemes and NGO contracting NHA, NASA, automation of accounts, strengthen supervision systems and PFM capacity building Establish systems for health resource tracking and integrated county planning and oversight Analyze cost recovery for private insurance patients; Analyze services for cost recovery for the three disease services
National health strategies (NHS)	<ul style="list-style-type: none"> Development of a unified national advocacy strategy for resource mobilization and policy buy-in at the state and LGA levels Scale-up area-based planning and monitoring mechanisms; social impact bonds pilot; grants to NGOs through Thai Fund Strengthen the planning system and improve planner's tech skills Development, consultations, and supervision of PPP and CRS strategies; joint missions with the private companies to support the three diseases Training re national budgetary system and expenditure tracking; Upscaling models of TB/HIV in prisoners, migrants, and KPs Needles syringe programs, PrEP coverage documentation, registration of XDR drugs; migrant health insurance
Community responses and systems (CRS)	<ul style="list-style-type: none"> Dev info mgt system for community-based activities; social mobilization; joint monitoring; Train community organizations in social mobilization, monitoring of services, strengthen local organizations, HRG response, and technical skills; Organizing community cadres, conduct needs assessment for community systems, create enabling environment and conduct community mobilization Establishing health migrant insurance, scale-up migrant volunteer network Strengthening referral systems, develop and disseminate referral tools; hold advocacy meetings conduct patient satisfaction surveys; establishment of Maternal death surveillance and response committees Support community-led advocacy for monitoring policies/rights issues; provide legal support to KPS Development of community health strategy to strengthen communities in local oversight

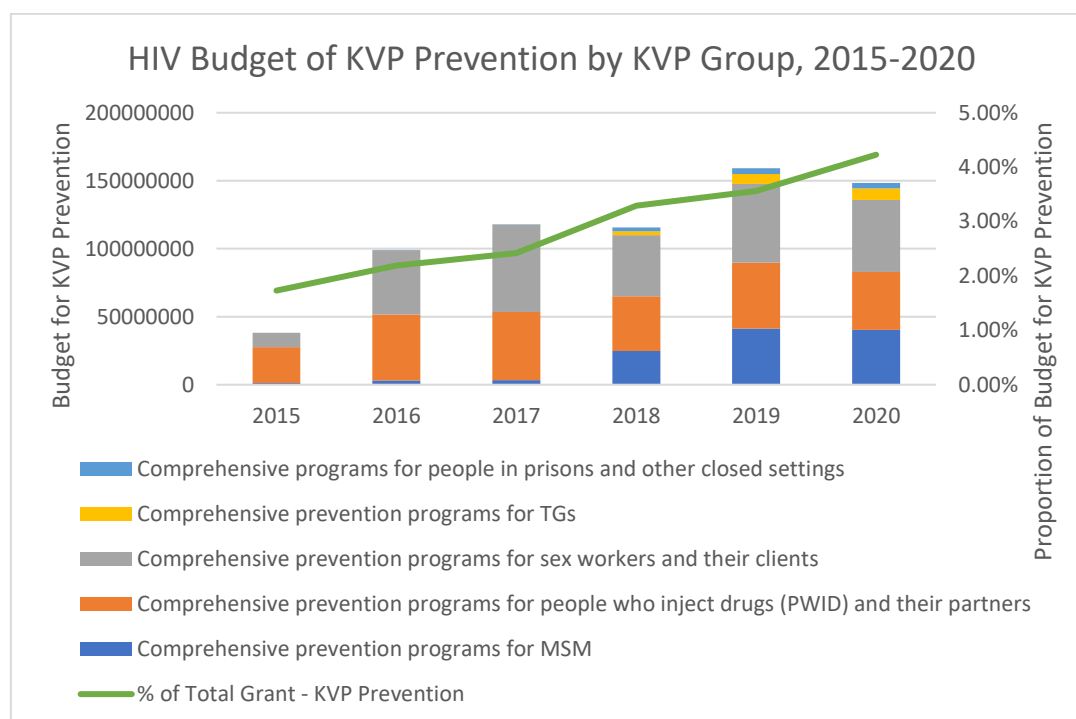
Conclusion

In summary, the RSSH findings of SR2020 review indicate that even though most Global Fund supported countries have made considerable progress along the health (systems) development continuum and continue to have substantial investments in RSSH, **little of it is going towards strengthening of the country's health systems to eventually facilitate sustainability of those investments and transition from Global Fund support.** Most investments are going towards supporting the implementation of information and procurement systems, with additional substantial investments for human resources, particularly community health workers. Few countries have investments for the integration of service delivery or community systems, which are seen as key to sustainability in the long run.

Strategic Objective 3: Promote and Protect Human Rights and Gender Equality

The Global Fund has increased funding toward human rights and gender, but these resources remain limited. Measurement of progress has been limited by the availability and appropriateness of data. Incidence of HIV among adolescent girls and young women has declined, but not enough to meet the Global Fund Strategy target.

The Global Fund has substantially increased investments to increase coverage, support and impact for key populations, human rights and adolescent girls and young women. However, these investments still make up a very small portion of Global Fund investments. The Global Fund has prioritized investments in key populations, human rights and adolescent girls and young women by creating matching funds initiatives for HIV grants each area: Key populations impact - \$26,817,316 (0.25% of overall funds); Programs to remove human rights-related barriers - \$28,292,964 (0.27% of overall funds); and Adolescent girls and young women - \$120,343,930 (1.13% of overall funds). Investments in KVPs has increased from 2.1% (2015-2017) of HIV and HIV/TB grant funds to 3.7% (2018-2020) of HIV and HIV/TB grant funds, investments in reducing human rights barriers has increased from 0.4% (2015-2017) to 0.6% (2018-2020) of HIV and HIV/TB grant funds, and investments in adolescents and out of school youth has increased from 1.3% (2015-2017) to 2.6% (2018-2020) of HIV and HIV/TB grant funds. Given the large contribution that these populations make to incidence of HIV, it will be important to scale up these programs in order to reduce incidence and mortality for KVPs and AGYW.



Current methods to assess service coverage for KVP do not facilitate country-level or longitudinal assessment. It is hard to assess outputs and impact on disease given the dearth of comparable data that exists for specific KVPs. Specifically, countries often rely on bio-behavioral surveillance studies to estimate population sizes of KVP, predictors of disease, and current disease burden. However, these estimates are often incorrectly extrapolated from specific study geographies to entire countries. Recent research has shown age biases in BSS recruitment methods, which can lead to under-

estimates of HIV prevalence.⁵⁶ Additionally, longitudinal analysis can be difficult due to irregular collection of data and methodological changes. These concerns could mean that the true state of the epidemic amongst KVP is misrepresented. As these data are heavily relied on to provide targeted guidance, there are uncertainties around if program planning and target setting represents what is actually occurring within a country. Integration of service coverage for KVPs into routine data collection using innovative approaches to limit stigma is needed to identify needs and better target and plan programs for KVPs.

Incremental improvements have been made in the elimination of human rights barriers to access to services, but there is still much work to be done. Whilst funding for prevention has improved amongst KVP, specifically for HIV, there exist significant human rights barriers which pose a hinderance to positive health seeking behavior. Though criminalization of sex work, injection drug use, same sex behavior, and gender non-conformity has decreased in some regions of the world, many countries still enact severe punishments for these groups. In looking at systemic changes to remove human rights barriers to accessing care, most countries have implemented interventions which assure confidentiality and privacy, but few governments carry out due diligence where reports/documentation of human rights issues take place, specifically in PMTCT programs. One third of countries do not have a complaints procedure, or procedures/systems to protect and respect patient privacy or confidentiality. Additionally, two-thirds of countries do not have laws protecting against discrimination on the bases of HIV status, highlighting the need for countries to adapt human rights centered disease policies. There is some positive outlook in that perceived participation of KVP in civil society has improved from 2017 to 2019 across Global Fund countries, though there has been no change in this perception within government. Data suggest that key and vulnerable populations still avoid healthcare due to stigma and discrimination across the globe but especially in Western and Central Africa and the MENA regions; this results in worse health outcomes. For example, in looking at transgender people, sex workers, prisoners, people who inject drugs, and men who have sex with men, no group except transgender persons in Asia, has reached 90% ART coverage when looking at West Central Africa, South-Eastern Africa, EECA, Asia, and the Americas.

The Global Fund is on track to meet its modest targets for reduction of human rights barriers to services. The Global Fund has conducted baseline assessments of national programs for reducing human rights-related barriers to services in 18 countries and 17 countries have been about to incorporated matching funds into their country grants. Substantive stakeholder meetings have commenced in nine countries, but to date, none of the 20 targeted countries has established a comprehensive program to reduce human rights barriers to services. Although the Global Fund rates this progress as 'on track' to meet the Global Fund Strategy target of four countries with comprehensive programs to reduce human rights barriers to services, significant scale-up is needed in order for these programs to impact service coverage and burden of disease.

Global Fund programs for AGYW are too nascent and diffuse to show demonstrable progress. The scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights is essential to stemming the leading edge of the HIV epidemic. However, less than 50% of country strategies and policies specifically incorporate activities for Adolescent Girls and Young Women (AGYW). A little more than a third of countries have set targets for prevention among AGYW and their partners, a starting point for being able to measure progress. Where prevention strategies are implemented, less than half provide comprehensive programs that included community-based outreach, youth-friendly health services, school-based HIV prevention campaigns, new media interventions, and less than a quarter have social support/economic

⁵⁶ Johnson LF, Mulongeni P, Marr A, Lane T. Age bias in survey sampling and implications for estimating HIV prevalence in men who have sex with men: insights from mathematical modelling. *Epidemiol Infect.* 2018;146(8):1036-1042. doi:10.1017/S0950268818000961

empowerment programs. Intervention like the DREAMS program show that targeted interventions assist greatly in reducing HIV incidence in this population (25-40% reduction) and should be scaled.

Incidence of HIV among AGYW has declined, but not enough to meet Global Fund Strategy target. Globally, incidence of HIV has declined 14% between 2015 and 2019.⁵⁷ The Global Fund assesses the impact of investments toward AGYW by assessing change in HIV incidence among this group within 13 countries. As of the end of 2018, HIV incidence among AGYWs in these countries has declined 16% since 2015. The Global Fund rates this progress as ‘at risk’ to meet the Global Fund Strategy target. If recent trends continue, approximately ¾ of the target (58% decline between 2015 and 2022).

Strategic Objective 4: Mobilize Increased Resources

Donor and country resources have increased during the current and next grant periods. However, documentation of country contributions remains opaque. The global economic recession that has resulted from the coronavirus pandemic threatens recent progress.

The Global Fund has effectively mobilized increased donor and country resources. The Global Fund was successful in mobilizing 12.9 billion dollars during the fifth replenishment (2017-2019) and 14.0 billion dollars from donors during the sixth replenishment (2020-2022). The Global Fund rated these resources, along with committed country resources, as sufficient to meet 2017-2022 Strategy targets for Lives Saved and reduction in new cases/infections.

Globally and across diseases, domestic commitments have increased substantially from 2012-2020. Domestic commitments to TB have increased the most, followed by HIV, and then Malaria. Of note, Global Fund contributions to malaria also declined during this period. Regionally, there are differences in how domestic commitments have changed overall and by disease. ESA and WCA had the smallest increases in domestic commitments from 2012-2020 across all diseases. In fact, WCA reduced domestic commitments over the time-period (2012-2020) both for Malaria (-558%) and TB (-8.9%). WCA was the only region where Global Fund investments increased during this period across all three diseases. We did not observe a correlation between change in domestic commitments and GNI.

Overall, the Global Fund has determined that countries have largely met their commitments to domestic spending for HIV, TB and malaria. Of the 88 countries represented, the average proportion of domestic spending versus commitment was 106% during 2015-2017. Additionally, countries also contributed 124% of what the Global Fund requested. However, there are some outliers. Guyana, Pakistan, Timor-Leste, Ukraine, and Uzbekistan all contributed <50% their commitment during 2015-2017.

Documentation of country contributions in lower-income countries is challenging, infrequent, inconsistent and not transparent. The types of resources committed vary among higher and lower resource countries. In higher resource settings, countries have been able to take over payment of specific inputs, such as medication or bed nets. In lower resources settings, contributions are less specific and include contribution to the overall health system for HIV, TB and malaria. The Global Fund Secretariat reviews financial ledger and other country-level systems to verify domestic contributions in each country at the end of each grant period. However, the processes to conduct this verification are not well defined, vary by country and are not available publicly. Thus, it is difficult to know whether countries, particularly lower resource countries, have actually increased domestic contribution to HIV, TB and malaria programs.

⁵⁷ <https://aidsinfo.unaids.org/>, accessed 28 July 2020.

Finally, the coronavirus epidemic threatens both donor and country resources. The coronavirus pandemic has had a devastating impact on the global economy and on how countries provide healthcare to protect vulnerable populations. As donors shift priorities due to changing political landscapes and COVID-19 response, there is the possibility of decreased investment among both donors and recipient countries. As such, it will be essential to rely on strong domestic capacity to innovate and increase efficiency in order to continue to effectively respond to HIV, TB, and Malaria.

ANNEX 4.III: PROCUREMENT AND MARKET SHAPING (SRQ11)

The Global Fund delivers significant value in the market shaping space directly under its control. There is great opportunity for further VfM gains in the areas where it has less control, but potential for influence. The Market Shaping Strategy Mid-Term Review concluded that the Global Fund's market shaping work has continued to deliver strong performance under the current strategy and is a main driver of economies achieved by the Global Fund. Approximately 50% of Global Fund finance goes towards health commodity purchase such as bed nets, condoms, diagnostic tests, and medicines. The Global Fund has increasingly taken on a more deliberate market shaping role in global health commodities over time; this came about in tandem with the change in the business model in 2013-2014, the shift to an allocation-based funding model that led to more active engagement from the Secretariat. The Global Fund has become a key player in shaping the markets for the three diseases, acting as a bulk purchaser of high quality commodities within the three disease areas through its Pooled Procurement Mechanism (PPM), consolidating demand from LMICs which individually are unlikely to benefit from significant buying power that is achieved through this consolidation, passing these benefits on to countries in the form of newer, higher quality products at affordable prices. In 2019, 59% of health products budgeted in grants were procured through Pooled Procurement Mechanism (PPM) amounting to approximately US\$ 870m in orders. The recent Mid-Term review (MTR) of the Market Shaping Strategy (MSS) xx date 2019 found that The Global Fund's Sourcing and Supply Chain team (now called the Supply Operations Department (SO) has driven strong improvements in availability and affordability, and broader market-shaping successes across product categories, through *"category-specific strategies developed by the SSC team, in consultation with others, to guide sourcing and market-shaping activities; tenders and implementation of long-term framework agreements (LTAs) using a performance-based approach to manage suppliers; clearly defined and reported metrics for PPM spend; comprehensive transaction data, and; partnerships with other major procurers."* The targeted savings for KPI 12b have been exceeded - US\$ 174m of savings achieved in 2019 through PPM, exceeding annual savings target of US\$ 115m⁵⁸. 85% of PPM orders were delivered on time and in full (OTIF) in 2019, also exceeding internal target. The target for number of defined products with >3 PPM suppliers meeting Quality Assurance requirements at 71% is not being met, however the indicator was not allowing for the market characteristics of low volume / pediatric products and appropriately, a new indicator with more realistic methodology, differentiating between products (Low/High volume) will be used from 2020. For a summary of results under PPM spend for certain product categories, see the Figure 2 below from the MTR MSS.

⁵⁸ For 2019, 83% of the 59m savings surplus is driven by ARV and LLIN product categories. 1st line ARV regimen volume increased by 18% vs. projection from late 2018. 1st Line regimen is the key driver of ARV savings. Further price decrease of ARV 1st Line regimen by 8% and lower prices for other ARV products achieved as a result of regular supplier negotiations. There has been an increase in PBO LLIN volume 15% vs. 5% of overall volumes projected. Increased PBO net uptake and PBO net price decreases due to supplier negotiations resulted in larger LLIN savings. Further 11% decrease in prices of ANTM medicines (AL) has been achieved as a result of upstream strategy of securing artemisinin supply and stabilizing artemisinin prices.

Figure 2: Key market-shaping achievement

Figure A – Key market-shaping achievements Source: PPM Transaction files

Slide source MSS MTR July 2019

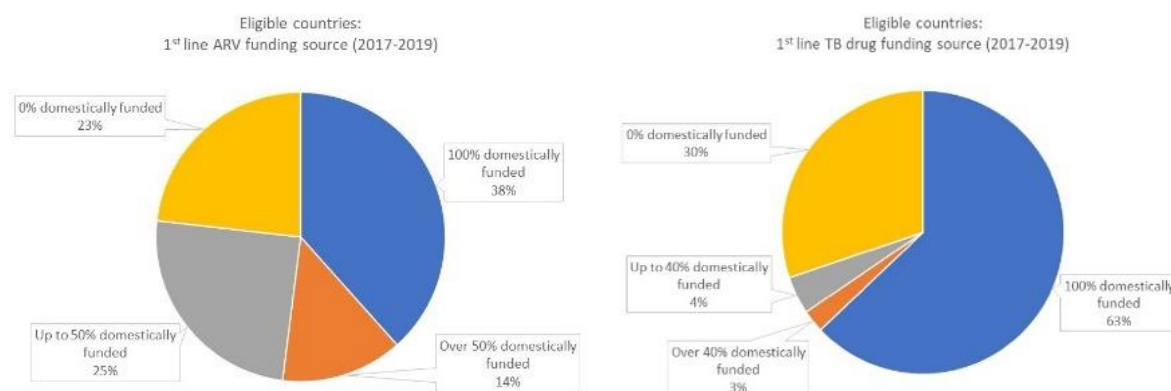
Going forward, key opportunities for the Global Fund will be to step up as an organization on how to introduce innovative products rapidly, to maintain the gains on the SSC's teams core business even as the Global Fund becomes a smaller portion of the overall market in some product categories, and to help countries maintain secure access to affordable, quality products as their share of domestic finance towards health products increases.

Given the fact that SR2020 review began only a few months after the MTR MSS was concluded, it was agreed that SR2020 would focus on those areas suggested by the MSS MTR as important for the Global Fund's overall strategy – risks associated with increased domestic financing; market-shaping objectives beyond availability and affordability, to cover spend channels beyond PPM; and institution-wide efforts shape markets through supporting introduction and scale of new or underused health products.

There has been a long-term trend towards increased uptake of health commodity costs with domestic funding, which increased through the last allocation cycle (2017-2019) under the implementation of the STC policy. Prior to introduction of the New Funding Model (NFM) in 2014, 27% of eligible countries were procuring 100% of first line ARV treatments with domestic funds, while now 38% of eligible countries are fully procuring 1st line ARVs and 39% of eligible countries are partially procuring 1st line ARVs, leaving only 23% of countries which are 100% reliant on Global Fund finance for their ARVs.⁵⁹ With regard to first line TB drugs, prior to NFM 1, 53% of eligible countries were procuring 100% of 1st line TB drugs with domestic funding, whereas now the figure is 60% and 10% of eligible countries are partially procuring first line TB drugs.⁶⁰

⁵⁹ Examples of countries fully funding ART with domestic funds: Bangladesh, Philippines, DPRK, Egypt, Columbia, Botswana, India, Honduras, Georgia, Sri Lanka. Countries relying fully on Global Fund or other partners are primarily LI or LMIs, COE and small island economies, and almost universally have high or less than high disease burden (as opposed to severe or extreme, 42/48) i.e. Ethiopia, Mozambique, CAR, Gambia, Rwanda, Kiribati, Samoa, Tonga, Guinea Bissau

⁶⁰ 63% (out of 116) of countries procure TB FLD drugs domestically. A little over of these countries have severe – extreme burden of disease, for example Bangladesh, Cambodia, India, Kenya, Kiribati, Lesotho, Mali. 30% of the countries rely entirely on external support, of those half of them are COE countries. 75% of the countries that are unable to domestically procure FLD TB experience severe – extreme burden of disease, for example Afghanistan, CAR, DRC, Ethiopia, Haiti, Iraq, Malawi, Niger, Mozambique, Tanzania

Figure 3: Proportion of countries domestically procuring 1st line HIV and TB drugs⁶¹

The trend toward increased uptake of health commodity costs with domestic funding is likely to continue into the next allocation cycle (2020-2022). In more than half of the allocation letters for the 2020-2022 cycle, country teams chose to make reference to increased uptake of drugs (ART, ACTs, TB) and other health products (vector control and diagnostics) as one priority area for country dialogue discussions.⁶²

The Global Fund uses a variety of strategies to support and strengthen domestic procurement of quality health products.

- Implementation of the Market Shaping Strategy, including benchmark pricing, procurement capability building in select countries, extension of PPM LTAs via collaborations with countries and partners. Two examples from SR2020 case study countries:
 - The Strategic Sourcing team is offering TA to the Ethiopia EPSA, on the request of the CT, to help EPSA have a more stable supply base and be able to build in supplier performance into tender criteria
 - In Ukraine, Global Fund supported procurement platform strengthening, including addressing national procurement, regulatory, and registration challenges to accessing quality affordable drugs.
- Financing of Technical Assistance through grants and strategic initiatives to address systems and capacity related issues hindering effective procurement of quality assured health products, including NRA strengthening, for example the “T” part of the STE SI provides the majority of funding used by the Global Fund to support transition / sustainability planning and analysis, and has also been critical to launching pilot initiatives to address specific transition challenges (including, but not limited to UNICEF collaboration in EECA on procurement)
- Engagement of Global Fund CTs and HPM specialists to encourage quality domestic procurement, support national capacity, foster early planning, advocate for use of international pooled procurement platforms, where appropriate. See below for Indonesia example
- Strengthening Secretariat capacity and improving Secretariat guidance (i.e. updated STC Guidance Note, with annex on Health Product Management)

⁶¹ Slide source: Jan 2020 wambo.org consultations: Health financing trends and Global Fund efforts to strengthen the sustainability of national procurement programs.

⁶² Jan 2020 wambo.org consultations: Health financing trends and Global Fund efforts to strengthen the sustainability of national procurement programs

- Finally the Global Fund's is working on extending its Pooled Procurement Mechanism (PPM) approach to non-grant financing through the Wambo.org platform, to provide an additional tool for countries to consider when thinking about maintaining quality, affordable health product procurement (including in transitioning or transitioned contexts). Lessons learned and findings from an evaluation of the pilot are expected to be reported to the Board for consideration no later than November 2022 (e.g., GF/B42/DP05)

SR2020 conducted a review of several sources of information available within the Secretariat⁶³ and found a high number of countries have experienced challenges with domestic procurement and/or finance of health products. At least 38⁶⁴ countries have experienced challenges with domestic financing and procurement during this strategic period, including paying high prices for first line drugs; weak quantification systems and/or long government procurement processes causing stock-outs; late and partial government counterpart payments causing procurement delays and stock-outs. Although other Global Fund reviews have documented selected country experiences with domestic procurement⁶⁵ and GDF has published data on challenges with domestic procurement for TB drugs specifically⁶⁶, this is the first effort to more systematically review the challenges experienced by Global Fund supported countries in domestic financing and procurement for both TB and HIV drugs during the current strategy. Illustrative examples of issues are shown in Box 2.

⁶³ i) the TRP database 2017-2019, ii) Sustainability issues identified by the GAC, iii) 4 HPM focus groups iv) Interviews with members of Secretariat.

⁶⁴ Methodology notes: TRP issues coded as PSCM and STC were searched using key words (e.g. stock-outs, procurement) and reviewed for relevance specifically to challenges related to domestic finance or procurement of health products. Issues related to supply chain and distribution were excluded. This was supplemented with 3 additional information sources (HPM focus groups, Secretariat interviews and review of the GAC sustainability concerns database).

⁶⁵ TRP lessons learned, the STC Review and the MSS MTR

⁶⁶ Waning, B. Risks of decentralized procurement in fragile TB markets: Observations, implications, and recommendations at national and global levels. 2018 as quoted in MSF Access Campaign Policy Brief JULY 2019, BEWARE THE GLOBAL FUND PROCUREMENT CLIFF Safeguarding supply of affordable quality medicines and diagnostics in context of risky transitions and co-financing

Box 2: Examples of PSM issues faced with domestic financing of health products

HIV/AIDS, Window 3, Program Continuation, Grant making, PSCM (EECA)

Domestic ARV procurement results in poor value for money.

Issue: Azerbaijan is paying twice pooled procurement mechanism (PPM) prices for first line antiretroviral drugs (ARVs) procured domestically, partly due to the small market size. With plans to procure further ARVs with domestic funds, and given the current uncertainty of domestic resource contribution and the move to test and treat, the applicant is vulnerable to stock outs, which may hamper the achievement of the proposed targets.

Action: The TRP recommends that the applicant investigate the possibility of using the pooled procurement mechanism (PPM), until domestic procurement with reliable national fund release can achieve comparable pricing, quality and supply security.

HIV/AIDS, Window 4, Program Continuation, Grant-making, HIV treatment and care (LA)

Risk of disruption to ARV treatment and achievement of value for money.

Issue: TRP notes that with the 30 percent reduction in Global Fund allocation for 2017-2019, the Government of Jamaica has chosen to fully absorb all treatment costs (ART and treatment monitoring). The World Bank study referenced in the program continuation request shows that Jamaica has made significant progress in the payment of treatment costs; however, due to long governmental procurement processes, recurrent stock-outs have been experienced.

Action: The TRP requests that the applicant works with the Secretariat, technical partners and other donors to address existing bottlenecks in the procurement and supply chain system in order to reduce stock-outs and improve access to quality and affordable medicines.

TB/HIV Window 3, Tailored material change, Grant-making, Sustainability, Transition and Co-financing (WCA)

Late and partial payment of government counterpart commitments

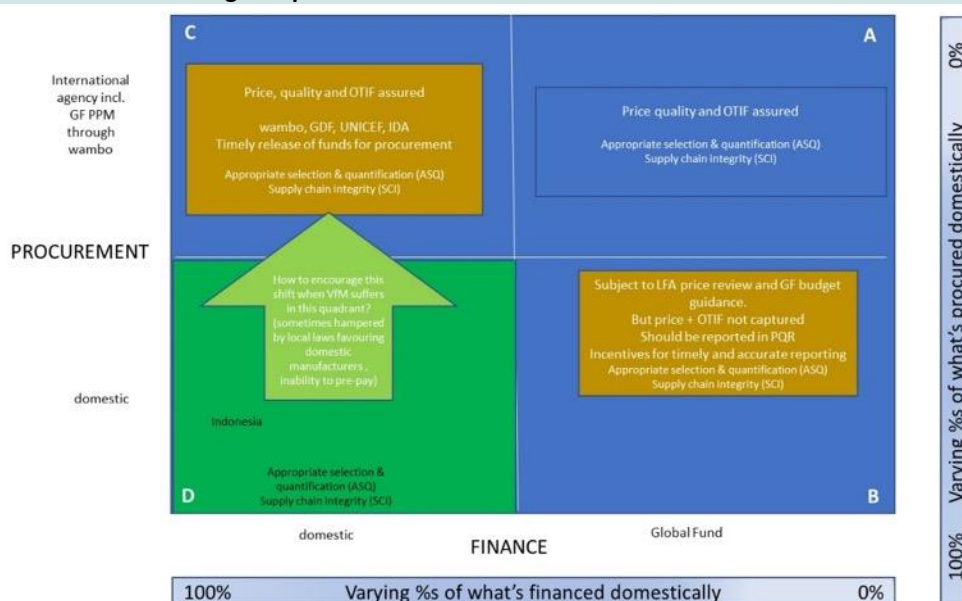
Issue: The government has only provided partial information for willingness-to-pay compliance. There are on-going fiscal constraints associated with insecurity in the country and gaps associated with government expenditure reporting. Given these constraints, there is an ongoing risk that counterpart financial obligations will be delayed therefore putting at risk counterpart commitments overall.

Action: The applicant is requested to provide a contingency plan detailing how critical elements of the program will be carried out if government financing is not made available as needed. It is recommended that the Government procurement be focused to fully cover a limited number of commodities, with benchmarks (capacity and financing) and a timeframe for eventually undertaking procurement of all critical drugs and commodities. While there will be benchmarks within the grant period, the full timeframe is likely to go beyond the time period of this grant.

Figure 4 below shows the four main scenarios Global Fund countries fall into for financing and procurement (although there may be different percentages of total amounts financed and procured domestically, so the heterogeneity is greater than the 2x2 matrix implies). Transactions which are Global Fund financed and procured (A. upper right), Global Fund financed and domestically procured (B. lower right), domestically financed and procured via international procurement agency (C. top left), and domestically financed and domestically procured (D. lower left). As the graphs in Figure 3 above shows, **77% of countries are partially or fully procuring their first line ARV drugs while 70% of countries are partially or fully procuring their first line TB drugs. This means that the majority of Global Fund countries are partially or fully in the green Box D, where most of the 38 challenged countries identified by the SR2020 are located.** There are some very large “big hit” countries in Box B (Figure 4) like Ethiopia and Kenya for ARVs, who are using Global Fund finance to procure domestically. With support from the Global Fund Supply Operations Department, they are doing so increasingly successfully in terms of not only prices but also on terms of on time, in full delivery (OTIF). They are required to report prices in the PQR and are subject to LFA price review and Global Fund budget guidance on the prices paid. However, there are problematic incentives for timely and

accurate reporting in the PQR, and no penalties for failing to do so. Also, OTIF is not captured by PQR. In Box C below (Figure 4), price quality and secure supply is assured, but countries can still face challenges with timely finance release for procurement. Countries such as Ukraine, Philippines have moved from Box D to Box C, having experienced some challenges with domestic procurement. Other countries have difficulties moving to Box C due to local laws favoring domestic manufacturers, or inability to pre-pay when ordering. Ukraine has spent the past few years strengthening its procurement systems to be able to move back down to Box D and domestically procure again. Regardless of which box countries fall into, all countries need to consider appropriate selection and quantification as well as supply chain integrity, which are the pre-requisites pre and post procurement to assure access.

Figure 4: Scenarios for financing and procurement



SR2020 analysis of experiences with non-PPM procurement heightens the urgency of the MSS MTR's recommendation to expand KPIs to capture information on spend beyond PPM, however current proposal for KPI 6a will not provide insight into the experience of the vast majority of Global Fund supported countries. Procurement through national systems is a Board concern and KPI 6a was designed to capture intelligence on this subject. The original intent was to use PQR⁶⁷ to measure these indicators across all procurement channels (e.g. national systems, sub-contracted procurement agent, Global Drug Facility, multi-lateral PRs), but there were challenges in using the PQR to collect the data and the indicator continues to be discussed and negotiated. In the most recent Board papers, an approach was put forward to explore the option of adjusting the cohort to include the 6 national procurers and 4 international agencies that make up approximately 30% of Global Fund health product spending and focus on price reporting only, removing the indicator measuring of on time supply availability. This was justified on the basis of the ease of collecting the data and the value of expenditure captured, "When taken together with PPM, 85% of health product spend would then be monitored via standard indicators; focusing on small number of high volume procurers will streamline the data collection process and overcome challenges." Under this approach, procurement via the 3 quadrants in blue would be captured but not procurement and supply activity in the green quadrant D, where most countries are at least partially located and

⁶⁷ Grant recipients who procure domestically with Global Fund finance (Box B) are required to record and track the prices paid for some medical commodities on a publicly available web-based system called the Price Quality Reporting (PQR).

where most of the challenges are being experienced. So while it is true that KPI 6a will capture intelligence on 85% of procurement value, it will miss out on the majority of the health product transaction volume, and the area where the monitoring is actually needed. Also, it should be noted that KPI 6a also will not provide any information on procurement-related stock-out issues countries may be experiencing in quadrants B, C and D or quality issues experienced in quadrant D. **In choosing the focus of KPI6a, it should be acknowledged that this will capture fewer, higher value transactions in well performing countries with good capacity, not capture smaller volume less well capacitated or transitioning countries where challenges are occurring and the opportunity to create value may be greater.**

The Global Fund has processes in place to identify, mitigate and manage risks with domestic finance/procurement; there is no mechanism to collect and analyze these experiences across – countries and when an issue is identified for a single country, there is weak follow up and accountability to ensure that actions are taken to mitigate risks in a way that addresses the root cause of the problem.

The Integrated Risk Tool, Transition Readiness Assessment, and country review meetings are the tools used in GMD to identify mitigate and manage risks, including those related to procurement and supply chains. The fact that 38 countries experienced issues implies that risks are not being systematically identified or mitigated in an effective or sustainable way; this is consistent with OIG’s conclusion in the May 2020 Annual Report “there is still limited follow-up and weak accountability in the implementation of key mitigating actions by front-line grant management units”.⁶⁸ The TRP review process is another mechanism to identify and possibly mitigate risks, and as discussed earlier, many of the 38 experiences identified were indeed flagged during the TRP review process. SR2020 was able to follow through one illustrative example from the SR2020 Pakistan country case study, where TRP guidance was not actioned, with negative consequences. (Box 3). This is consistent with the OIG’s conclusion that “controls are not yet in place to ensure follow-up on these recommendations as part of key decision-making processes during the grant lifecycle, such as the Annual Funding Decisions and/or Disbursement requests. Instead, the follow-up practices are ad hoc and inconsistent across different country teams. As a result, a risk remains that key programmatic recommendations from TRP may remain unresolved during the grant implementation cycle.”

⁶⁸ SR2020 was not able to gain access to the IRT

Box 3: Challenges to domestic finance and procurement of TB FLDs in Pakistan

During NFM2, 20% of the Global Fund allocation for TB was provided as a co-financing incentive, linked to an additional US\$26 million investment by the government. The country committed to gradually taking over the procurement of first-line TB drugs from 50% in 2018, to 70% in 2019, up to 80% in 2020, through provinces providing PC-1 funds (a project-based mechanism in which funds are approved in principle but released subject to availability, typically only partially and after delays). The TRP's review acknowledged the risks arising from insufficient assurance of provincial governments' contribution to TB funding and advised several actions to enable greater visibility of progress in spending against plans and facilitate course-correction and contingency planning should there be a problem with timely release of funds. The TRP also flagged the linked issue of uncertain maintenance of price, quality and secure supply of FLDs while transitioning to domestic finance, and advised the applicant take steps to assess financial and procurement capacity at province level, with a view to preparing for eventual transition of TB FLD finance and procurement to provincial level. The CCM response to TRP issues talked around the issues, but offered no remedies; this response was accepted by the CT. In SR2020 interviews, the CT acknowledged they were aware that release of PC-1 funds covering 50, 70 and 80% of TB FLDs would be unlikely and a choice was made to be ready with mitigating strategies - following closely with 6 monthly reviews with partners, ensuring a higher amount of buffer stocks and re-programming to cover the deficit. An April 2020 OIG audit of the Pakistan TB grant stated that the government procured only 19% and 12% of the medicines in 2018 and 2019, which resulted in the Global Fund stepping in to procure medicines to prevent a nationwide stock-out. A supply chain diagnostic conducted by the Global Fund Supply Chain Initiative was conducted in late 2019 and identified several issues with provincial procurement: lengthy procurement times and budget constraints; the price of locally purchased FDCs were 50% higher than GDF prices; tender quality requirements were either non-existent (risking compromised quality) or too restrictive, limiting competition. The diagnostic recommended a variety of actions to address the root causes, including exploring the option to release the Global Fund funding only after PC1 funding has been fully released in accordance with the Global Fund/GoP agreed plan.

The Global Fund deals with domestic procurement challenges in a variety of ways, in the context of lack of a corporate policy which defines what the Global Fund's role should be. The most common approach to mitigating identified risks with domestic procurement is to influence factors within the control of the Secretariat - pre-emptively overstocking pipelines; reprogramming grants to cover shortages; and calling on the SSC's rapid supply mechanism that responds to emergency orders.⁶⁹ **There is currently heterogeneity in the approaches taken by CTs and a diversity of views within the Secretariat as to what the role of the Global Fund should be, with some taking the view that the Global Fund has no role in influencing what the government does with its own funds and others of the view that "If the Global Fund has a QA policy for medicines, how can we support a program where there's domestic financing for products and we're not confident in quality of those products?"**

The diversity of views and potential for leverage plays out at the country level, for example in Indonesia⁷⁰ where the Global Fund is contributing US\$ 160 million of taxpayer money to the TB program, making it Global Fund's third largest TB grant, the view of the country teams seem to be that the Global Fund has a responsibility to ensure overall programmatic and disease impact from that investment, including taking a role in ensuring VfM in the government's contribution to TB medicines. The Indonesia country team is engaged with the issue proactively through not only budgeting for emergency procurements and closely monitoring stock levels and domestic procurement timelines to prevent stock outs, but also working with the PR and partners to negotiate reductions in import permits in cases of emergency orders, negotiating prices with parent companies and their local entities, engaging in high level advocacy with the senior management

⁶⁹ The rapid supply mechanism started in 2015 and responds to emergency orders for antiretroviral drugs for HIV, artemisinin combination therapy for malaria, and rapid diagnostic tests for TB. The rapid supply mechanism is accessible in all countries supported by Global Fund grants, and leverages Global Fund Framework Agreements that require vendor-managed inventory.

⁷⁰ VfM in domestic procurement is hampered in several ways in Indonesia; local laws and regulations favor local tax paying suppliers who can charge high mark-ups added by the local agent/distributor in country; procurement delays result in the need for emergency procurements; and there is a long importation process for Global Fund procured products which are not registered in country.

within MoH (DG level) to accelerate importation of TB diagnostics (and in case of ARVs shortage for HIV program with the office of president and Vice president). There has also been work with partners both in-country and at Headquarter level to support local entities with local production capacity; for example, through partnership with United States Pharmacopeia Convention (USP), the Global Fund has supported pre-qualification of one supplier for TB second-line drugs (SLD) (levofloxacin) so that local procurement can be conducted with Global Fund funding. In nearby Philippines,⁷¹ where the Global Fund contributes only 4% of the country's HIV response, the HIV program is experiencing similar issues and partners such as USAID are helping DOH to address underlying issues, while the Global Fund grant funds are being used to support the development of an eLMIS system, to remedy one of the root causes of stock-outs.⁷² **Clearly different contextual factors will influence the likelihood of influence and the tools and tactics chosen**, not only the size of the Global Fund financial contribution to the overall program budget but also factors like whether the commodity challenges are related to a specific intervention the Global Fund is funding, whether the challenging commodity line is shifting as part of a Global Fund co-financing agreement, whether the challenges are related to the need for skills and processes capacity building/development or if they are more structural, related to legal and political barriers and industrial development objectives or governance and even corruption issues, whether the Global Fund SO has a relationship/or is providing TA enabling some skills/process correction, whether the Country team and HPMs have the capacity and skills to advocate and negotiate the more intractable structural barriers, and whether other partners are engaged in trying to support and influence across the wide sphere of fiscal, health and trade policies relevant to the subject.

⁷¹ Experiencing similar problems with long domestic procurement delays, stock outs, higher prices for RDTs, VL and ART, with Global Fund having to buy emergency nevirapine and VL POC tests cost 50 US\$/unit

⁷² The review team understands that partners such as USAID are helping DOH to address underlying issues, although no further details are available

ANNEX 4.IV: INTERVENTION SELECTION (SRQ10)

Market shaping for innovative health products: Under the current strategy, the Global Fund has catalyzed new market entry of innovative technologies. Collaboration with partners and cross-team Secretariat work is making this work stronger, though still with opportunities to improve.

Innovative health technologies are important to impact, and without market shaping effort, they take many more years to be reach scale in LMICs. A modelling exercise conducted as part of the Global Fund investment case the concluded that disease impact goals would have been reached 3 years later without the 10 health product innovations that were introduced over the last few years, underlining the important contribution of innovation. Without deliberate market shaping efforts by global partners, we know the counterfactual is that innovations can take up to 17 years to reach LMICs 20% coverage. Data in a study published by the Lancet shows how much time different health products took to reach the 20% LMIC target coverage: 8 years for ARVs, from Non-Nucleoside Reverse Transcriptase Inhibitor approval in 1997; 16 years for Hepatitis B vaccine, from approval in 1981; 17 years for oral rehydration solutions, from Bangladesh rollout in 1980.

The Global Fund does “smart procurement” very well, helps to scale innovations, and helps PRs and countries to optimize product selection. The Global Fund’s role in market shaping is more indirect – providing a “pull” incentive to enhance incentives for R&D; incentivizing quality standards, though requiring grant funds to be used only for WHO-recommended products which have a WHO-PQ, ERP, or SRA-approved manufacturer. There has been less focus on operating outside of the core sourcing-centric mandate, for several legitimate reasons - capacity, skills, the principle of country ownership meaning that the Global Fund does not select products for countries, coordination with other market shaping partners, and the limitations due to the internal Secretariat structure, with country teams, supply operations and technical leads – all required for product introduction and scale up - separated into GMD, SSC and TAP divisions, with no structured mechanism to coordinate in this area.

Under the current strategy, the Global Fund has had an important role in enabling several underutilized or new innovations to be researched, introduced or scaled; increasingly, these efforts involve support from teams beyond SSC and are funded with dedicated SIs

- **SSC enabled scale up, and effective use, of early infant diagnosis testing:** In 2014, there was high variability in prices both geographically – between and within countries - and over time for VL-EID diagnostics. Two main suppliers dominated the market, there was limited price transparency, ‘hidden’ costs (e.g., servicing, warranty, consumables), all of which led to under-utilization of VL equipment. SSC developed a novel approach to address these market dynamics – the “total cost” approach whereby LMICs were able to procure machines via an all-inclusive pay-by-the test price which includes machine rental, maintenance, service, warranty and consumables. This strategy facilitated price transparency and comparison; the number of countries procuring VL/EID has increased from 32 in 2015 to 50 in 2018.
- **SSC enabled scale up of pediatric ARVs:** Through its long-term framework agreements, SSC was able to provide the volume visibility to manufacturers to enable the scale-up of capacity for pediatric pellets/granules of Lopinavir/ritonavir (LPV/r).
- **SSC is facilitating rapid transition to improved adult ARV regimen:** The transition to TLD as the preferred first-line treatment was the third transition in ten years. The first orders of TLD procured through the PPM arrived only six months after WHO issued a new consolidated ART guideline recommending the switch to TLD, and demand for TLD is expected to increase threefold in the 12 months between Q3 2019 and Q3 2020, with demand forecasts at enough to treat roughly half the HIV positive population currently under ART.
- **SSC was able to facilitate a price drop based on a volume commitment for a drug used in advanced HIV disease:** The Global Fund and Unitaid worked with the supplier to identify

conditions to ensure successful scale-up of Flucytosine for the treatment of adjacent diseases for patients with advanced HIV disease. The supplier was able to commit to a price reduction, given a volume commitment of 10,000 bottles. Unitaids earmarked a US\$ 10 million grant to support pilot implementation of Flucytocine and the Global Fund introduced Flucytocine in its 2018 ARV tender. Unitaids was able to take full advantage of the Global Fund's commercial leverage to negotiate the best, yet sustainable, price with a supplier with whom the Global Fund has lasting relationships.

- The Global Fund was able to support doubling the uptake of Seasonal Malaria Chemoprevention from 2017 to 2018 and a new way of working within the Secretariat was found:** Unitaids put together a grant which spanned 2014-2018 to support the launch of AQ+SP for SMC in the Sahel Region, in order to prove largescale SMC was feasible and cost-effective, with a strong public health impact. Capacity issues with a sole ERP-approved supplier of AQ+SP resulted in the Global Fund effectively competing for procurement with other procurers like PMI and partners like Unitaids, who was donating products. The fact that demand was concentrated on the transmission season reinforced these capacity issues. The lack of formal coordination forums between partners, and the lack of coordination within the Global Fund between the TAP and SSC Teams, contributed to this issue as well. Eventually, partners were able to coordinate to address product scale-up issues. Volumes for AQ+SP doubled in 2018 compared with 2017, the year it was introduced. Several lessons were learned from the SMC experience. The work started at a time when there was not a mechanism for partners to engage with GMD and TAP divisions. Eventually a TAP focal point was assigned, and this - combined with the fact that countries were demanding SMC so the FPMs were interested - led to improved engagement and a new way of working. SMC was an additional intervention (rather than a switch to a new drug) so it was especially successful considering that new funds were required to introduce it. The SMC focal point opined "Unitaid's SMC project was brilliant; we started piloting it across most of the eligible countries, developed operational guidance, looked at key issues in terms of resistance, pharmacovigilance and laid a platform for us to hit the ground running. We've been able to carry on and scale up during NFM 2 at a high level"
- New SI for HIV Self-testing:** A new HIV catalytic initiative focused on differentiated service delivery will support countries to scale-up HIV self-testing in xxx countries. This dovetails with UNITAID grants in this area and is building on the SMC lesson learned that a Secretariat focal point in TAP helps ensure communication with country teams and monitoring of uptake and demand trends.
- New SI for PBO nets:** A missed opportunity for impact was evident in that ten years passed between the recommendation of the first pyrethroid-PBO net by WHOPES in 2008 based on entomological efficacy, and the conditional recommendation by WHO/Global Malaria Program for pyrethroid-PBO Nets, based on the epidemiological efficacy results of a first randomized controlled trial in Tanzania with the Olyset Plus pyrethroid-PBO net. A Unitaids/IVCC/Global Fund 'New Nets' project (2018-2021) has been established under a dedicated SI to target some of the barriers that prevented rapid scale-up of pyrethroid-PBO nets, including trials to generate epidemiological data and cost-effectiveness data needed for WHO endorsement, a copayment mechanism to enable this piloting and evidence generation. Five million PBO nets will be procured through PPM in 2019 and price reductions have already been achieved. Building on lessons learned from the SMC collaboration, a strong TAP-Supply Operations-GMD partnership has been put in place developed to manage this SI, and will help manage the source of co-pay to allow early access to new nets
- RTS,S malaria vaccine SI:** Jointly funded with GAVI and UNITAID, this work is funded by a multi-million dollar SI and will evaluate policy questions related to safety, impact and feasibility of the implementation through routine immunization systems in selected areas of

three countries - Ghana, Kenya and Malawi, informing WHO policy recommendation on broader use of RTS,S vaccine.

Market shaping partners are in agreement that the internal arrangements and information flows within the Secretariat have been one of the most limiting factors in enabling the Global Fund to make a greater contribution to market shaping in recent years. It made RDT and ACT forecasting difficult in the past when innovations were being scaled in these areas. Because the Secretariat divisions, and information holding, is so piecemeal, it becomes necessary to talk to each FPM to find out for e.g. when net campaigns are scheduled, which size nets, type, quantities each country will buy. Under the new nets project, the TAP focal point will be responsible for doing that “but it would be so much better if it were possible to just click a button and have the information”.

There have also been missed opportunities to shape the market in malaria RDTs due to the Global Fund waiting for WHO normative guidance, although the Global Fund could have acted unilaterally. PMI and Global Fund volumes have focused on only two manufacturers, who have 97% of market share. The constraint to widening supply sources has been a question of interchangeability. Countries have been trained on these two RDTs from those two companies, Global Fund looked to WHO to offer guidance on interchangeability which would allow procurement from other manufacturers, WHO said guidance is not necessary because they are interchangeable. Eventually PMI did a study to show that RDTs are interchangeable and PMI moved to interchangeability before the Global Fund did.

In cases where WHO guidance leaves room for interpretation, the Global Fund has potential to shift the market in important ways simply by the policies in place. In some cases, WHO guides the decision, e.g. WHO is clear on the preference for dispersibles for children in malaria. Those decisions are made on a technical basis and not considering the market implications. But in cases where WHO guidance is subject to some interpretation, such as the previous RDT example, or in the case of PBO nets (where WHO advises that countries can buy them only if overall coverage is not compromised – meaning its only possible to buy them if there’s money left over after UCC), then it becomes up to the Global Fund to determine policies which will shape the market.

The two KPI2’s where coverage is the furthest behind targets are IPTP3 and TPT. These are product sectors where the Global Fund has relatively less influence.

TB Preventative treatment uptake has been hindered by the cost and length of treatment, the need to find TB contacts and to integrate TPT into HIV programs. Several developments offer hope to remedy these challenges, but there’s a lag in countries transitioning to improved regimens: TPT is recommended for the management of LTBI, especially in priority high-risk groups, such as PLHIV, children under 5 and household contacts of a person living with TB. Although recent data have shown an increase in the number of people receiving preventive therapy for LTBI, primarily isoniazid preventive treatment (IPT), the coverage and completion of treatment have been disappointing, except for in a few countries, and TPT is well behind Global Fund KPI 2 targets. The main challenges for adoption have been the length, the burden of pills and the cost of new preventive treatment as well as the need to find the household contacts of TB patients and integrate TPT into HIV services. However, several shorter preventive treatment options have now been approved by WHO which would reduce therapy from the current 1 pill/day for 6 to 36 months (IPT) to either 1 pill per week for 12 weeks (3HP) or 1 pill per day for 1 month (1HP). And in late 2019, the Global Fund and Unitaid negotiated the price of 3HOP from US\$ 45 per treatment course to US\$ 15. Several FRs arriving in W1 of NFM3 did not acknowledge this development, still requesting funds for IPT or assuming the former

price of 3HP, so this raises questions about the reasons for delays in uptake of significantly improved regimens with great potential for improving adherence and outcomes.⁷³

Uptake of IPTp3 is behind the Global Fund KPI2 targets; it is an intervention where the Global Fund has less influence for a variety of reasons. Low uptake of IPTp can result from a disconnect between MNCH and malaria programs, negative perceptions of drug use in pregnancy, and practices of deprioritizing preventive interventions in ANC. There are also perceptions of SP resistance despite demonstrated efficacy of SP when used for chemoprevention and not for first-line treatment. Poor quality SP and low supply of quality-assured SP is an ongoing problem. “IPTp is the one malaria intervention that tends to get hived off as appropriate for domestic contribution; governments commit to buy the SP, then don’t, or they buy poor quality.” (KII)

⁷³ <https://www.theglobalfund.org/en/news/2019-10-31-landmark-deal-secures-significant-discount-on-price-of-medicine-to-prevent-tb/>

ANNEX 4.V: PROCUREMENT AND SUPPLY CHAIN (SRQ 10 & 11)

The Global Fund's market shaping work under the current market shaping strategy is concerned with affordable, quality products arriving predictably to the country, with emphasis on economy of inputs (the 'money' side of VfM). The overall Global Fund Strategy is however concerned also with the value achieved with those inputs, and this requires attention to how those products get to patients, and ultimately how well the products are used.

The wider Global Fund partnership supports health product management in a variety of ways, notably in PSM Working groups in countries, which provide a partner coordination forum to agree priorities and implementation plans. **Through grants and catalytic investments, the Global Fund is supporting countries with the full PSCM cycle - product selection, quantification and forecasting, procurement, storage, and distribution.**

PSM is one of the main RSSH pillars and has been supported through RSSH as well as disease grants. Countries are encouraged to request support for interventions that are not limited to disease specific supply chains only and which improve the performance and efficiency of supply chain systems to ensure uninterrupted availability of health products. The RSSH Information note advises, "National strategic plans endorsed by relevant national authorities and other relevant stakeholders should guide funding requests to the Global Fund. Plans should include cross-cutting interventions in domains such as integration of disease specific supply chains into larger systems, governance structures, business models, information systems, demand forecast, selection, procurement, warehousing and distribution, regulatory capacity and waste management and demonstrate synergies and complementarity across sectors and donor support."⁷⁴ See Box for selected examples of RSSH PSM strengthening through grants.

Box 4: Selected examples of Global Fund-supported PSM Strengthening

Through joint planning, co-investment, and collaboration with national governments and development partners such as USAID, DFID, World Bank, UNICEF and UNFPA, Global Fund investments have supported supply chain integration for multiple disease programs in Kenya, Ethiopia, Uganda, Tanzania, Zambia, Zimbabwe, Nigeria and Ghana.

In Mozambique, the Global Fund has supported a partnership between Central de Medicamentos e Artigos Medicos (CMAM) and Coca-Cola to map all routes from central to health facility level and identify the optimal network and most cost-efficient models for distribution of health products.

In Tanzania, the Global Fund is contributing to a program to strengthen health products management. The Medical Stores Department (MSD) was supported to improve system governance at the board level, information systems, finance, human resources, and logistics system re-design, including laboratory system standardization while the Tanzanian Food and Drug Authority (TFDA) was also equipped to implement a quality improvement program and to establish pharmacovigilance systems to monitor and report adverse drug reactions.

There has been considerable investment in PSCM strengthening yet PSCM is continually flagged by the TRP as a challenge. In the TRP Report on RSSH Investments in the 2017-201 cycle, it was noted that some funding requests propose robust plans for addressing PSM strengthening, however a large number of funding requests continue to acknowledge serious, long-standing PSCM challenges which are affecting program performance, without adequate explanation about how those challenges will be

⁷⁴ The Global Fund RSSH Information Note Page 10 August 2019

addressed. Common PSCM challenges include stock outs; above-market prices and sub-standard product quality; weaknesses in forecasting, LMIS (Logistic Management Information System), quality assurance and control, and coordination between partners. The TRP identified weaknesses common in PSCM funding requests as: lack of information on PSM support from national governments and other donors; inadequate use of performance indicators (i.e. coverage indicators and/or work plan tracking measures) to demonstrate that PSM investments are producing results and contributing to improvements across the three diseases; lack of consistent language and definitions used for PSM, often confounding PSM with health commodity purchase line items in the funding request text or budget lines; and a tendency to focus on interventions to address warehousing and logistics constraints at central, regional and sometimes district levels, with less focus on delivery of supplies below the district level ‘last mile.’

In 2016, the Global Fund decided to take a more deliberate role in supporting products to reach the “last mile”. This came about due to internal risk assessments, an evaluation of key roadblocks in the Global Fund-initiated “Impact through Partnerships,” as well as OIG audits of programs in several countries and the overarching OIG report on In-Country Supply Chain Processes. Consequently, **a new Supply Chain Department was created**, led by senior managers with significant private sector experience. At the outset, the plan was to conduct in-depth diagnostics in 12 high-risk countries by the end of 2017, and work with government and private sector partners to implement supply chain transformation projects, with the goal to significantly improve product availability, reduce product waste, reduce supply chain costs, significantly improve forecast accuracy and also increase inventory turnover.

A 2017 OIG⁷⁵ report on supply chain activities noted that a Supply Chain Strategy was being developed as part of the new Supply Chain Department. It appears this has not yet been completed, and it creates some discontent because country teams observe that they are given strategic directives⁷⁶ through a few slides which are not attached to a strategy formally endorsed by management.

There are 3 SIs to strengthen PSM in 20 priority countries: South Africa, India, Malawi, Niger, Nigeria, Cameroon, Mali, Côte d’Ivoire, Uganda, Burkina Faso, DRC, Chad, Liberia, Togo, Haiti, Ethiopia, Bangladesh, Pakistan, Sudan, Tanzania and Ghana:

- PSM 1.1 \$20M USD: Diagnostics conducted in 20 countries and 16 country transformations have been started, focused primarily on warehousing, logistics, last mile delivery and inventory analysis.
- PSM 1.2 \$10 million Innovation challenge fund: Support research, development and testing of innovative, efficient, cost-effective and well-structured SC systems models, including public-private partnership models, to ensure un-interrupted supply of medicines, diagnostic services and health products and prevent stock outs. Big Data solutions deployed in-country, based on DHIS2 or other; Implementing Bar Coding and improved standards for inventory management; Pool of Lab Technical Experts available to countries for lab network optimization in 12 countries; development of Waste Management guidelines and adoptions of good waste management practices in 5 countries; Innovative Last Mile deliveries, i.e. use of drones, for health products and diagnostics needs.
- PSM 1.3 \$12 million: Developing Local Resources: Optimizing Workforce Performance in health Supply Chains to contribute to improved commodity availability and improved health outcomes: Support capacity building in countries for development and implementation of

⁷⁵ The Global Fund’s In-country Supply Chain Processes April 28 2017

⁷⁶ Private sector engagement in supply chain and supply chain segmentation

national strategic guidance and best practices in procurement and supply chain management; inter-country and south-south collaboration and regional initiatives to address country PSM challenges.

The products produced through the PSM SI are of high quality and there are several advantages to having a Secretariat-led strategic initiative focused on this important area, similar to those identified for the STE SI. It is administratively efficient to have a central process to identify TA providers and commission them for work; having centralized Secretariat expertise means that cross-country lessons learned can potentially be better captured as a “global public good” for the benefit of the entire portfolio.

SI utilization has been low and progress over-stated to management. As of April 2020, report to MEC⁷⁷, utilization was graded significantly below target <45% for all 3 SIs. The OIG Advisory Report on Managing Strategic Initiatives was quite critical of the PSM SIs, noting concerns that progress had been misrepresented in reports to the MEC, the limited validation of the SI self-reported performance status outside of the SI Project Team before its presentation to the MEC, and lack of a dedicated Steering Committees to support oversight.

The Supply Chain Department and PSM SI's have been challenged in several respects: (as mentioned) the department is operating void of strategy; the PSM SIs were not developed in consultation with CTs and there is some feeling that the initiatives have been thrown at countries and GMD has been told to “make it work”; the perspective brought by the private sector orientated team reportedly sometimes misses the political side and complexity; there was extensive debate about the countries to be included in the SI cohort – eventually the ones chosen are largely high impact countries often where partner PSM support is already high, which makes it more challenging to coordinate, get buy in for the work, and add value with a relatively small funding amount; the SIs need to demonstrate that they are delivering and this appears to have created incentives to misrepresent progress.

There continues to be weak delineation of roles between HPMs, SO, SCM and RSSH in supporting PSCM in countries. Based on SR2020 interviews, observations made in the 2017 OIG⁷⁸ report appear to still be valid, *“In terms of structure, the Secretariat currently has a siloed approach to procurement and supply chain with responsibilities spread across two divisions and five departments, of which all have different objectives, priorities and performance measures.*

The split of over 50 staff across the different divisions and departments without an effective mechanism to drive collaboration among the respective teams (including those within the same division), affects their ability to achieve synergy in their work. Linkages have not been established with the Strategic, Investment and Impact Division. This is critical because the Secretariat is also developing a strategy for strengthening health systems through the resilient and sustainable system for health (RSSH) initiative.”

Gathering data for the KPI indicator on PSCM is expensive and it does not reflect useful information on performance of the SI nor on the country's supply chain integrity. KPI6b: is the Procurement and Supply chains indicator “On shelf availability” (OSA), which measures % of health facilities having tracer medicines and diagnostic services with tracer items on day of the visit or as per LMIS - is linked to this work and is intended to evaluate whether grant investments supported by Supply Chain Transformation Plans are improving availability at facility level. The target of 15% reduction of non-availability was met for all Dx, TB and HIV FLD and almost met for malaria FLDs. In the May 2020 Board update⁷⁹ the conclusion drawn from meeting the KPI 6b target was that “grant investments supported

⁷⁷ Strategic Initiatives: Additional Supporting Materials for Update, MEC Presentation April 6 2020

⁷⁸ The Global Fund's In-country Supply Chain Processes April 28 2017

⁷⁹ Strategic Performance Report end 2019 Annex 2: Detailed KPI results, 43rd Board Meeting

by Supply Chain Transformation Plans are improving availability at the facility level.” Several limitations about this indicator should be noted. First, the indicator only looks at facility-level availability of health products, not at central level; so the information comes too late (if a stock out is identified at the periphery due to lack of stock at the centre, it would mean that there was a quantification problem from 1 year ago). The indicator is also binary – is there on shelf availability or not? No information is recorded on the level of stock or expiry dates. The number of sites of facilities sampled is also too small to enable meaningful conclusions; unless the country has an LMIS system that can give this information (few in the cohort do), it requires a LFA-contracted site visit every quarter which is expensive; the return on this investment is low because the data is not reflective of the SI investment nor of supply chain integrity more broadly. Finally, there is no root causes analysis of what the data means and why the stock level might be at a certain level. SR2020 case study findings are illustrative of this; Ethiopia and Pakistan show good results on the OSA KPI 6b measure, but the Ethiopia case study mentions problems with Xpert cartridge availability and in Pakistan, there have been TB FLD stock-outs.

It is also worth noting that the Nigeria, Uganda and Malawi – countries in the PSM SI cohort - all continue to have significant PSM weaknesses, according to their most recent FRs. (Box for Nigeria example) The supply chain diagnostics and/or transformation plans were not shared with the TRP members during W1 March 2020, which is a missed opportunity for the TRP to better frame requests for PSM strengthening within the context of needs and gaps. This continued into W2 of NFM3, with Burkina Faso supply chain diagnostic and transformation reports not provided to the TRP.

Box 5: Nigeria’s continuing PSM needs

As noted in a 2017 message from the Executive Director on Supply Chain Processes, the Global Fund has been working in partnership with the national Government and partners including the UK’s Department for International Development, investing US\$20 million in Nigeria, to support supply chain integration for otherwise multiple vertical programs, with the aim to address structural problems, reduce cost and improve customer service by improving the efficiency/performance of the public-sector health product supply-chain⁸⁰

In Nigeria’s most recent FR from W1 NFM 3, it was noted that the country’s disease programs are not integrated, resulting in several separate donor-driven national supply chains. The cost of running these supply chains through regional warehouses and the third party logistics is very high. The Global Fund Secretariat, in consultation with the supply chain steering committee, is advocating for the formulation of a long-term transition plan from Chemonics to a PPP model with partners.

⁸⁰ <https://www.theglobalfund.org/en/oig/updates/2017-04-28-message-from-the-executive-director-supply-chain-processes/>

ANNEX 4.vi: DETAILED VALUE FOR MONEY RECOMMENDATIONS

1. Organizational attention required: Moving beyond seeing market shaping as only the economy part of VFM, with SO having sole responsibility

In order to achieve wider value for money in health technologies, there is a need to rethink internal processes, ways of working. The SSC team is too standalone, not integrated enough organizationally or strategically with the work of GMD and TAP.

- Internal communication, information sharing needs to be reshaped to align towards joint objectives and accountability for value for money in health technologies, not just seen as the SO team's job, parallel to the rest of the Secretariat. If SO is to move beyond being simply a strategic buyer, and the Global Fund as a whole is to work together to drive not just economy but value for money in procurement, there needs to be a shift in internal working processes. Some of this has already started, with the identification of focal points for new technology scaling and the HPM/SO teams working more closely on forecasting ordering to the benefit of strategic purchasing. These developments need to be built on, to facilitate better alignment in relation to product selection, new technology uptake, and working together on options to mitigate challenges associated with increases in domestic procurement (see below).
- Integrate the MSS strategy development and review process with the main Global Fund Strategy: Having a separate strategic development process, timelines and reviews of MSS vs the main Global Fund Strategy only exacerbates the organizational division described above; these strategic processes need to be brought together, even if the skills to conduct the Strategic Reviews will require quite different skill sets.
- M&E: Accountability for achieving value for money in health technologies aka market shaping needs to be corporate wide, not just SO
- Similarly, organizational attention is required on supply chain work: Improved clarification of roles responsibilities and accountability between HPMs and supply chain department needs some attention for greater impact. Also, previous reviews have also noted issues with governance, performance and accountability of the supply chain department, which requires resolution.

2. M&E related to VfM in health technologies:

Recommendation: There is a need to direct M&E efforts where the problems are occurring, where measurement can happen with existing data and where the progress is partially attributable to Global Fund. Specifically:

- In choosing the focus of KPI6a, a decision needs to be made as to whether the intent is to capture fewer, higher value transactions in well performing countries with good capacity, or drive the oversight focus towards smaller volume less well capacitated or transitioning countries where challenges are occurring and the opportunity to create value may be greater. There are valid reasons to focus the KPI only on the former; however, if this is the choice, then the recommendation would be to use other existing data available to the Secretariat to monitor progress on the latter, through means other than a KPI. (See number 3 below)
- KPI 6b should be refocused on a metric which a) can be monitored with existing country systems and b) which is directed at an indicator closer to the control of the Global Fund.
- The Modular Framework should include indicators to enable monitoring utilization of health technologies, GeneXpert in particular. This will require some work by the Secretariat to develop a methodology guidance, so that countries use the same definitions for numerators and denominators

3. Recommendations on non-PPM space

There are a variety of ways the Global Fund addresses the risks associated with sustainability of health product procurement as domestic financing increases.⁸¹ However, these interventions are delivered by different Secretariat teams with insufficient linkage and debate. Country teams decide whether to recommend health product uptake as part of the co-financing commitment, without input from the Strategic Sourcing team which might encourage a more nuanced rather than blanket recommendation about how such a transition might take place. There is no one looking at the bigger picture, saying which countries should be taking up x% FLDS to raise the co-finance across the entire portfolio, while ensuring VfM for patients. TRP catches many of the challenges when FLDs are transitioned without adequate risk mitigation, but a) the TRP review is quite late in the process and b) There is an organizational gap related to TRP recommendations being acted on.⁸² SR2020 recommendations include:

- There needs to be more systematic Secretariat approach to track what happens when FLDs are transitioned, relying on data sources already available within the Secretariat, to track experience in securing supply at PPM-like price and quality. There needs to be cross-team SO, GMD and TAP work and accountability - better systems to predict, mitigate and manage, holding teams and individuals accountable for identifying root cause of problems, implementing mitigating actions which deal with root causes, and incorporating TRP feedback into the grant. Risk assessment and risk mitigation strategies related to domestic procurement should be dealt with in a cross-Secretariat process prior to TRP review, and the results of this process, decisions, made and their rationale, should be made available to the TRP as part of the Secretariat Briefing Note, to support the TRP's assessment as to whether the transition parameters are supportive of value for money. A solid process prior to TRP review should reduce the number of times TRP is flagging this as an issue and ultimately, this should reduce the occurrence of challenges. Progress with this should be tracked internally.
- Further develop wambo so that as many countries as possible can benefit from the Global Fund's market shaping work. Countries in receipt of Global Fund grants should rely on the PPM, or another reliable procurement agent, until national processes can outperform global market prices and achieve comparable quality and on-time, in-full delivery. For some countries and some products, this may imply a long-term reliance on third party procurement; this should not be interpreted as lack of national sovereignty or sustainability but as a natural market imperative
- There needs to be a rational look, wider consultation including the Strategic Sourcing department, and increased debate on the most sensible line items to transition in different contexts. If transitioning FLDs is determined to be risky, options might include: transitioning central HR costs instead; revisiting the percentage or timeframe of FLDs transition; making the use of wambo or another procurement platform a requirement of the grant (see Pakistan Box for supply chain division's advice along these lines); support work on developing financial systems to enable predictable budget allocation and finance release for health product financing (consider making timely release a grant condition); consider how to build in performance based contracting to reward performance on achieving timely finance release, procurement of quality products at PPM-comparable prices; consider transitioning a larger burden of drug financing to countries with large markets and able procurement systems⁸³ (e.g.

⁸¹ See Page 73 MSS MTR

⁸² See the OIG Annual Report May 2020, which states that "controls are not yet in place to ensure follow-up on these recommendations as part of key decision-making processes during the grant lifecycle, such as the Annual Funding Decisions and/or Disbursement requests. Instead, the follow-up practices are ad hoc and inconsistent across different country teams. As a result, a risk remains that key programmatic recommendations from TRP may remain unresolved during the grant implementation cycle." (OIG Annual Report 2020)

⁸³ For example, Kenya is only funding 12% of FL ARVs (Global Fund funds the remaining 88%), yet - with 1 million people on ARVs and relatively high procurement capacity, Kenya is achieving good pricing on quality ARVs, using a combination of Global Fund and domestic funds. That's 8880,000 PLHIV on ARVs as compared with Azerbaijan's 8000 people on ARVs, transitioned to domestic funding and paying

Ethiopia, Kenya) while transitioning other line items besides drugs in countries like Cameroun and Pakistan, where the challenges are well known and unlikely to be resolved within the grant cycle.

The options are much wider than this, as the Indonesia experience shows, albeit influenced by a variety of factors including the leverage the Global Fund has in each country. There needs to be an agreed corporate policy on Global Fund's role, backed by a set of tools and actions, and organizational ways of working, and appropriate Secretariat resourcing to enable drawing on a variety of skillsets (political influence and negotiation, procurement and sourcing expertise, financial systems).

On this topic, SR2020 agrees with the MSS MTR recommendations, which are worth restating here: "Developing a comprehensive approach to address risks associated with increased domestic financing. A proposal to address these risks would include:

- Benchmarking information (new or already existing) to assess risks/bottlenecks and prioritize solutions associated with countries' abilities to conduct key procurement and regulatory functions.
- A proposal for how to organize Global Fund functions to address these issues. This should address questions including whether the Global Fund should use only existing grant funds versus adding a new strategic initiative; whether to develop new expertise in RSSH team or leverage existing SO team to provide TA; how best to incorporate activities into grant objectives where Country Teams can influence but not control outcomes; and how to coordinate among SO, GMD, and other teams to address these topics.
- A plan to expand the Wambo pilot granting access to LTAs for domestically financed procurement. This pilot should assess the value, operational barriers, and long-term potential risks to country systems, and it should inform a long-term Wambo strategy and governance model. A long-term strategy would consider topics like Wambo's potential impact on country-level procurement systems, its impact on global markets for health products, and its value proposition for countries and suppliers as compared with other global/pooled procurement channels. The Global Fund should lift certain restrictions on which entities can procure through Wambo (e.g. governments in Global Fund-supported countries where the government is not a current PR) for the pilot to ensure that purchases made through the pilot are similar to those which may be part of a longer-term Wambo strategy. Delivering impact on channels and objectives outside of PPM will likely require process and resourcing adjustments (since current processes are tailored to availability/affordability and quality of PPM). "

4. Value for money

There has been important progress in analyzing allocative and technical efficiency at the country level, which should help identify waste and inefficiency in service delivery. Some of this work is already having impact but it is still early. Consideration needs to be given as to how the Global Fund business model will influence action based on findings from this work, including more attention to results based financing models which incentivize countries to maximize VfM.

twice the market price given the small market size and other factors. Similarly, Ethiopia is funding 0% of their FL ARVs (all funded by Global Fund) and they're the 5th largest buyer worldwide. Nigeria funds 8% of its ARV needs. Zimbabwe funds 11% of its FL ARVs. It is not clear how the decision is made about which countries switch to domestic financing of FLDs and what is the basis for the decision, although KIIs report that the decision is made by the FPMs without .

Recommendations:

- This work is especially important in countries with few other donor partners and it should be further scaled, focusing on the most costly and most frequently used health interventions and examining work contracted via Public Private Models and community systems and responses.
- Optimization modeling for allocative efficiency at the funding request stage should be repeated as part of program review process, to revisit what assumptions were wrong and lessons to be learned.
- Catalytic investments could be positioned to reward efficiency achievement outcomes rather than to incentivize investment/inputs. This would require some follow through on the STE work, looking pre and post grant to measure and reward efficiency improvements. Constructing, managing and monitoring contracts for performance, including efficiency improvements, requires a shift in skill set within the Secretariat, and further moves the Secretariat along on a continuum from a purely financing agency to a technical and financing agency.

5. System-wide efficiency

SR2020 identified a number of efficiency challenges in relation to implementation arrangements in countries.

- Issue: Private sector providers are making a contribution especially in TB case finding and case management, however the efficiency of different models needs to be studied more systematically. Recommendation: There should be more work on comparative cost-effectiveness of private sector delivery models, as was done in the recent Pakistan OIG review (currently this is not included in the STE SI funded modelling). Cost-effectiveness studies of nascent PPM models were recommended by the TRP for Nigeria and Bangladesh PPMs during NFM 2; no doubt such studies would be useful in other countries where PPM contributions are scaling up.
- Issue: Avoiding possible false economies of government as service implementer (to be distinguished from government as PR). Recommendation: SR2020 recommends that the Secretariat should start to track this trend of government PRs proposing to take over service delivery functions from non-government PRs. If an FR proposes such a shift in service delivery, there should be a government capacity assessment prior to the transition, and then (if the transition goes ahead) there should be work to follow through and understand the impact of the transition, especially where the service in question involves KPs.
- Adapting implementation arrangements of Global Fund grants to devolved and federal structures was identified as a significant challenge affecting efficiency and effectiveness of grant implementation in SR2020 cases studies. Recommendation: SR2020 recommends that the Secretariat should set up a working group including drawing on expertise of funders like the World Bank, to understand different options for how the business model might be tailored to work better in these devolved contexts.

ANNEX 4.VII: ABSORPTION (SRQ9)

Absorption increased dramatically in 2017 and 2018 from previous years, although still varies substantially between investment areas.⁸⁴ Our analysis (see Annex 4.vii.a) of financial data provided by the Secretariat shows that:

- *Expenditure*: Rose fairly consistently each year from US\$ 2.5bn in 2010 to US\$ 3.5bn in 2016 and then spiked in 2017 to US\$ 5.2bn before returning to US\$ 3.2bn in 2018.
- *Absorption*: Having remained fairly constant since 2010 at around 70%, absorption rose sharply to 94% in 2017 and 87% in 2018.

This represents a significant increase, particularly considering that many NFM2 grants started in 2018, which could reasonably be expected to have reduced both expenditure and absorption.

Triangulating across the Secretariat's analysis of absorption for the period 2015 to 2017, as presented to the Board in May 2019⁸⁵, and our own analysis of absorption for the period 2018 to mid-2019, a number of observations can be drawn:

- *Absorption is **higher** for commodities than non-commodities*. The Secretariat found that when removing commodities from the analysis, absorption was broadly similar for HIV, TB and malaria components, with RSSH slightly lower. Our analysis shows that absorption for commodities is equivalent to or below that of other modules, although we expect that this is due to incomplete data.
- *Absorption is **higher** for program management, human resource and indirect and overhead costs*. Evidence from the PCE and other sources suggests that this is largely due to these costs being easier to plan and budget for, with a fairly fixed expenditure per month/quarter/year.⁸⁶
- *Absorption is **mixed** for prevention interventions*. Absorption for HIV PMTCT was over 100% between 2016 and mid-2019, but just 56% between 2018 and mid-2019 (likely due to some incomplete data, particularly for commodity costs). Across all other HIV prevention modules, absorption was 78% between 2016 and mid-2019, and 67% between 2018 and mid-2019. However, absorption between 2016 and mid-2019 was significantly lower for adolescents and youths (63%) and prisoners (65%), than for the general population (87%), PWID (86%) and MSM and TGs (79%). Absorption for malaria vector control was also 66% (likely related to campaign cycles), although much higher for specific prevention interventions (90%).
- *Absorption is **mixed** for RSSH interventions*. Absorption across all RSSH modules was 66% between 2016 and mid-2019, and 60% between 2018 and mid-2019. This did however vary by module, from 76% (up to 87% between 2018 to mid-2019) for financial management systems to 51% (down to 37% between 2018 to mid-2019) for integrated service delivery and quality improvement.
- *Absorption is **lower** for interventions addressing human rights issues*. Our analysis shows that absorption for modules on human rights was 52% between 2016 and mid-2019, and 42% between 2018 and mid-2019.
- *Absorption is **lower** for PSM costs*. Our analysis shows that absorption for PSM-related costs was 59% between 2016 and mid-2019, and 52% between 2018 and mid-2019.
- *Absorption is **lower** for travel costs*. Our analysis shows that absorption for travel-related costs was 69% between 2016 and mid-2019, and 63% between 2018 and mid-2019.
- *Absorption is **lower** for living support*. Our analysis shows that absorption of costs for living support to clients or target populations was 64% between 2016 and mid-2019, and 53% between 2018 and mid-2019.

⁸⁴ Absorption is defined as the percentage of the budget that was spent within a given time period.

⁸⁵ The Global Fund. 2019. Strategic Performance Reporting – end 2018. For Board Information (GF/B41/14)

⁸⁶ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

- Absorption is **lower** for communications costs. Our analysis shows that absorption for costs related to communication material and publications was 63% between 2016 and mid-2019, and between 2018 and mid-2019.

The observed increases in absorption are largely attributable to a few key processes/initiatives introduced by the Secretariat. More specifically:⁸⁷

- *Grant application:* The introduction of differentiated processes by country context for funding requests, review, grant-making, and approval processes were designed to streamline (where possible) country information requirements and reduce the time taken to complete grant application processes.⁸⁸ One of the key justifications for this was to reduce the disruption to program implementation caused by the application process, thereby supporting greater absorption of Global Fund resources. Our analysis shows that absorption in the first year of grant implementation increased for all application types, except for the Tailored NSP pilot category, but particularly for the Tailored Simplified, COE, Transition and Material Change categories. Absorption also appears to have increased for Portfolio Continuation grants, but only modestly.
- *Portfolio optimization:* A prioritization framework was introduced in 2017 to “direct the investment of additional available sources of funds” made available through additional donor contributions, unutilized funds from a previous allocation period, and funds forecasted by the Secretariat to remain unutilized across the portfolio.⁸⁹ Portfolio optimization has been applied across the grant cycle:
 - *Grant making:* This involves the Secretariat, working through the GAC, to identify savings in the budgets submitted as part of the Funding Requests that are then reallocated for other purposes across the portfolio. Although important for allocative efficiency we do not consider that this process in itself could be expected to have a material effect on absorption.
 - *Grant implementation:* This is linked to the grant revision/reprogramming process, where savings are identified that are not projected to be spent within the grant cycle and reallocated across the portfolio. This process is designed to improve absorption both for the grants where funds are being removed, as well as added. However, stakeholder feedback suggests that the latter has not worked optimally, principally because the process did not happen early enough in many instances and has proven difficult to quickly integrate and initiate new activities within existing grants that are up and running.
 - *Grant closure:* This involves unused funds at the grant end date being ‘returned’ to the Global Fund (instead of being rolled over to future grants) and redistributed along with other funds available through the next allocation.⁹⁰ Our analysis suggests that the incentives posed by this mechanism (i.e. to achieve high levels of expenditure and absorption by the end of the grant period) significantly influenced the spike in expenditure/absorption in 2017, although as noted in SR2017, stakeholders have raised concerns that this does not necessarily incentivize high quality implementation and VfM, which is likely to be a particular problem in countries where human resource capacity is low.⁹¹ Our analysis shows that a

⁸⁷ (a) Thirtieth Board Meeting Geneva, Switzerland, 7–8 November 2013; (b) Introduction to the 2017–19 funding cycle and the differentiated funding application process: Access to Funding Training; (c) Thematic Review of the Allocation Methodology.

⁸⁸ Access to Funding and Grant Management Support Departments. 2017. Access to Funding, Grant-making and Approval. Operational Policy Note, 12 January.

⁸⁹ Global Fund. 2017. Guidance Document: Prioritization Framework for Financing Items on the Register of Unfunded Quality Demand.

⁹⁰ https://www.theglobalfund.org/media/4789/fundingmodel_allocations2017-2019_faq_en.pdf?u=636679305230000000.

⁹¹ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group’s (TERG) position on absorptive capacity.

majority (~60%) of this ‘additional’ expenditure in 2017 was for health commodities and technology, with around 15% for HIV prevention and 15% for program management.

- *Analysis of absorption:* SR2017 noted that historically data on absorption was of poor quality and rarely analyzed, although at that time efforts were underway to use aggregated data to inform high-level decision making (e.g. related to the allocation mechanism and portfolio optimization).⁹² Observations through the PCE, supported by our analysis conducted for SR2017 and through this assignment, suggest that the introduction of the Grant Operating System, Modular Framework and revised Progress Update and Disbursement Request (PU/DR) process, have helped to improve the quality of data on absorption, which is now much more closely scrutinized. This has enabled the application of portfolio optimization. Stakeholders did however note that the analysis could go further and be more strategically deployed – i.e. to focus on the high value areas and/or ‘drivers’ of absorption, which could then be targeted for remedial action and/or technical assistance.
- *More flexible documentation requirements:* SR2017 found that a lack or poor quality of required documentation (often required through Condition Precedents) was one of the most critical issues leading to delayed disbursements, implementation and absorption.^{93,94} For the NFM2 cycle the Secretariat moved away from the use of Condition Precedents towards management actions and work plan tracking measures. As noted by stakeholders and analyzed through the PCE, these measures are more flexibly applied, and disbursements are often not contingent on them being completed. As such, where there are delays to the completion of tasks, implementation can continue, and absorption is not affected. It is however unclear whether this more flexible approach has any implications for the completion of the related tasks/activities.

A number of other measures have also been introduced to respond to well-known issues affecting absorption, although it is unclear how and whether they are working. This includes:

- *Allocation:* The allocation methodology for 2017–19 included a qualitative adjustment process where the initial formula-derived allocations were adjusted for a series of factors. This included country ‘potential for impact’ and ‘potential for absorption’.⁹⁵ Our analysis shows that these changes were however minimal, with only: US\$ 149m added across 20 component allocations with the justification of ‘potential for absorption’ (i.e. an average change of US\$ 7.45m per component); and US\$ 81m removed from 37 component allocations (i.e. an average change of US\$ 2m per component). Our analysis further suggests that these changes have not helped to increase absorption, with absorption falling in 2018/19 as compared to previous years in components where funds were added and removed, whereas absorption increased in components where no changes were made.⁹⁶
- *Risk management:* A number of TERG-commissioned reviews (e.g. SR2017 and the PCEs), OIG analyses (e.g. on grant implementation in WCA and grant management in high risk environments), and other reviews (e.g. as published through AidSpan) have noted that risk management is a critical constraint to absorption, with a general perception that the

⁹² Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group’s (TERG) position on absorptive capacity.

⁹³ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group’s (TERG) position on absorptive capacity.

⁹⁴ https://www.aidspace.org/gfo_article/identifying-secretariat-level-impediments-full-absorption-global-fund-grant-money

⁹⁵ At the portfolio level, this resulted in: US\$ 196m moved toward the top 15% of country components with greatest potential for impact and absorption; US\$ 214m moved toward 70% of country components with average potential for impact and absorption; and US\$ 404m moved out of the lowest 15% of country components with the lowest potential for impact and absorption. *Global Fund Strategy Committee (2016): Allocation 2017-2019: Report on Qualitative Adjustments.*

⁹⁶ The analysis compares the average absorption between 2014 and 2017 with the average rate of absorption between 2018 and 2019. It shows that absorption fell across components where funds were both added and taken out of the allocation through Stage 2 of the qualitative adjustment process. Absorption in components where no changes were made increased.

organization places too great a focus on risk management at the expense of focusing on grant implementation.^{97,98,99,100,101} The adoption of the Risk Appetite Framework in 2018 is designed to more actively balance financial and programmatic risk considerations (see Section 4.2.2), with the intention of allowing implementation to take place even where risks are present, thereby increasing absorption. However, it is unclear how well this is being operationalized. Our high level analysis of absorption shows that absorption has increased over time more rapidly for components where a fiduciary or fiscal agent is active and/or where additional safeguards are in place.¹⁰² However, other evidence suggests that there are issues in how these measures are implemented. For instance, the OIG's recommendations in WCA included relaxing fiduciary controls to increase absorption, although the Executive Director's response was that 'such recommendations...will need to be carefully assessed on a country by country basis taking a risk-based approach'.¹⁰³ The PCE and other studies have also highlighted continued issues with stakeholders being reluctant to use Global Fund money due to historic experience with mismanagement of funds and/or a fear of repercussion, which has resulted in lower absorption.^{104,105,106}

- *Partner engagement and provision of TA:* A range of Global Fund partners are engaged to provide TA to support implementation and absorption, including through bilateral set-asides (e.g. 5% initiatives), strategic initiatives, CCMs, TWGs, disease situation rooms and other forums (see Section 4.2.3). There is however some evidence that while this can be helpful to improve absorption, this is not widely used even in poorly performing countries.^{107,108,109,110} The Secretariat has initiated disease situation rooms as a model where partners are engaged to discuss and address bottlenecks to program implementation, ultimately anticipated to support increased levels of absorption.¹¹¹ This is also partly in response to issues noted through the PCE where the role of partners, including through the CCM, in identifying and addressing grant implementation weaknesses is not always clear during implementation.¹¹²
- *Strengthening of RSSH:* Weak health systems are widely recognized to be one of the most significant barriers to absorptive capacity, and so the strengthening of these systems is critical to increasing the rate of absorption of Global Fund resources.¹¹³ However, the effect of the Global Fund's investments in these areas (and particularly in financial management capacity building, which prior analyses suggest is particularly important to improving absorptive capacity) is unclear.¹¹⁴

⁹⁷ OIG. 2017. Audit Report: Global Fund Grant Management in High Risk Environments.

⁹⁸ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group's (TERG) position on absorptive capacity.

⁹⁹ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

¹⁰⁰ https://aidspan.org/gfo_article/state-principal-recipients'-find-ways-improve-global-fund-grant-absorption

¹⁰¹ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹⁰² The analysis compares the average absorption between 2014 and 2017 with the average rate of absorption between 2018 and 2019. It shows that absorption increased across components where one or more of the following measures were present: a fiduciary agent; fiscal agent; and/or additional safeguards. In contrast, absorption fell across components where none of the above were present.

¹⁰³ Global Fund. 2019. Message from the Executive Director – Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹⁰⁴ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

¹⁰⁵ https://aidspan.org/gfo_article/state-principal-recipients'-find-ways-improve-global-fund-grant-absorption

¹⁰⁶ https://aidspan.org/gfo_article/challenges-global-fund-secretariat-and-implementer-levels-found-impede-grant-absorption

¹⁰⁷ TERG. 2019. Rapid review on feasibility of implementing WHO's new TB treatment guidelines.

¹⁰⁸ TERG. 2019. Thematic Review of investments in RSSH.

¹⁰⁹ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹¹⁰ GMS. 2018. Grant Management Solutions - Final Report 2012-2017.

¹¹¹ We do however note that there was no clear evidence from the Implementation Through Partnership pilot that this model worked to increase the levels of absorption.

¹¹² EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

¹¹³ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group's (TERG) position on absorptive capacity.

¹¹⁴ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

A number of aspects of the business model remain problematic for absorption. Most notably:

- *Budgeting:* Analysis from the PCE demonstrates how, despite highly detailed budgets being in place for each grant, budgets: (a) can include inflated unit/service delivery costs; and (b) are often structured very differently, for instance with some front-loading budgets and others simply dividing the total allocation equally across the implementation period.¹¹⁵ As such, grant budgets rarely reflect stakeholder expectations on the quantum of and when resources would be expended. This is problematic for grant-level oversight, but the inconsistency across countries also creates difficulties for portfolio-wide financial management.¹¹⁶ For instance, where budgets do not reflect when resources are expected to be expended, the utility of absorption analysis is diminished (see Figure 13 which shows high levels of variation in grant absorption by country and year). This creates space for stakeholders to claim that they are able to absorb at a higher level than they are realistically able to within the allocation period, and limits the extent to which funds can be reallocated through reprogramming and/or portfolio optimization. We understand that a revised budgeting process will be introduced for the 2021-2023 grant cycle, which seeks to ensure that budgets are structured appropriately (i.e. aligned to expectations on when resources will be expended) and consistently across countries. Our analysis suggests that if well executed this will be extremely useful for grant oversight and for portfolio-wide management (i.e. to enable the application of portfolio optimization more consistently and smoothly across countries).
- *Grant start-up processes:* A number of studies have found issues with the transition process between grants, for instance, where PRs were capacity constrained while simultaneously working to close old grants and start new ones; there are no/limited 'hierarchical, functional or financial' relationships between PRs and SRs; the selection and contracting of SRs did not take place until after grant signature; and where new PRs were engaged (often from international to national agencies, such as in Cambodia, DRC, Mozambique, Senegal and Sudan) this resulted in low absorption and more could have been done to prepare these agencies in advance.^{117,118,119} Evidence from the PCE found that program continuation processes were applied to countries even where the allocations had changed substantially and as a result grant designs had to be altered through immediate reprogramming (e.g. in Sudan).¹²⁰
- *Grant revisions:* There has been a notable shift to encourage and facilitate more frequent within grant reprogramming throughout the grant life cycle. At the time of SR2017, stakeholders were particularly enthusiastic about the potential of this to support increased absorption of Global Fund resources. However, analysis by the OIG in WCA and through the PCE found that while grant revisions (including to the original budget and where additional funding was made available through portfolio optimization) were both common and substantial through to the midpoint of grant implementation, these were 'cumbersome' and

¹¹⁵ For instance, the PCE found that 'PRs were more likely to divide budgets equally between later grant quarters than earlier ones. Because it is difficult to plan specific activities for a three-year grant period, discrepancies occur between planned budgets and implementation by PRs and SRs. This, in conjunction with implementation delays, led to lower absorption during the first months of the grant period and created demand for reinvesting resources later on in the grant cycle'.

EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

¹¹⁶ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

¹¹⁷ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹¹⁸ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

¹¹⁹ https://www.aidspace.org/gfo_article/global-fund-civil-society-implementers-english-and-portuguese-speaking-african-countries

¹²⁰ EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

there was no evidence of an association between the number of grant revisions and absorption (although did note that at the time of the analysis it may have been too early to expect to see this).^{121,122}

- **Implementer capacity:** A number of studies have noted this as an issue, including various OIG reports^{123,124}; the SR2017 analysis of absorption which identified PR weaknesses in financial and SR management as a cause for low absorption¹²⁵; and a study by The Eastern Africa National Networks of AIDS Service Organizations (EANNASO) which found that civil society PRs sometimes lack the capacity to appropriately budget and report on finances and implementation progress.¹²⁶
- **COE Policy:** Contextual factors are widely recognized to influence grant absorption and country absorptive capacity. Most notably, these include ownership and leadership by national stakeholders, complex bureaucracies in government ministries and capacity of decentralized administrative units, political instability and civil unrest, and disease outbreaks (such as Ebola in Liberia, Guinea and Sierra Leone; and presumably across many countries in response to COVID-19).^{127,128,129} As shown in Annex 4.vii.a and highlighted in the Secretariat's analysis of KPI7b, absorption is significantly lower in COE countries as compared to the wider portfolio.¹³⁰ The COE Policy is designed to allow certain flexibilities to processes to support ongoing grant implementation in some COE countries. However, analysis by the OIG in WCA found that in spite of the COE Policy, COE countries often use the same processes as non-COE countries (e.g. for reporting) which causes delays.¹³¹ The PCE in Sudan, a COE country, also found that flexibilities were not employed, in part due to concerns around risk which hampered implementation and absorption.^{132,133,134}
- **Three-year funding cycle:** This is widely recognized to disrupt implementation and significantly impact absorption, notably due to the lack of alignment to five-year country planning cycles, and with Year 1 of Global Fund grants often being delayed and focused on starting the grant, Year 2 focused on implementation, and Year 3 hampered by planning for the next allocation period and/or being focused on expending remaining resources before the end of the grant period. As such, there is strong potential for this policy to not only affect the absorptive capacity of Global Fund resources, but also the implementation of country programs more generally. This is a particular problem for RSSH grants, where the pace of absorption for commodities and RSSH activities is very different, yet the resources are being disbursed via the same mechanism and under the same cycle.¹³⁵

¹²¹ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

¹²² OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹²³ OIG. 2017. Global Fund Grant Management in High Risk Environments.

¹²⁴ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA)

¹²⁵ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group's (TERG) position on absorptive capacity.

¹²⁶ https://www.aidspace.org/gfo_article/global-fund-civil-society-implementers-english-and-portuguese-speaking-african-countries; <https://drive.google.com/file/d/1wOWgXBD3bk8vtjSGILdOaiPsUK69gdbv/view>

¹²⁷ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA).

¹²⁸ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group's (TERG) position on absorptive capacity.

¹²⁹ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

¹³⁰ The Global Fund. 2019. Strategic Performance Reporting – end 2018. For Board Information (GF/B41/14).

¹³¹ OIG. 2019. Advisory Report: Grant implementation in Western and Central Africa (WCA).

¹³² EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report.

¹³³ https://aidspace.org/gfo_article/state-principal-recipients-find-ways-improve-global-fund-grant-absorption.

¹³⁴ <https://www.theglobalfund.org/en/oig/updates/2019-04-29-audit-of-grants-in-sudan/>.

¹³⁵ Itad. 2017. Additional analysis to the Strategic Review 2017 to guide the Global Fund Technical Evaluation Reference Group's (TERG) position on absorptive capacity.

ANNEX 4.VII.A: ANALYSIS OF GLOBAL FUND GRANT ABSORPTION (SRQ9)

Introduction and limitations

This annex presents our analysis of Global Fund grant absorption (i.e. expenditure divided by budget). This is drawn from four sources:

1. Data provided by the Secretariat Finance Team in May 2020 providing annual (2014-19) budget and expenditure data by country and grant. This is a cleaned dataset that has enabled high level analysis of absorption.
2. Data downloaded from the Corporate Data Warehouse in February 2020, providing detailed budget and expenditure data disaggregated by country, grant, month (2015-19), module, intervention, cost category and cost input. This has enabled disaggregated analysis of absorption but is known to include some data quality issues and only limited data for 2018 and 2019.
3. Data provided by the Secretariat for the purposes of SR2017 providing annual (2010-15) budget and expenditure data by country and component. This was used for the Secretariat's own analysis of absorptive capacity in September 2016, based on 2015 annual reports by Principal Recipients.¹³⁶ It has been used to extend our analysis of absorption back to 2010, but has only been used where data from other sources was not available.
4. Data provided by the Secretariat Finance Team in May 2020 providing expenditure data for NFM1 and NFM2 grants by component, region and days since the start of the grant cycle. This has enabled analysis of expenditure over time and a comparison between NFM1 and NFM2 grants.

Although we understand that the source data for the datasets is the same there are substantial differences between them, which we understand is due to completeness and the data having been cleaned for some and not other datasets.

For each of the charts in the section below we note which of these sources has been used.

This analysis has been complicated by changes in the way that data is reported, notably between the Global Fund's Grant Management System and Grant Operating Systems. It is worth noting that while the accuracy of the data is felt to be reasonably strong, there may be a number of legitimate reasons for countries having lower than expected rates of absorption which would reasonably be expected to skew the data (e.g. due to other health emergencies, civil unrest, etc.). There is also the significant possibility that: (a) the exclusion of data on commitments and obligations from the data skews trends, particularly for the most recent years; and (b) inaccurate budgeting (also linked to issues with target setting) is artificially inflating/deflating the absorption rate across countries. While the analysis should be interpreted with a degree of caution, it is still useful to identify trends.

Analysis

Figure 5 presents budget, expenditure and the rate of absorption across all grants between 2010 and 2019. While 2019 expenditure data is included, it is known to be incomplete and should be interpreted with caution. Key points to note are as follows:

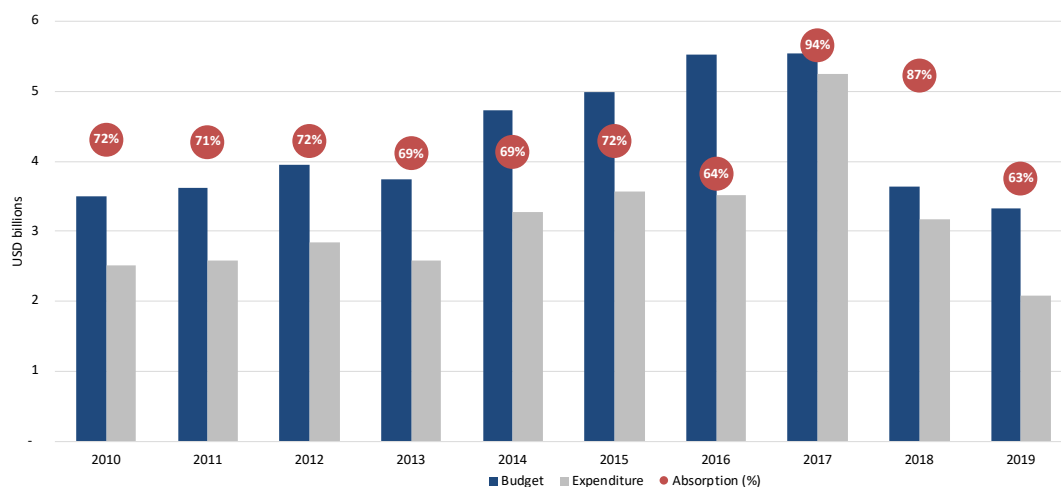
- Annual budgets grew between 2010 and 2017 but then declined dramatically in 2018. This is partly related to the introduction of portfolio optimization where allocated funds could no longer be rolled over across grant cycles.¹³⁷
- Expenditure rose steadily from US\$ 2.5bn in 2010 to US\$ 3.5bn in 2016 and then spiked in 2017 to US\$ 5.2bn before returning to US\$ 3.2bn in 2018.¹³⁸

¹³⁶ Itad (2017) Strategic Review 2017.

¹³⁷ https://aidspan.org/gfo_article/countries-cannot-roll-over-unused-funds-their-2017-2019-allocations

¹³⁸ The spike in 2017 is also likely due to portfolio optimization at grant closure where unused funds are 'returned' to the Global Fund and redistributed along with other funds available through the next allocation. This places strong incentives on stakeholders to achieve high levels of expenditure at the end of the grant period.

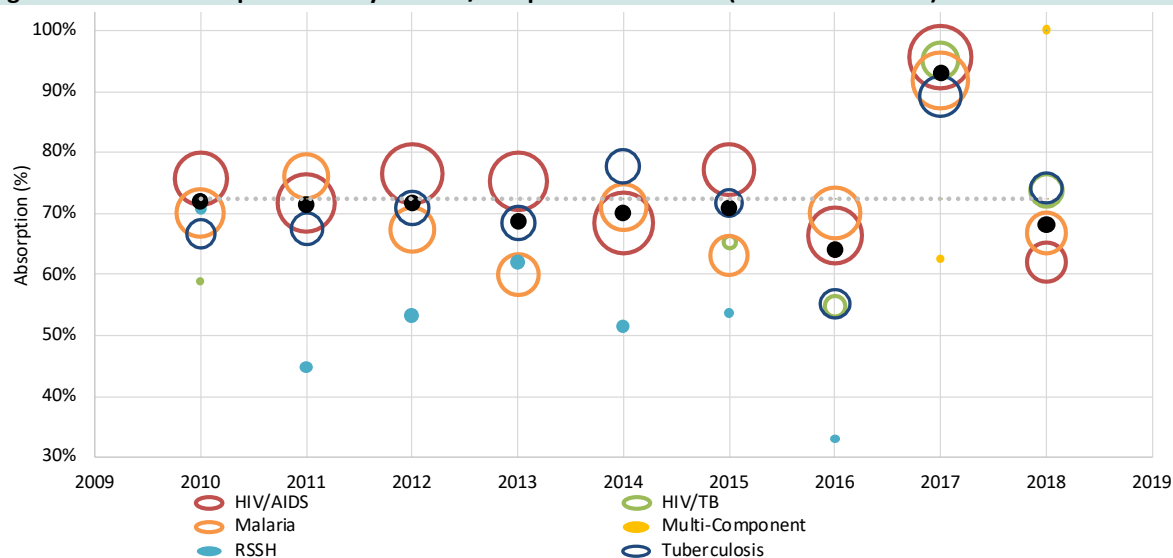
- Absorption remained fairly constant at around 70% between 2010 and 2015, falling in 2016 to 64% and rising sharply to 94% in 2017, also remaining high (87%) in 2018.

Figure 5: Portfolio-wide absorption by year (2010 to 2019)

Source: 1,3

Figure 6 presents annual absorption by disease/component across all country grants, with the value of total expenditure for each component depicted by the size of bubble. Key points to note are as follows:

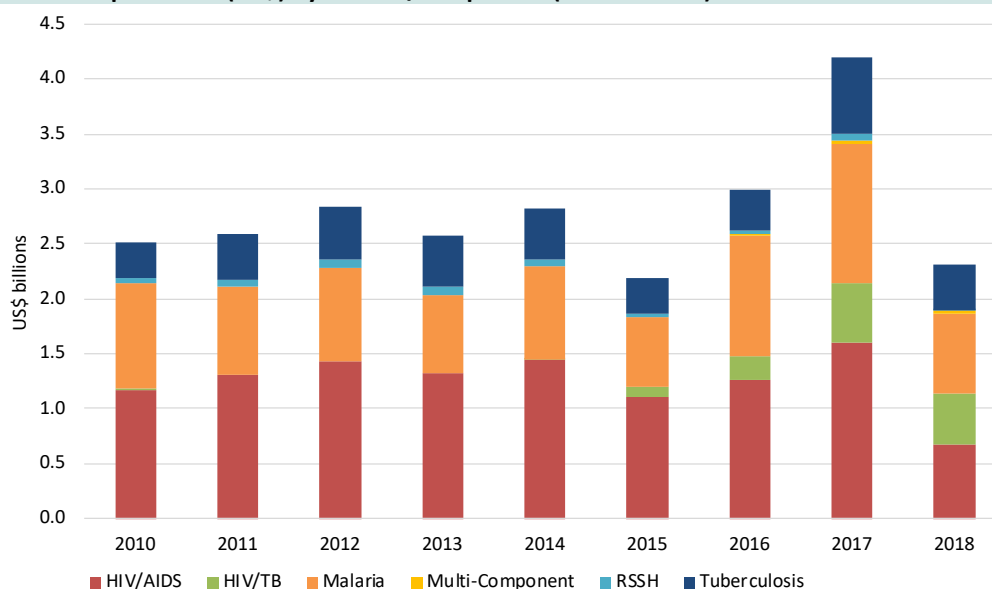
- Absorption for all grants over the period 2010 to mid-2019 was 73%, as compared to:
 - 75% for HIV (which accounted for 45% of total expenditure over the period);
 - 71% for TB (16% of total expenditure);
 - 76% for HIV/TB (6% of total expenditure);
 - 72% for malaria (31% of total expenditure);
 - 56% HSS/RSSH (2% of total expenditure).
- Absorption for all components remained fairly consistent (69% to 72%) between 2010 and 2015, before falling to 64% in 2016 and rising sharply to 93% in 2017. We note that the rate of absorption in 2018 (68%) is considerably lower than other data provided by the Secretariat (87%), which is thought to be mostly due to data completeness.
- We have not included data for 2019 which is very incomplete in this dataset.

Figure 6: Annual absorption rate by disease/component and value (2010 to mid-2019)

Source: 2,3

Figure 7 presents total expenditure across all grants disaggregated by disease/component between 2010 and 2018. This supports the observation in Figure 6 that expenditure increased dramatically in 2017 and shows that this was for all components.

Figure 7: Annual expenditure (US\$) by disease/component (2010 to 2018)

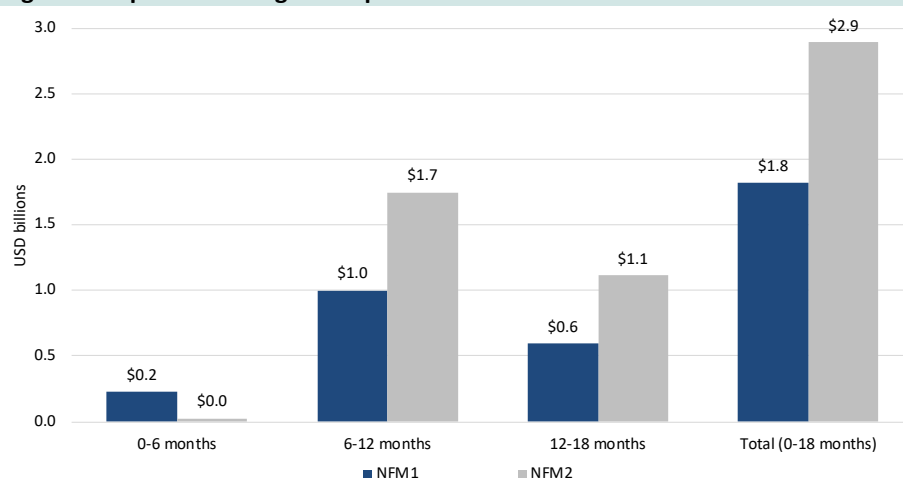


Source: 2,3

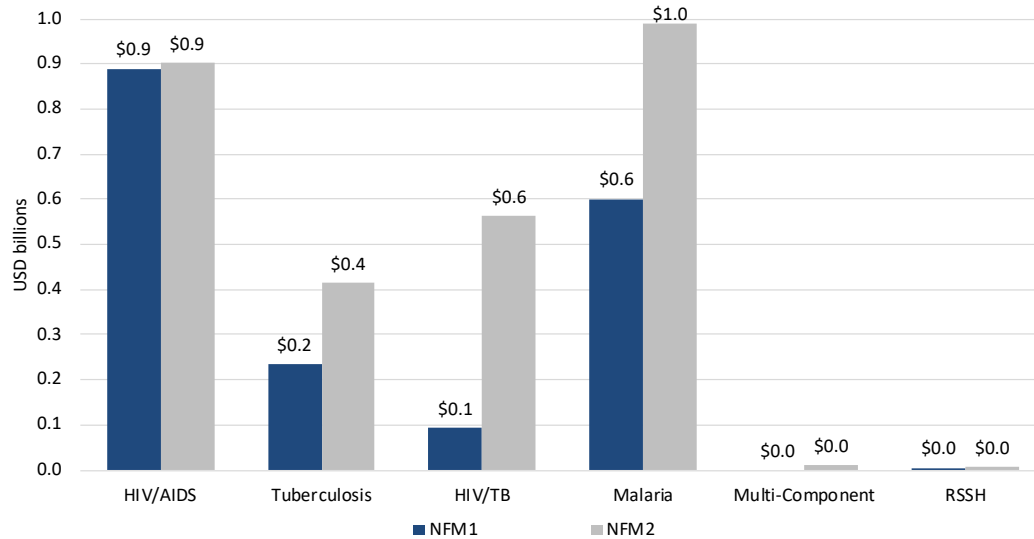
Figure 8 and Figure 9 and Figure 10 present analysis of expenditure (in absolute terms) for the first 18 months of grants starting up for the NFM1 and NFM2 cycles. Key points to note are as follows:

- Expenditure for the first 18 months of implementation across all 56 NFM2 grants that reported data was US\$ 1.1 billion higher than the 44 NFM1 grants reported.
- Increased rates of expenditure were mainly driven by increases in HIV/TB and malaria, and also in the AME region, rather than being evenly spread across all components and regions.

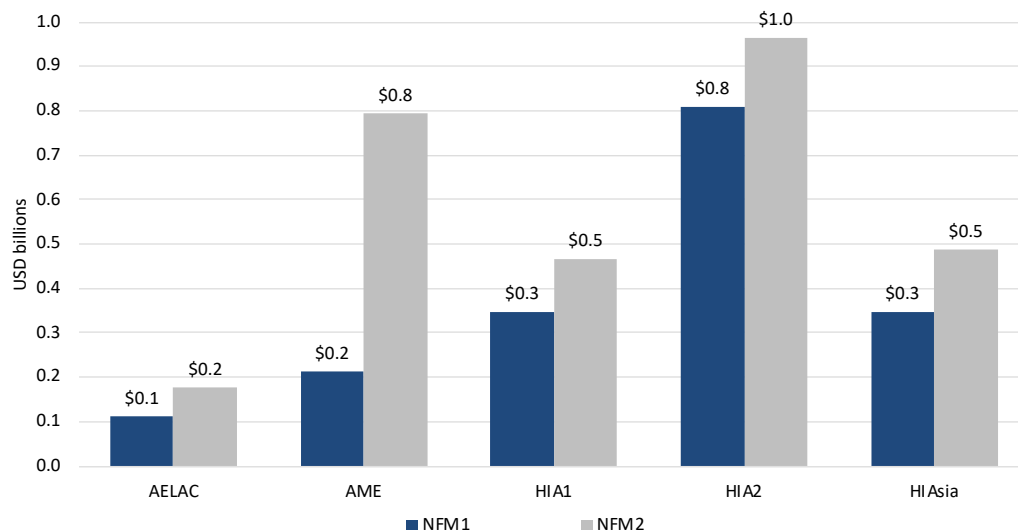
Figure 8: Expenditure on grants up to 18 months from the NFM1 and NFM2 start date



Source: 4

Figure 9: Expenditure by component for NFM1 and NFM2 grants at 18 months cycle start date

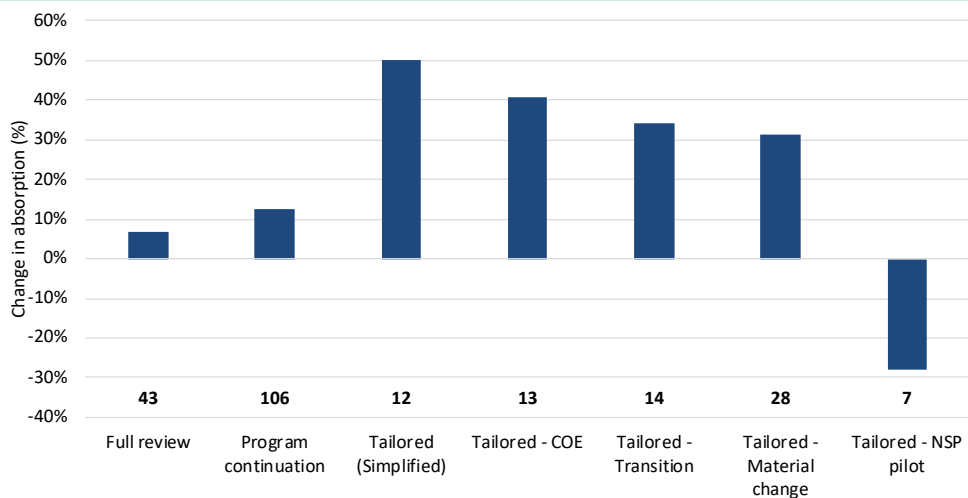
Source: 4

Figure 10: Expenditure by region for NFM1 and NFM2 grants at 18 months cycle start date

Source: 4

Figure 11 presents the change in absorption (absorption in 2018 minus average absorption between 2014 and 2017) by differentiated grant application type, as well as the count of countries along the bottom. As shown, absorption increased for all applications types except for the tailored NSP pilot category.

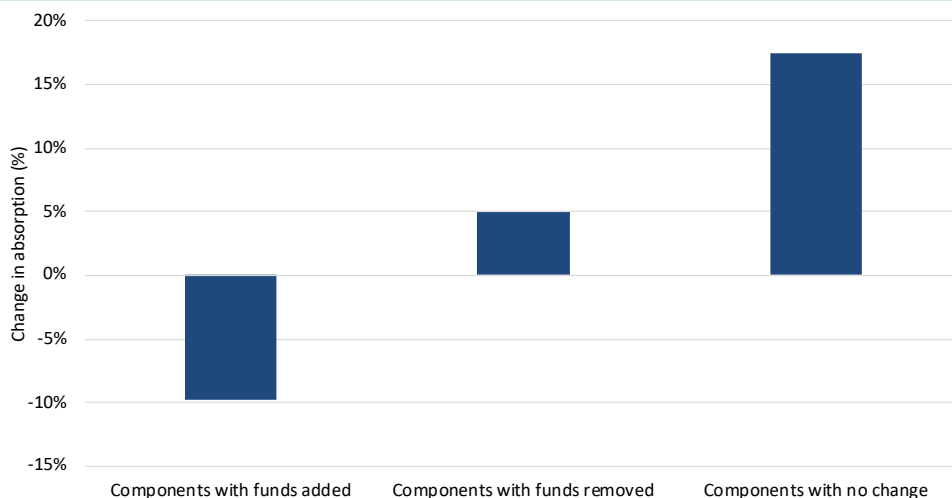
Figure 11: Change in absorption (absorption in 2018-avg. absorption between 2014 and 2017 vs.) by differentiated grant application type



Source: 1

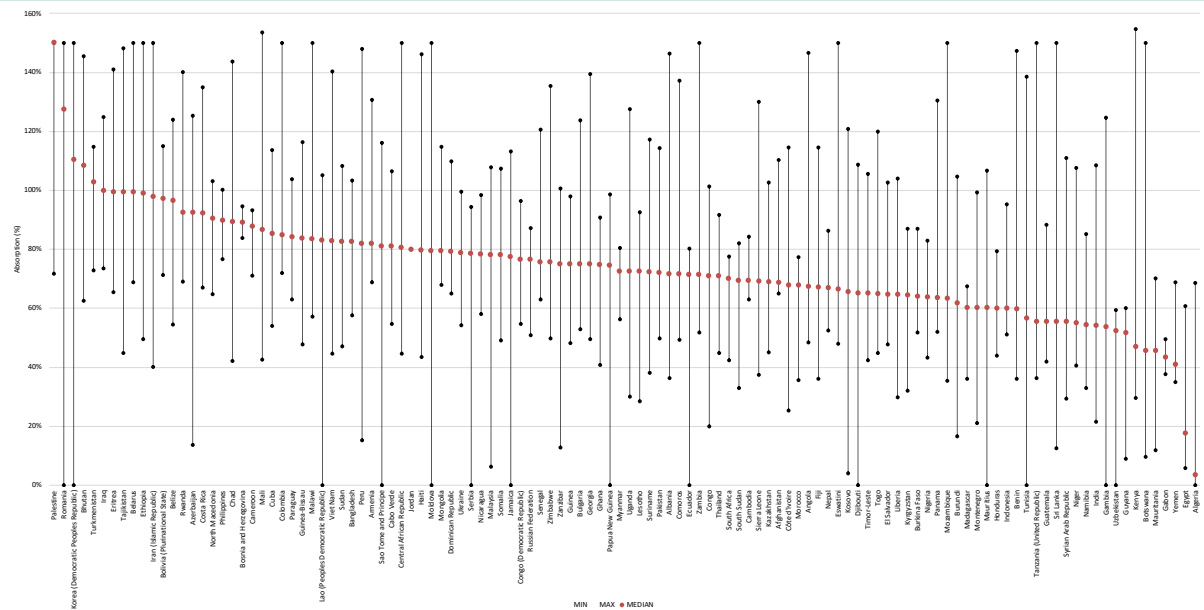
Figure 12 presents the change in absorption (absorption in 2018 minus average absorption between 2014 and 2017) by components where funds were added and removed from the initial allocation through Stage 2 of the qualitative adjustment process, and components where no change was made.

Figure 12: Change in absorption (absorption in 2018-avg. absorption between 2014 and 2017 vs.) by differentiated grant application type

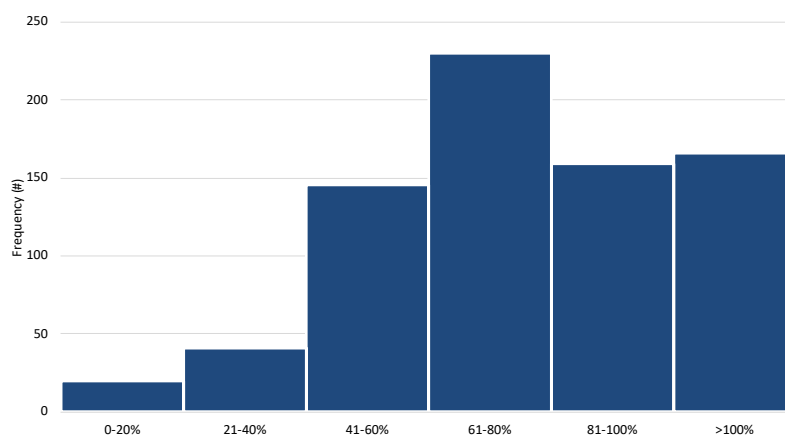


Source: 1

Figure 13 presents the minimum, maximum and median absorption at the individual country level (i.e. across all grants within a country) between 2010 and mid-2019, sorted by median absorption. As shown, there is huge variation in the rates of absorption by year within and between countries. Figure 14 shows that while there is huge variation, it is unusual for grants to report absorption of 40% or less, but not very unusual for grants to report absorption of more than 100%.

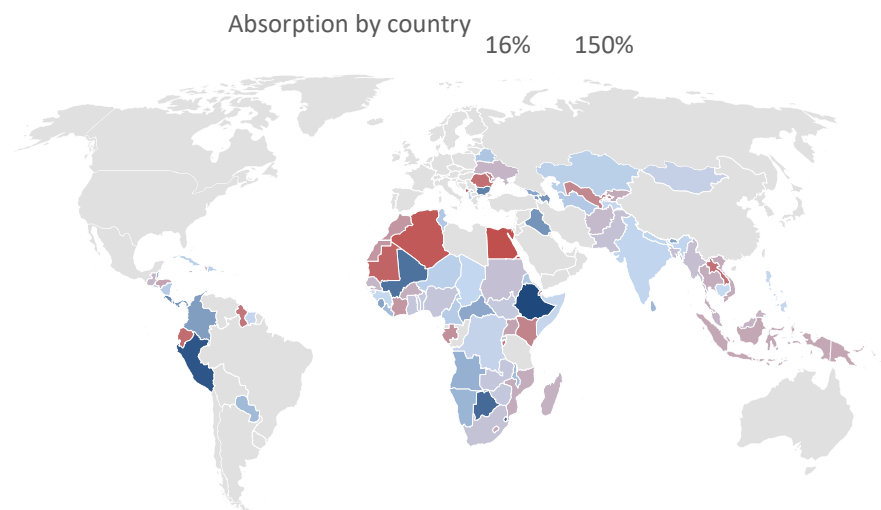
Figure 13: Min, max and median absorption by country, capped at 150% (2014 to 2019)

Source: 1

Figure 14: Histogram of annual absorption rates by country (2014 to 2019)

Source: 1

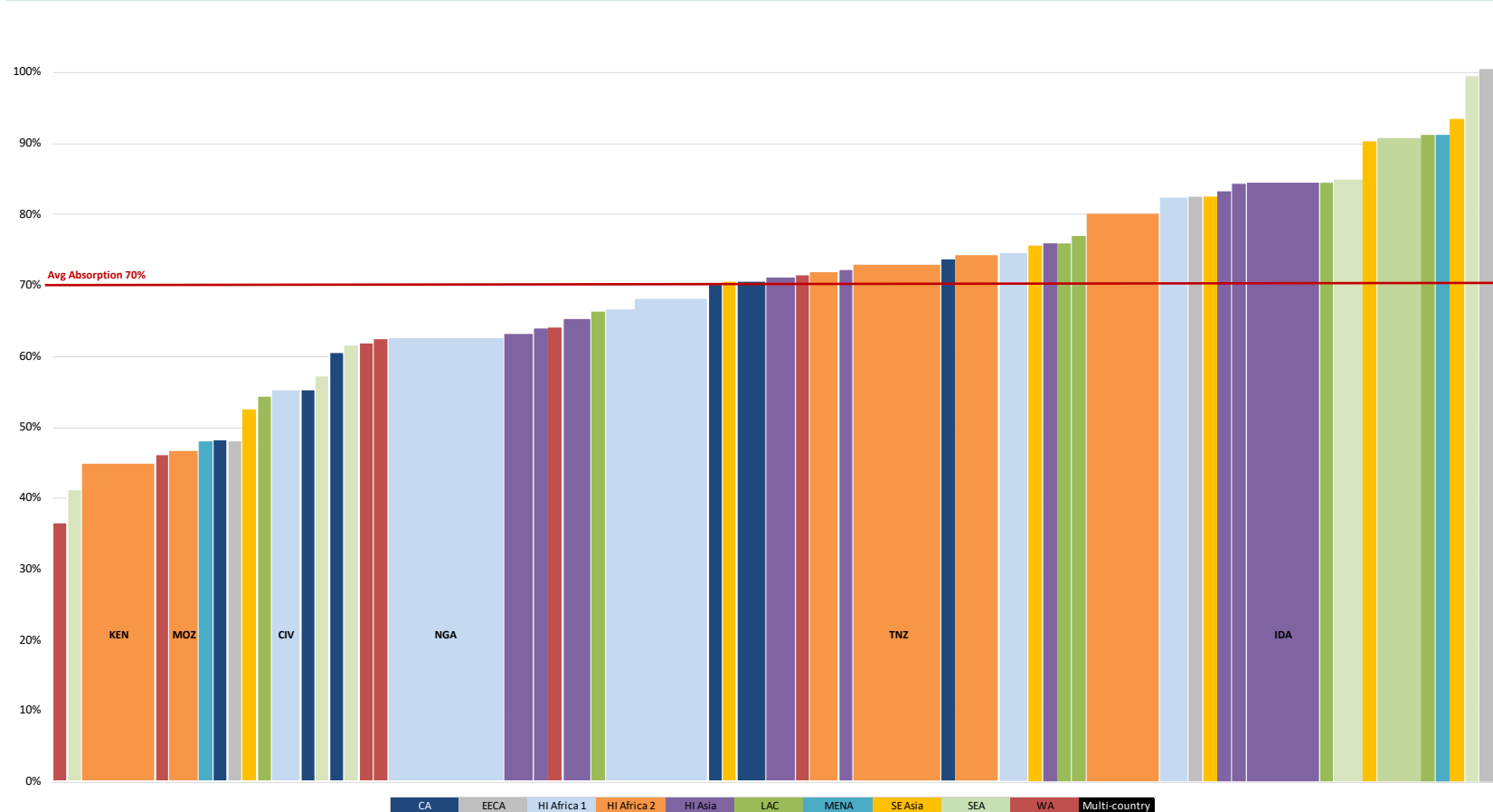
As shown in Figure 15, there are no clear trends in absorption by region for the period 2018-19.

Figure 15: Absorption rates by country (2018 to 2019)

Source: 1

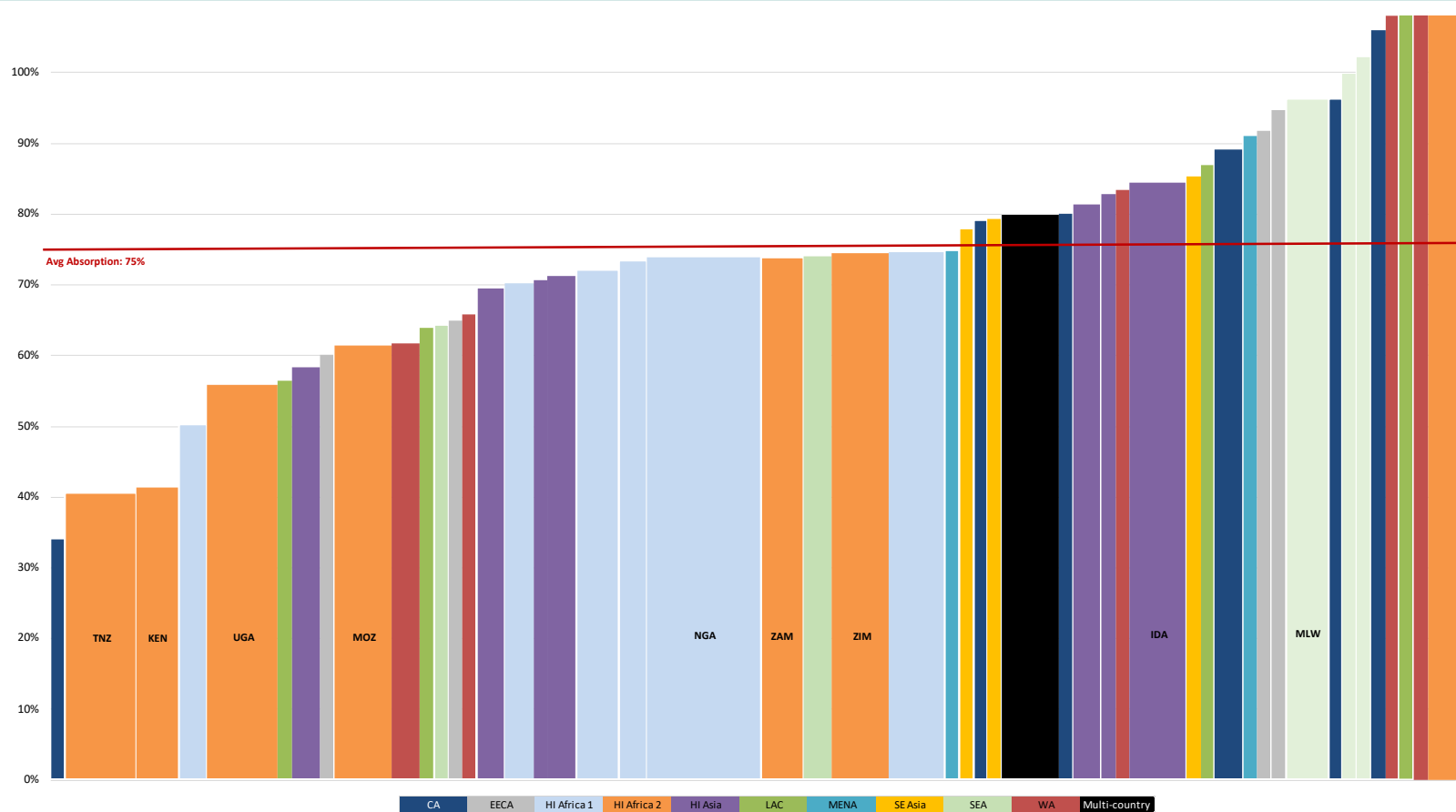
The next two figures seek to compare absorption, weighted by the size of grants to each country, over two periods: Figure 16 shows absorption between 2013 and 2015, as analyzed by the Secretariat in 2016 and used as the basis of analyzing absorption for the SR2017; and Figure 17 shows absorption between 2018 and 2019. The figures are not intended to show all countries but focus on the countries with larger grants. We also recognize that there are limitations with comparing the two time periods. Some observations are however worth noting when looking across the two periods:

- Although absorption has increased for most grants, there remains a similar dispersion of high and low absorbing countries across the portfolio.
- Some countries with large grants have dramatically increased rates of absorption between the two periods:
 - **Mozambique** – the seventh largest country by budget with an absorption rate of 47% (2013 to 2015) and 61% (2018 to 2019).
 - **Nigeria** – the country with the largest budget, and with an absorption rate of 63% (2013 to 2015) and 74% (2018 to 2019).
 - **DRC** – the country with the sixth largest budget, and with an absorption rate of 68% (2013 to 2015) and 75% (2018 to 2019).
 - **Malawi** – the country with the tenth largest budget, and with an absorption rate of 85% (2013 to 2015) and 96% (2018 to 2019).
- Other countries with very large grants have reduced or similar rates of absorption between the two periods:
 - **India** – the fourth largest country by budget, and with an absorption rate of 85% (2013 to 2015) and 85% (2018 to 2019).
 - **Zambia** – the eleventh largest country by budget, and with an absorption rate of 74% (2013 to 2015) and 74% (2018 to 2019).
 - **Kenya** – the twelfth largest country by budget, and with an absorption rate of 45% (2013 to 2015) and 41% (2018 to 2019).
 - **Zimbabwe** – the eighth largest country by budget, and with an absorption rate of 80% (2013 to 2015) and 74% (2018 to 2019).
 - **Uganda** – the third largest country by budget, and with an absorption rate of 73% (2013 to 2015) and 56% (2018 to 2019).
 - **Tanzania** – the second largest country by budget, and with an absorption rate of 73% (2013 to 2015) and 41% (2018 to 2019).

Figure 16: Country absorption rates by grant size and region (2013-2015)¹³⁹

Source: 3

¹³⁹ Note that individual countries within a given region will be a shade of the colour denoted in the legend, in order to distinguish between country portfolios. Given the aforementioned issues with data quality and the need to interpret the analysis with a degree of caution, it is inappropriate to label each country.

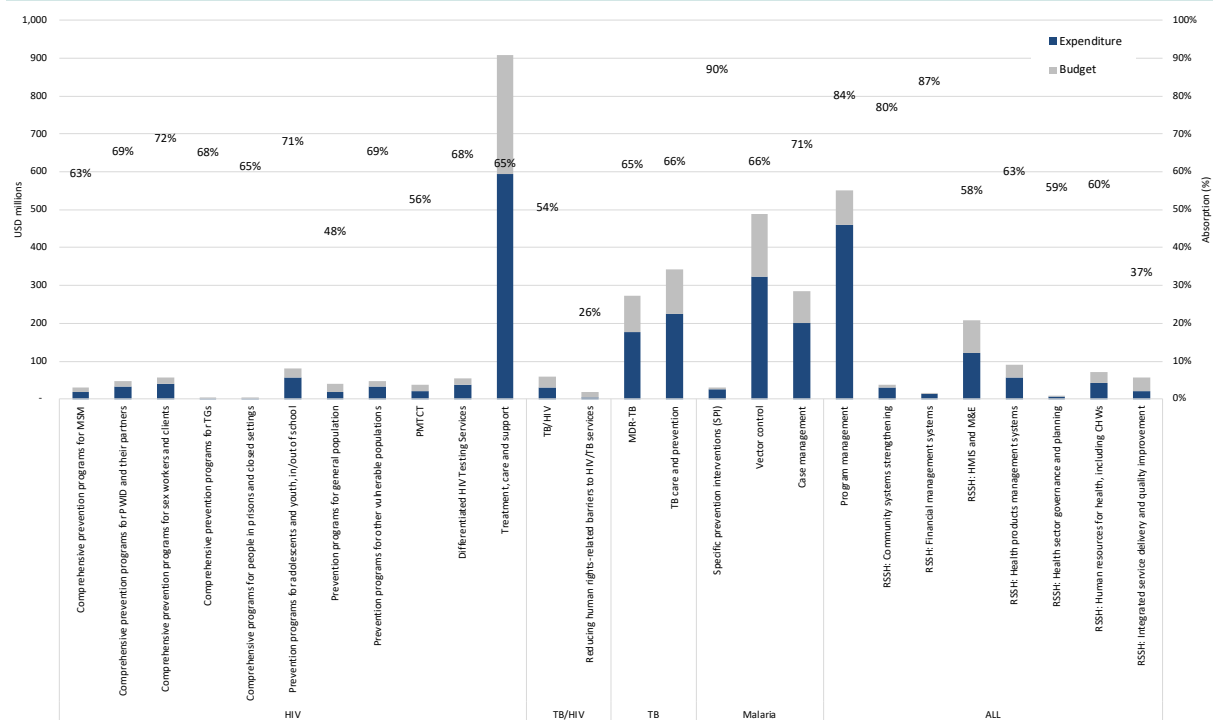
Figure 17: Country absorption rates by grant size and region (2018 to 2019)¹⁴⁰

Source: 1

¹⁴⁰ Note that individual countries within a given region will be a shade of the colour denoted in the legend, in order to distinguish between country portfolios. Given the aforementioned issues with data quality and the need to interpret the analysis with a degree of caution, it is inappropriate to label each country.

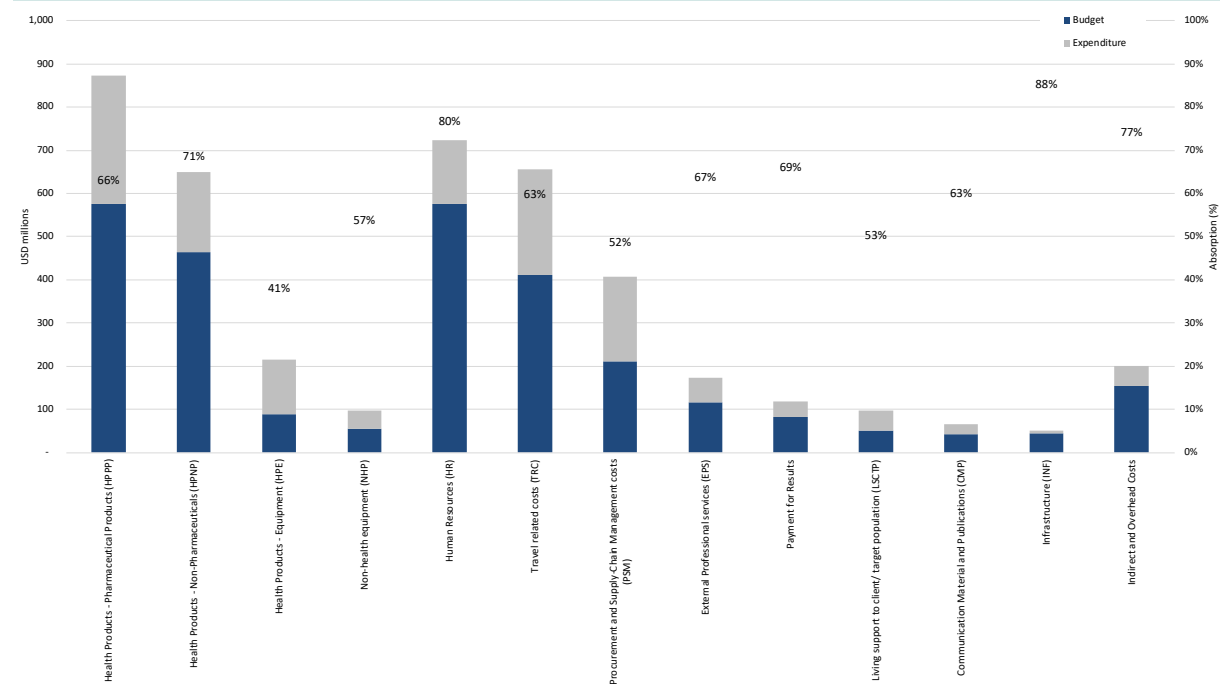
Figure 18 shows budget, expenditure and rate of absorption by module and Figure 19 by cost category between 2018 and mid-2019. Key points to note are as follows:

- The composition of grant budgets is dominated by investments in a few areas, most notably:
 - HIV treatment, care and support; TB care and prevention and MDR-TB; and malaria vector control and case management. Together these comprise 60% of the total budgeted grant funds. Program management comprises a further 14% of the budget (18% of expenditure).
 - Health products and non-health equipment account for 42% of the budget. Human resources and travel related costs comprise a further 17% and 15%, respectively.
- The total value of unspent budgeted funds was US\$ 1.2 billion.
- Absorption varies widely by module:
 - *Prevention*: Absorption across all HIV PMTCT was 56% and across all other HIV prevention modules was 67%, and particularly low for prevention programs for general population at 48%. Absorption for malaria vector control was also 66%.
 - *Treatment and care*: Absorption was 65% for HIV treatment, care and support, 66% for TB prevention and care, and 71% for malaria case management. We assume that this is linked to the rate of absorption for health products and influenced by the absence of commitments and obligations from this data.
 - *Human rights*: Absorption for the module reducing human rights-related barriers to HIV/TB services was the lowest of any module at 26%.
 - *RSSH*: Absorption across all RSSH modules was 60%, although varied from 87% for financial management systems to 37% for integrated service delivery and quality improvement.
 - *Program management*: Absorption was 84%.
- Absorption also varies widely by cost category:
 - *Health products*: Absorption across all cost categories for health products and non-health equipment was 64%.
 - *Human resources*: Absorption was 80%.
 - *Travel related costs*: Absorption was 63%.
 - *Other*: Absorption varies from 88% for infrastructure and 77% for indirect and overhead costs, to 52% for PSM costs and 53% for living support.
- What this data hides are rates of absorption of 0% and in excess of 150% for virtually all modules and cost categories when looking across all countries in the portfolio, emphasizing the high levels of variability in absorption (as also noted above).

Figure 18: Budget, expenditure and rate of absorption by module (2018 to mid-2019)

Source: 2

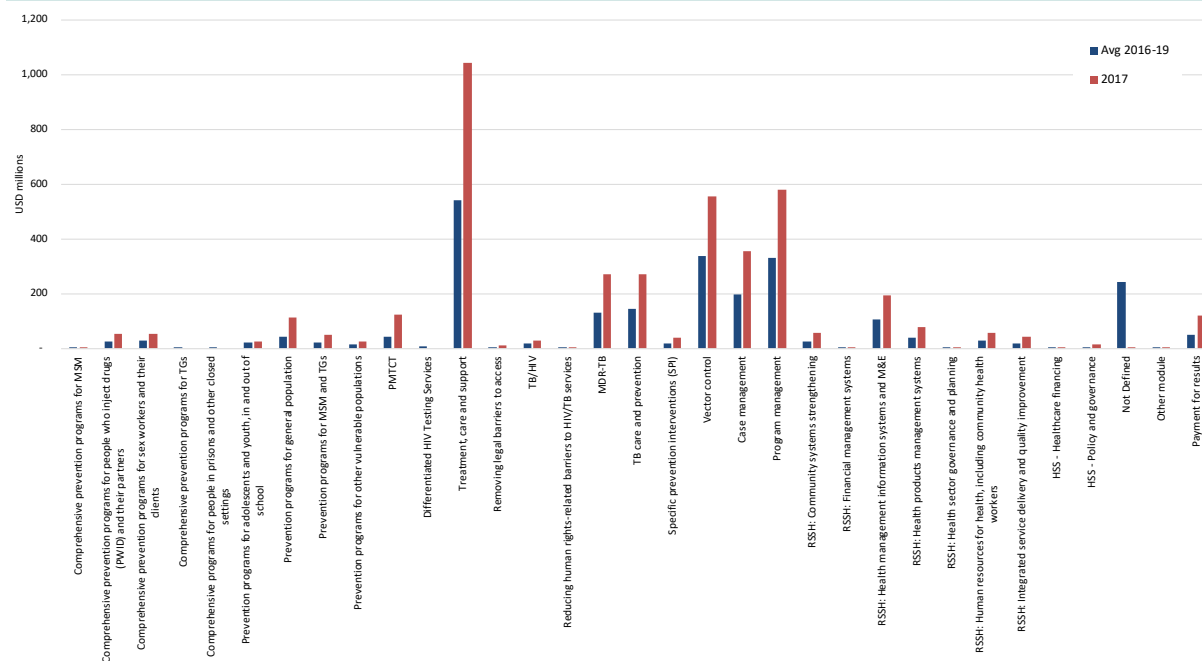
Figure 19: Budget, expenditure and rate of absorption by cost category (2018 to mid-2019)



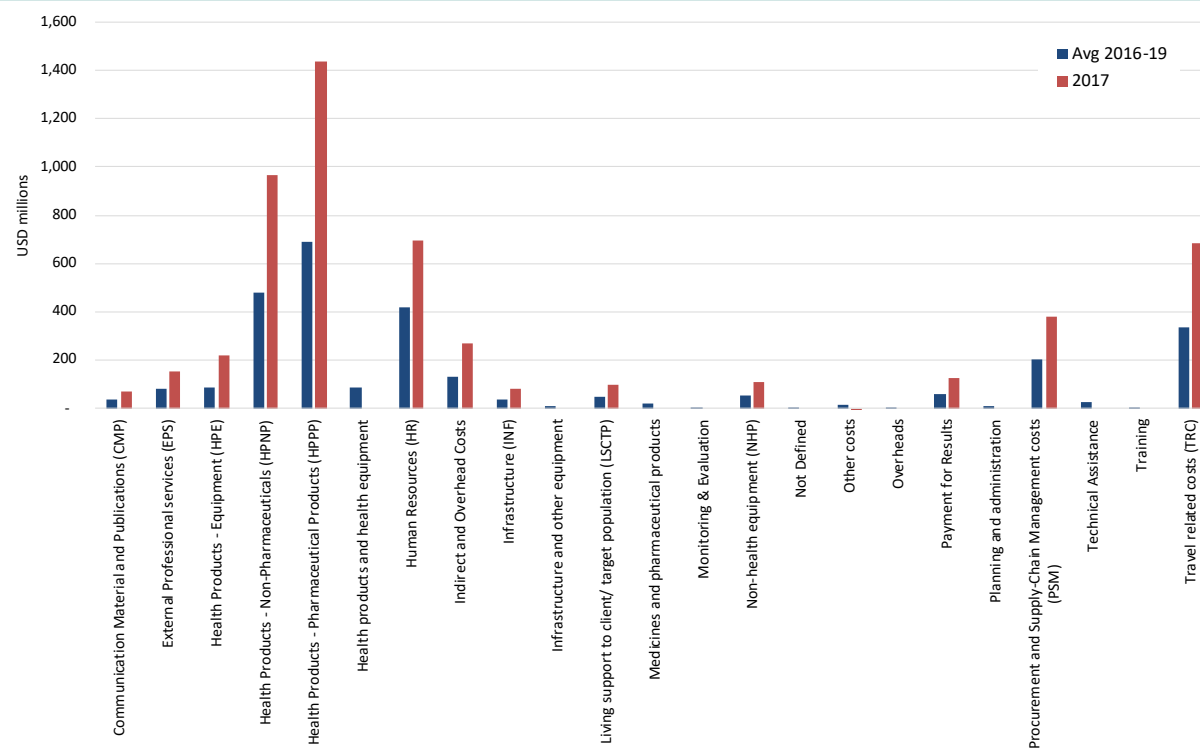
Source: 2

Figure 20 shows expenditure by module and Figure 21 by cost category as an annual average between 2016 and mid-2019, as compared to 2017. The purpose of this analysis has been to determine what the additional funds expended in 2017 were used for. While the analysis has limitations, some observations can be drawn as follows:

- The majority of ‘additional’ funds expended in 2017 were used for commodities. This is based on:
 - 67% of ‘additional’ funds being concentrated among four modules: HIV treatment, care and support (29%); TB care and prevention (7%); MDR-TB (8%); malaria case management (9%) and malaria vector control (13%).
 - 62% of ‘additional’ funds being concentrated within cost categories for health and non-health products and PSM costs. There were also substantial increases in expenditure for human resources and travel cost categories (15% and 14% of ‘additional’ funds, respectively).
- The other major area of additional expenditure was program management. 14% of ‘additional’ funds were allocated to this module. Further, 6% of ‘additional’ funds were allocated to the cost category for indirect and overhead costs (the increase in expenditure for human resources and travel cost categories would also support this observation).
- Expenditure does appear to have increased for some prevention and KVPs modules in 2017, but to a much lesser extent than the areas above (on average accounting for 1% of ‘additional’ funds).

Figure 20: Expenditure by module: Average 2016 to mid-2019 vs 2017

Source: 2

Figure 21: Expenditure by cost category: Average 2016 to mid-2019 vs 2017

Source: 2

ANNEX 4.VIII: FUNDING MODEL (SRQs 7, 14, 15)

Table 7: HRG and RSSH Analysis of Funding Request Forms 2020: Differentiated Approaches

Type of Application	Effectiveness in HRG and RSSH
Full Review	HRG: Applicants are required to discuss human rights and gender barriers under country context (section 1.2) and under funding priorities (sections 2.1 and 2.1). Must address focus requirements (2.2 d), role of CBOs (3 b). Gap: No HRG discussion under STC (section 4)
	RSSH: Applicants are required to discuss "Information on disease-specific and the overall health systems, along with the linkages between them" under country context (section 1.2) and describe Global Fund and other donor's contribution to achieving national health targets (in general) (section 1.3). Must explain links with broader health systems (2.2 c) and implementation risks related to the broader health systems (3 d). Required to discuss financing of key program costs of national disease plans and/or health systems (4 c). Gap: no explicit reference to RSSH under STC.
Program Continuation	HRG: Question 4: Promote and Protect Human Rights and Gender Equality. Gap: No requirement to discuss role of CBOs. Limited information on previous program activities, no discussion of HRG under sustainability.
	RSSH: Question 3: National Policies and Strategies, including discussion of opportunities for integration with other health programs and the broader health system. Gap: No discussion of RSSH under sustainability.
Tailored for National Strategic Plans	HRG: Applicants must indicate where the NSP addresses "Gender and age-related barriers/inequities in access to health services," "Community responses and systems" and "Role of community groups in the design and delivery of programs." Gap: Applicants are not required to have HRG component.
	RSSH: Applicants must explain the needs across other related health programs, links to the broader health system, implementation risks that may impact the broader health system. Gap: no RSSH section.
Tailored for Focused Portfolios	HRG: Discussion of KVP required in country context (section 1.1 a). Focus requirement must be addressed (1.1 f). Role of CBOs must be addressed (2 b) Gap: No discussion of HRG / CBOs under STC section
	RSSH: A table for integrated or cross-cutting programming is required, and RSSH is specifically indicated (section 1.1 c), integration and links with broader health system must be discussed (1.1 e), implementation risks and impact on the health system (2 d). Under co-financing, discussion of programmatic areas is required and can include health systems – but not a requirement (2 c). Gap: No RSSH discussion under STC section.
Tailored for Transition	HRG: Discussion of KVP required in country context (section 1.1 a). Focus requirement must be addressed (1.1 f). Role of CBOs must be addressed (2 b) Gap: No discussion of HRG / CBOs under STC section
	RSSH: A table for integrated or cross-cutting programming is required, and RSSH is specifically indicated (section 1.1 c), integration and links with broader health system must be discussed (1.1 e), implementation risks and impact on the health system (2 d). Under co-financing, discussion of programmatic areas is required and can include health systems – but not a requirement (2 c). Gap: No RSSH discussion under STC section.

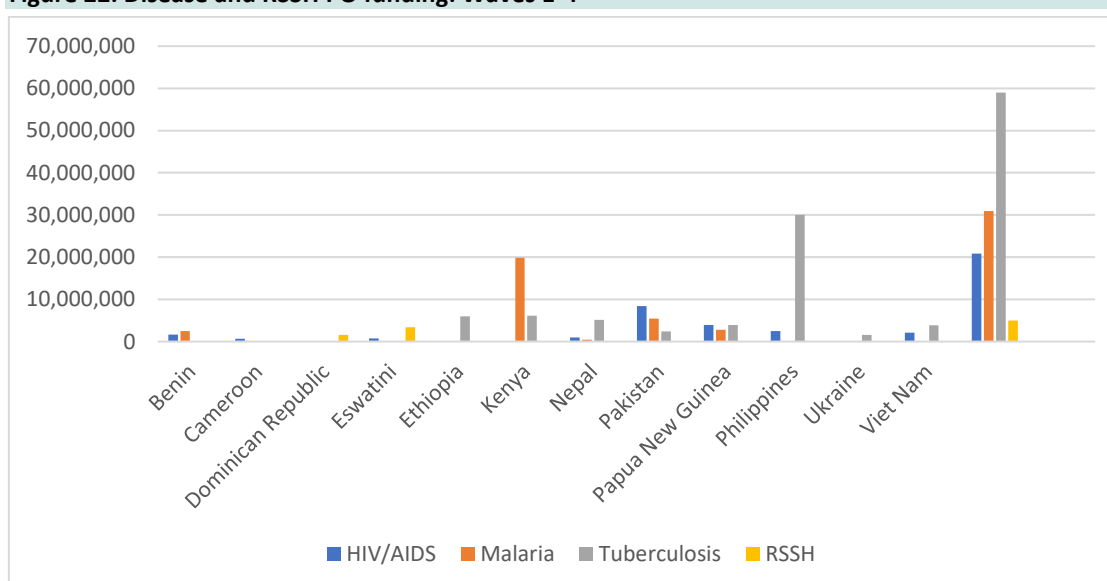
Portfolio Optimization (M3)

Data on portfolio optimization from country case studies: Waves 1-4

- RSSH is the smallest proportion of PO funds added to case study grants
- In modules for HIV, TB, Malaria, RSSH, there is no indication of PO funds being allocation for HRG

	HIV/AIDS	Malaria	Tuberculosis	RSSH
Benin	1,621,000	2,489,000		
Cameroon	687,928			
Dominican Republic				1,560,000
Eswatini	725,938			3,424,843
Ethiopia			6,000,000	
Kenya		19,861,734	6,100,658	
Nepal	960,000	408,000	5,103,787	
Pakistan	8,372,000	5,406,903	2,400,000	
Papua New Guinea	3,893,823	2,800,000	3,919,156	
Philippines	2,500,000		30,000,000	
Ukraine			1,600,000	
Viet Nam	2,100,000		3,847,305	
Totals	US\$ 20,860,689	US\$ 30,965,637	US\$ 58,970,906	US\$ 4,984,843

Figure 22: Disease and RSSH PO funding: Waves 1-4



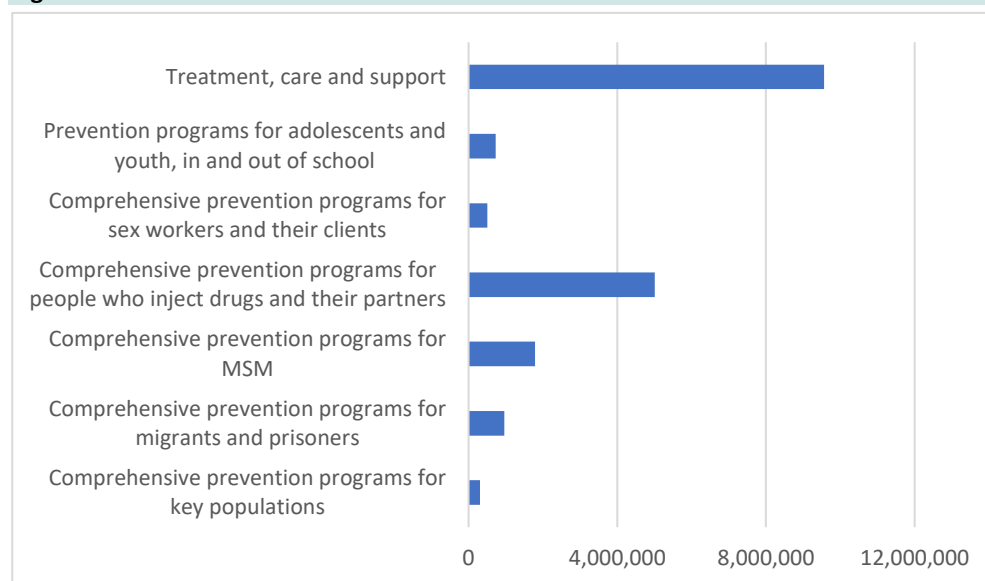
Data on HIV

- A significant proportion of PO funding for HIV was for high impact interventions including treatment, care, and support
- There was no funding made available for human rights and gender equality

HIV Module

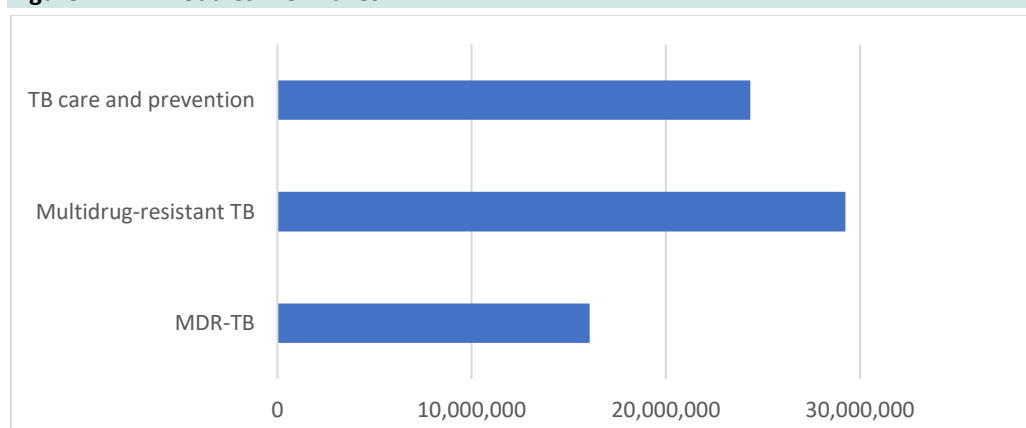
Comprehensive prevention programs for key populations	2,311,331
Comprehensive prevention programs for migrants and prisoners	960,000

Comprehensive prevention programs for MSM	1,788,669
Comprehensive prevention programs for people who inject drugs and their partners	5,012,000
Comprehensive prevention programs for sex workers and their clients	503,088
Prevention programs for adolescents and youth, in and out of school	725,938
Treatment, care and support	9,559,663
	20,860,689

Figure 23: HIV modules: PO Waves 1-4**Data on TB**

- All the funding made available from PO for TB was allocated for TB treatment, including care and prevention

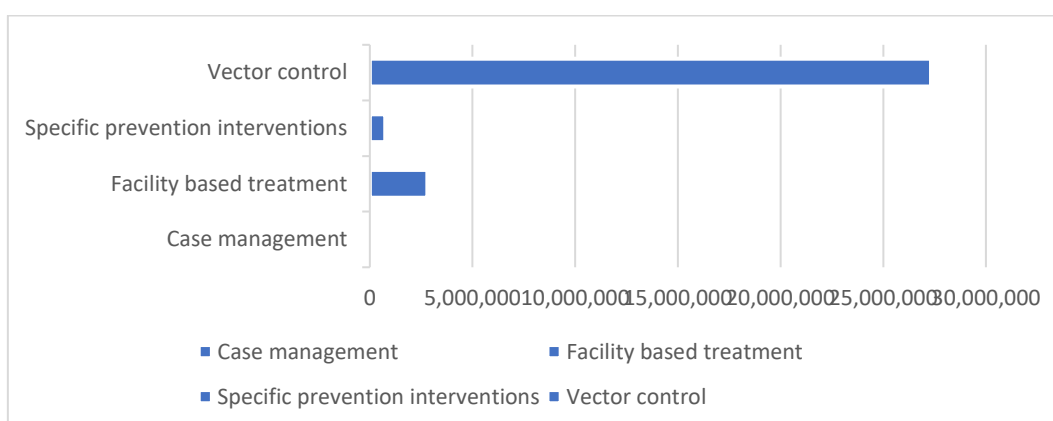
MDR-TB	16,078,834
Multidrug-resistant TB	29,240,980
TB care and prevention	13,651,092
	58,970,906

Figure 24: TB modules: PO Waves 1-4

Data on Malaria

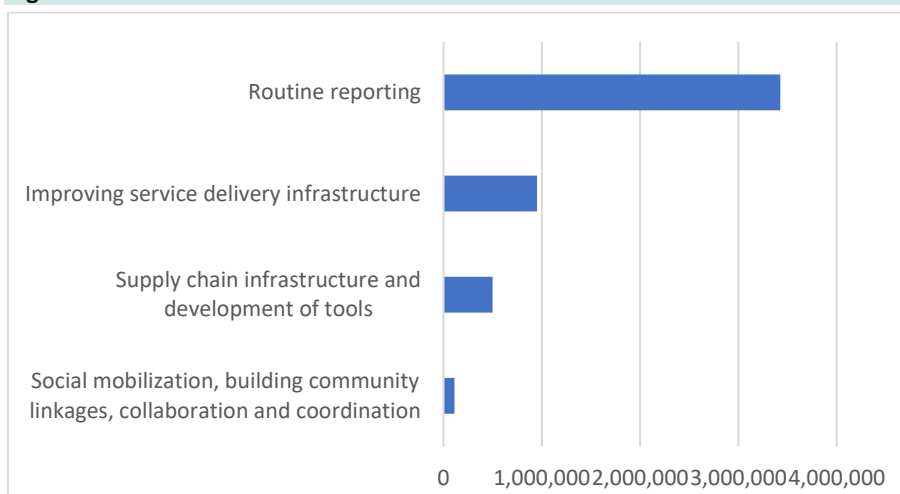
- Significant funds made available from PO for malaria was allocated for vector control/LLINs

Case management	88,000
Facility based treatment	2,800,000
Specific prevention interventions	750,000
Vector control	27,327,637
	30,965,637

Figure 25: Malaria modules: PO Waves 1-4**RSSH data:**

- RSSH funds made available through PO were largely allocated to PSCM

RSSH - Community responses and systems	110,000
RSSH - Procurement and supply chain management systems	500,000
RSSH - Procurement and supply chain management systems	950,000
RSSH - Health management information system and monitoring and evaluation	3,424,843

Figure 26: RSSH modules: PO Waves 1-4

ANNEX 4.IX: CATALYTIC INVESTMENTS (SRQ8)

As part of the 2017-19 allocation methodology, US\$ 800m was reserved for catalytic investments to “ensure delivery against the 2017-2022 Global Fund Strategy”.¹⁴¹ “They aim to do so by investing in priorities that are unable to be addressed through country allocations alone, yet deemed crucial to ensure Global Fund investments are positioned to deliver against its strategic aims. Where possible, catalytic investments are intended to build on country allocations to underpin direct investments in recipient countries and to strengthen countries’ responses to fight the three epidemics”.¹⁴²

Table 8 sets out the areas selected for catalytic investment, including the modality and investment amount.¹⁴³ Matching Funds account for 36% of the agreed budget (45% of the indicative allocation), multi-country approaches 37% (34% of the indicative allocation) and Strategic Initiatives 27% (22% of the indicative allocation). HIV, TB and malaria each account for 24-25% of the agreed budget, RSSH 20% and broader strategic areas 6%.

Table 8: Catalytic investment allocation areas¹⁴⁴

Area	Modality	Indicative allocation (US\$)	Agreed budget (US\$)
HIV			
KVP sustainability and continuity	Multi-Country	50	50
KVP impact	Matching Funds	50	50
Human rights	Matching Funds	45	45
Adolescent girls and young women	Matching Funds	55	55
TB			
Incentivizing programming to find missing cases	Matching Funds	115	115
Addressing barriers to find missing cases, esp. in KVPs	Strategic Initiative	7	10
Community and innovative approaches to accelerate case finding	Strategic Initiative	3	
Multi-Country responses	Multi-Country	65	65
Malaria			
Malaria elimination: Cross-cutting support in 21 low burden countries	Strategic Initiative	7	7
Malaria elimination: Southern Africa	Multi-Country	20	20
Malaria elimination: Mesoamerica	Multi-Country	6	6
Greater Mekong sub-region	Multi-Country	119	119
Catalyzing market entry of new LLINs	Matching Funds	33	33
	Strategic Initiative	2	2
Piloting introduction of the RTS,S malaria vaccine	Strategic Initiative	15	15
RSSH			
Sustainability, service delivery and health workforce			
Sustainability, transition and efficiency	Strategic Initiative	15	15
Integration of service delivery & health workforce improvements	Matching Funds	18	18
Technical support, South-to-South collaboration, peer review and learning	Strategic Initiative	14	14
Data			
Data - Data systems, data generation and use for programmatic action and quality improvement ¹⁴⁵	Matching Funds	40	40
	Strategic Initiative	10	20
PSM			
Diagnosis and planning	Strategic Initiative	20	20
Innovation challenge fund	Strategic Initiative	10	10
Developing local resources	Multi-Country	12	12

¹⁴¹ GF/B35/DP04

¹⁴² GF/B36/DP04 – Revision 2

¹⁴³ These areas were approved by the Board based on collective inputs by technical partners, the Secretariat, communities, civil society and the TRP, and under the guidance of the Strategy Committee. GF/B36/DP04 – Revision 2

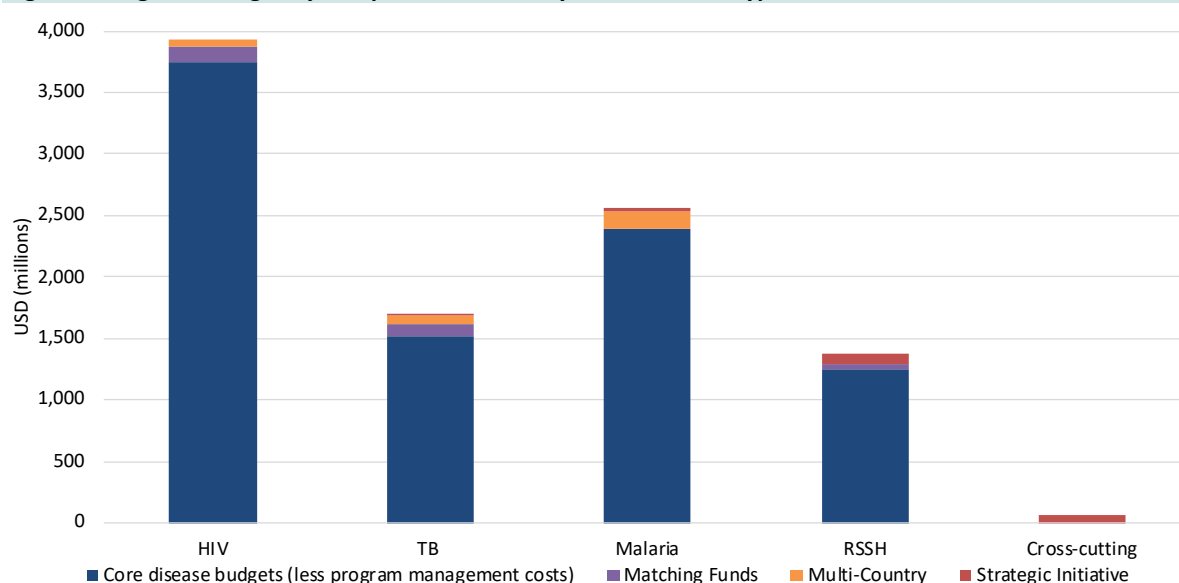
¹⁴⁴ GF/B36/DP04 – Revision 2

¹⁴⁵ Includes national strategic planning for data systems; district data systems for quality improvement; disaggregated data generation, analysis and use; impact and epidemiological measurement, reviews and evaluations.

Area	Modality	Indicative allocation (US\$)	Agreed budget (US\$)
Pre-qualification of medicines and IVDs	Strategic Initiative	12	12
CRG			
CRG	Strategic Initiative	15	15
Broader strategic areas			
TERG prospective evaluations	Strategic Initiative	22	22
Emergency Fund	Strategic Initiative	20	20
Human rights: breaking down barriers	Strategic Initiative	-	1.7
CCM Evolution	Strategic Initiative	-	5
Total		800	710

As shown in Figure 27, these investments are small in the context of the agreed budgets for each component across the portfolio.

Figure 27: Agreed budget by component and catalytic investment type¹⁴⁶



Source: Data on final agreed grant budgets provided by the Secretariat

Aside from the overall guidance that catalytic investments should be targeted to strategic priorities that are unable to be addressed through country allocations alone, it is unclear what the Secretariat means by the term ‘catalytic’.¹⁴⁷ Its guidance focuses mostly on leveraging additional funding for strategic priority areas (Matching Funds); providing funding for issues of strategic importance that require engagement of partners globally (Strategic Initiatives); and providing funding for strategic priority areas that could not be addressed through country allocations alone (Multi-Country Approaches).

In our view, catalytic funding should be considered as leading to one or more of the following criteria being met:

- **More:** Additional funding is leveraged from other sources and/or additional activities are now implemented.
- **Improved:** Activities that were being conducted previously are now appreciably more efficient, effective and/or strategic.

¹⁴⁶ The data for each component is based on the agreed budget for all NFM2 grants for all component modules, with TB/HIV allocated to HIV, and excluding program management costs. The data on the agreed budgets for Matching Funds and multi-country grants was taken from Table 8 above and subtracted from the component budget. We note that this means program management costs are included for catalytic funding sources.

¹⁴⁷ PCE (2018) Synthesis report.

- **Unique, new or innovative:** Activities/contributions that are exclusive or exceptional to catalytic funding and/or those that are entirely new, original or initiated because of catalytic funding.
- **Faster:** Activities that were being conducted previously but now at an accelerated pace.

The following tables summarize the available evidence to consider the case for each of these criteria being met for the three catalytic funding mechanisms – Matching Funds (Table 9); Multi-Country Approaches (Table 10); and Strategic Initiatives (Table 11). This has involved analysis of data on absorption and programmatic performance for the modules/interventions and indicators of relevance to each investment – our mapping of investment to modules/interventions and indicators is provided in Annex 4.ix.a. We note that this assessment has been focused predominantly on Matching Funds (as per our Inception Report).

Throughout we use a RAG rating as follows to determine: (a) the extent to which the intended use of funds can be considered as ‘catalytic’; and (b) whether the criteria for assessing the catalytic nature of investments has been achieved as intended, taking into account both financial and programmatic performance. The two ratings should be considered together for each investment.

RAG rating	Design	Implementation
Green	Strongly catalytic (e.g. catalytic funding has leveraged significant additional resources)	Meets/exceeds expectations
Amber	Moderately catalytic (e.g. catalytic funding has leveraged modest additional resources)	Below expectations
Red	Not catalytic (e.g. catalytic funding has leveraged only very limited/no additional resources)	Significantly below expectations

Matching Funds

- Matching Funds were developed to incentivize the programming of allocations towards key strategic priorities. As such, in theory, catalytic funding should primarily meet the criteria for ‘more’. However, our analysis – summarized in Table 9 below – suggests that the actual design of the Matching Funds has meant that significant additional resources have only been leveraged in two areas: HIV adolescent girls and young women; and TB finding missing cases.
- In a number of instances, despite the introduction of Matching Funds, country grant budgets for the areas being supported have fallen compared to the previous grant cycle – it is likely that this is due to many having reduced allocations for this cycle. In some instances, it is unclear whether Matching Funds were really required, for instance in South Africa where Matching Funds for AGYW accounted for US\$ 5m of a total budget of US\$ 68m for the related module; and in Ethiopia where Matching Funds for integrated service delivery and health workforce accounted for US\$ 3m of a total budget of US\$ 23m for the related modules.
- Further, although it has not been possible to directly track the implementation of Matching Funds, the limited evidence we do have (e.g. based on absorption against the mapped modules/interventions) suggests that they have not always been operationalized as intended.
- These findings are in line with the TRPs observations that Matching Funds have resulted in some innovative approaches (e.g. to increase attention to human, KVPs and AGYW), but “many other proposals did not present a coherent approach likely to catalyze better program performance (e.g. with long, non-prioritized lists of programs and interventions, which as a result were not likely to have impact)”.¹⁴⁸

¹⁴⁸ The Technical Review Panel’s Observations on the 2017-2019 Allocation Cycle.

- Evidence from the PCE, and acknowledged by the Secretariat, suggests that the late approval of catalytic investments meant many Matching Funds were not well integrated into wider grant approaches, which hampered initial implementation and increased the transaction costs of applying for support.¹⁴⁹

Table 9: Assessment of catalytic nature of Matching Funds

Matching Funds	Catalytic by design	Catalytic in implementation
HIV: Key populations impact	<ul style="list-style-type: none"> • Budget: US\$ 44m across 12 countries • More: The aim is to incentivize country programming for KVPs as part of the national response. The amounts provided per country are however small (avg. allocation US\$ 4.2m) considering needs. Our analysis shows that 9 countries (75%) met the matching criteria through the use of Global Fund resources, with small allocations in Benin, Ghana and Zimbabwe. Despite the introduction of Matching Funds, the annual Global Fund budgets to related modules between 2016 and 2019 appears to have increased in only 2 countries, remained constant in 8 and fallen in 2. • Improved: TRP feedback noted that some innovative approaches had been proposed, but raised concerns in some countries, such as Benin where activities had not been sufficiently prioritized; Cameroon and Myanmar where approaches and targets were not felt to be ambitious enough; and Jamaica where proposed activities were not felt to be sufficiently catalytic. 	<ul style="list-style-type: none"> • More: The average rate of absorption for the modules associated with these funds was 51%, as compared to 59% for all HIV and TB/HIV modules. • Improved: We have not been able to verify how TRP feedback was addressed. Most respondents to a survey by EANNASO in 2019 suggested that matching funds were used for useful activities.¹⁵⁰
HIV: Programs to remove human rights-related barriers to health services	<ul style="list-style-type: none"> • Budget: US\$ 33m across 20 countries • More: The aim is to catalyze scale-up of comprehensive human rights programming. Despite small Matching Fund allocations (avg. allocation US\$ 2.3m) our analysis shows that only 4 countries (20%) met the matching criteria through the use of Global Fund resources, with 7 countries not even allocating the full Matching Fund budget to the appropriate module. With the introduction of Matching Funds, the annual Global Fund budgets to related modules between 2016 and 2019 appears to have increased in almost all countries. • Improved: TRP feedback noted that some innovative approaches had been proposed and indicated that Matching Funds were relevant in some countries (e.g. Kyrgyzstan, Uganda) but raised concerns in others. For instance, in Ghana, the country requested a waiver for the matching criteria but the TRP felt this would be inappropriate and recommended a strengthened focus on human rights – our analysis suggests this did not happen. More urgency was requested in Botswana and activities did not seem fully relevant in Côte d'Ivoire or South Africa. In the Philippines, the core disease grant was not felt to address human rights barriers, and some activities included in the Matching Funds proposal were not felt to be catalytic and should have been funded from the core 	<ul style="list-style-type: none"> • More: The average rate of absorption for the module associated with these funds was low at 29%, as compared to 58% for all HIV and TB/HIV modules. • Improved: We have not been able to verify how TRP feedback was addressed. However, in response to the observation that Matching Fund activities were not well aligned to the core allocations, the Secretariat introduced the

¹⁴⁹ Catalytic Investments for the 2020-2022 Allocation Period: 41st Board Meeting: GF/B41/03 – Revision 1 15-16 May 2019, Geneva.

¹⁵⁰ EANNOSO (2019) Achievements of The Global Fund's Matching Funds and their Effect on Community, Rights and Gender Components in the Response to HIV and Tuberculosis in Anglophone Africa.

Matching Funds	Catalytic by design	Catalytic in implementation
	allocation ¹⁵¹). In Benin, due to the timing of the Matching Fund application coming before the HIV funding request, it was not possible to determine its relevance or if the matching criteria was being met.	Human Rights Strategic Initiative mid-cycle.
HIV: Adolescent girls and young women	<ul style="list-style-type: none"> Budget: US\$ 49m across 13 countries More: The aim is to catalyze the scale up of comprehensive, quality programming to reduce HIV risk and incidence amongst AGYW. The avg. allocation was US\$ 4.2m. Our analysis shows that 10 countries (77%) met the matching criteria through the use of Global Fund resources, with small allocations in Eswatini, Uganda and Zimbabwe. In South Africa, Matching Funds accounted for US\$ 5m of a total budget of US\$ 68m for the related module. With the introduction of Matching Funds, the annual Global Fund budgets to related modules between 2016 and 2019 appears to have increased in 8 countries, remained constant in 2 and fallen in 3.¹⁵² Improved: TRP feedback noted that some innovative approaches had been proposed and indicated that Matching Funds were relevant in some countries (e.g. Lesotho). It suggested some improvements in others (e.g. in Zambia to tie the investment to a wider testing strategy being implemented; in Cameroon to increase targets; and in South Africa to clarify what activities will be implemented with the funds). 	<ul style="list-style-type: none"> More: The average rate of absorption for the module associated with these funds was 44%, as compared to 65% for all HIV and TB/HIV modules. Improved: We have not been able to verify how TRP feedback was addressed. Respondents to a survey by EANNASO in 2019 reported that Matching Funds “have increased focus on programming for AGYW”.¹⁵³
TB: Finding missing TB cases	<ul style="list-style-type: none"> Budget: US\$ 95m across 12 countries More/innovative: The aim is to incentivize country allocations to find missing TB and MDR-TB cases through innovative approaches. Programmatic targets for people diagnosed and started on TB and/or MDR-TB treatment and coverage were increased along with Matching Funds. The avg. allocation was US\$ 9.6m. Our analysis shows that 11 countries (92%) met the matching criteria (calculated at the intervention level instead of module) through the use of Global Fund resources, with the exception being DRC. With the introduction of Matching Funds, the annual Global Fund budgets to related interventions between 2016 and 2019 appears to have increased in 7 countries, remained constant in 4 and fallen in 1 (Kenya). Improved: The TRP raised concerns in a number of countries, such as Nigeria where there was a lack of detail on the proposed use of funds; Myanmar where more analysis was required and targets increased; Mozambique where the proposed approach was not evidence based; and Tanzania where proposed activities were not felt to be catalytic and should have been funded from the core allocation. In Pakistan, 	<ul style="list-style-type: none"> More: The average rate of absorption for the interventions associated with these funds was 57%, as compared to 62% for all TB modules. Improved: We have not been able to verify how TRP feedback was addressed, but quantitative data suggests that case finding has increased, with some key informants suggesting that at least part of this

¹⁵¹ This included planning for advocacy and training for health care workers, law enforcement, legal experts and decision-makers emphasizing stigma, discrimination, violation and decriminalization.

¹⁵² The Global Fund find that US\$ 55m in Matching Funds has mobilized “an additional US\$ 140 million for programs to reduce new HIV infections, violence, and unintended pregnancies among 1m AGYW in the 13 countries” with these countries are “on track to see a 40-45% reduction in incidence by 2022”. The Global Fund (2019) Step Up The Fight: Ending HIV among AGYW.

¹⁵³ EANNASO (2019) Achievements of The Global Fund’s Matching Funds and their Effect on Community, Rights and Gender Components in the Response to HIV and Tuberculosis in Anglophone Africa.

Matching Funds	Catalytic by design	Catalytic in implementation
	more clarity was requested on program management costs included in the request.	progress is due to catalytic funding. Respondents to a survey by EANNASO in 2019 reported that Matching Funds have supported these gains and enabled some innovation (e.g. to trial piloted mobile screening vans). ¹⁵⁴
RSSH: Integrated service delivery and health workforce	<ul style="list-style-type: none"> Budget: US\$ 15m across 7 countries More/improved: Designed to incentivize programming to: a) identify, challenge and improve integrated service provision to reduce fragmentation and find efficiencies; and b) improve health workforce planning and implementation in order to ensure adequate provision and scale-up of integrated services. The avg. allocation was small at US\$ 2.6m. Our analysis shows that 6 countries (86%) met the matching criteria through the use of Global Fund resources, with the exception being Guinea. In Ethiopia, Matching Funds accounted for US\$ 3m of a total budget of US\$ 23m for the related modules. With the introduction of Matching Funds, the annual Global Fund budgets to related modules between 2016 and 2019 appears to have increased in 2 countries, remained constant in 1 and fallen in 4. Improved: TRP feedback confirmed the relevance of Matching Fund support in Benin but raised concerns related to the complementarity of this request to the allocation funding request. It also raised concerns in Guinea where the proposal was largely structured to remunerate CHWs. 	<ul style="list-style-type: none"> More: The average rate of absorption for the interventions associated with these funds was 24%, as compared to 50% for all RSSH modules. Improved: We have not been able to verify how TRP feedback was addressed.
RSSH: Data systems, data generation, data use	<ul style="list-style-type: none"> Budget: US\$ 28m across 13 countries More/innovative: Designed to develop innovative tools/guidance and implement activities to strengthen national health information systems and the data they produce for effective disease program management, improved program quality and health outcomes. The avg. allocation was small at US\$ 2.3m. Our analysis shows that 12 countries (92%) met the matching criteria through the use of Global Fund resources, with the exception being Togo. With the introduction of Matching Funds, the annual Global Fund budgets to related modules between 2016 and 2019 appears to have increased in 2 countries, remained constant in 6 and fallen in 5. Improved: TRP feedback confirmed the relevance of Matching Fund support in Myanmar, although asked for further clarity on sustainability. Some concerns were raised in Malawi where implementation of the Matching Funds relied upon data entry clerks that were only budgeted for under the PAAR. 	<ul style="list-style-type: none"> More: The average rate of absorption for the interventions associated with these funds was 48%, as compared to 52% for all RSSH modules. Improved: We have not been able to verify how TRP feedback was addressed.

¹⁵⁴ EANNASO (2019) Achievements of The Global Fund's Matching Funds and their Effect on Community, Rights and Gender Components in the Response to HIV and Tuberculosis in Anglophone Africa.

Multi-Country Approaches

- Multi-Country Approaches were developed to support regional strategic priorities that could not be addressed through country allocations alone. As such, in theory, investments in these areas should primarily meet the criteria for one or more of the following: ‘unique’, ‘new’ or ‘innovative’.
- Our analysis – summarized in Table 10 below – suggests that the actual design of the Multi-Country Approaches has mostly focused on interventions that ‘improve’ what could be done through country allocations, with only a few examples of genuinely ‘unique’, ‘new’ or ‘innovative’ interventions. Nonetheless, these grants are designed to address regional issues that clearly add value to country grants, particularly in response to issues created by migration, where a regional approach can offer efficiencies (e.g. supranational labs), where external funding can maintain focus on specific disease objectives (e.g. elimination) when burden is low and/or when a country transitions from other Global Fund support.¹⁵⁵ It is also likely that advocacy through regional engagement will add value to national efforts. However, the funding available for some Multi-Country Approaches appears too small to meet the grant objectives, which was also observed by the TRP – “the required ambition did not always match with funding envelopes”.¹⁵⁶
- There have also been some challenges in operationalizing the Multi-Country Approaches, with our assessment indicating that all but one has not fully met the expectations for it to be catalytic. This is in part due to the design of some activities (particularly where there are tensions between national and regional objectives and/or strategies and objectives are not well defined); late approval of catalytic investments which meant many grants were delayed; complex and/or unclear governance and oversight roles and responsibilities; and limited sharing of information between countries.^{157,158} There is also a lack of performance information available, which is an issue noted by the TRP (“in some cases, applications struggled to make link between inputs and outcomes”) and other commentators.^{159,160,161}

Table 10: Assessment of catalytic nature of Multi-Country Approaches

Multi-Country Approach	Catalytic by design	Catalytic in implementation
HIV: KVP sustainability and continuity	<ul style="list-style-type: none"> • Budget: \$50m • Improved: Designed to support civil society and community-based organizations for regional advocacy, legal and human rights support targeted at MICs with challenging social, legal and political environments for KVPs. 	<p>Improved: Operationalized through separate grants in five regions, there is limited information on current grant performance but most are extensions of previously well performing grants:</p> <ul style="list-style-type: none"> • South East Asia: Initiated in 2019, \$4m out of \$12.5m has been disbursed and \$8m committed. Our review suggests that the scope of work is focused on funding for KVPs in transition and aligned to what was intended.¹⁶² The TRP recommended to justify the selection of activities, strengthen M&E, and focus on addressing gender barriers. A previous grant implemented in 2017 and 2018 with similar scope and purpose (albeit less budget) received a grant rating of B1-Adequate indicating that it was broadly on track to meeting its objectives.¹⁶³ • Latin America: Initiated in 2019, \$1m out of \$10.5m has been disbursed and \$5m committed. Our review suggests that the scope of work is focused on funding for KVPs in transition and is aligned

¹⁵⁵ HMST, Health Focus (2018) TERG Thematic Review on Elimination of Malaria In Southern Africa.

¹⁵⁶ The Technical Review Panel’s Observations on the 2017-2019 Allocation Cycle.

¹⁵⁷ EHG (2016) TERG Thematic Review of the Global Fund’s Regional/Multi-country Grants.

¹⁵⁸ HMST, Health Focus (2018) TERG Thematic Review on Elimination of Malaria In Southern Africa.

¹⁵⁹ Catalytic Investments for the 2020-2022 Allocation Period: 41st Board Meeting: GF/B41/03 – Revision 1 15-16 May 2019, Geneva.

¹⁶⁰ The Technical Review Panel’s Observations on the 2017-2019 Allocation Cycle.

¹⁶¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5628788/>.

¹⁶² QMZ-H-AFAO. https://www.aidspace.org/gfo_article/global-fund-multi-country-program-southeast-asia-helps-countries-shift-towards

¹⁶³ <https://data.theglobalfund.org/investments/grant/QSE-H-AFAO/>.

		<p>to what was intended.¹⁶⁴ A previous grant implemented between 2016 and 2018 with similar scope and purpose (albeit less budget) received a grant rating of A1-Exceed Expectations indicating it exceeded objectives.¹⁶⁵</p> <ul style="list-style-type: none"> • Caribbean: Initiated in 2019, \$1m out of \$6.5m has been disbursed and \$4m committed. Our review suggests that the scope of work is focused on the removal of barriers that impede access to HIV and sexual and reproductive health services for KVPs and is aligned to what was intended. The TRP recommended to address issues highlighted in a recent PAHO review. A previous grant implemented between 2016 and 2019 with similar scope and received a grant rating of A2-Meets Expectations indicating it met its objectives.¹⁶⁶ • Eastern Europe and Central Asia: Initiated in 2018, \$3m out of \$8m has been disbursed with \$4m committed. Our review suggests that the scope of work is focused on the removal of barriers that impede access for KVPs and sustainability considerations, and is aligned to what was intended.¹⁶⁷ The TRP recommended to ensure approaches are based on best practice, and strengthen M&E, sustainability planning and the focus on human rights barriers. Performance information is not available.¹⁶⁸ A previous regional grant, with different PRs but focused on similar issues between 2016 and 2018, received a grant rating of C-Unacceptable.¹⁶⁹ • Middle East and North Africa: Initiated in 2019, \$7m out of \$13m has been disbursed. Our review suggests that the scope of work is focused on the removal of barriers that impede access for KVPs and is aligned to what was intended.^{170,171} The TRP recommended to strengthen M&E, sustainability planning and the focus on AGYW and human rights barriers, as well as allow flexibility in a COE context. Performance information is not available.¹⁷²
TB: Multi-Country responses	<ul style="list-style-type: none"> • Budget: \$65m • Improved/innovative: Multi-Country responses for: TB & mining; migrant and mobile populations; regional laboratory initiatives; and MDR-TB introduction of policies. 	<p>Improved/innovative: Operationalized through nine separate grants, performance (based on what limited information is available) has been mixed. The grant sizes also appear small given the ambitious grant objectives in some instances.</p> <ul style="list-style-type: none"> • Southern Africa TB mining: Initiated in 2018, \$12m out of \$21m has been disbursed and \$14m committed. Our review suggests that the scope of work is focused on finding missing TB cases in the mining sector and aligned to what was intended.¹⁷³ The TRP recommended to justify the selection of activities and focus on addressing gender barriers. The grant is now in closure after two successive grant ratings of C-Unacceptable. A previous grant implemented in 2016 and 2017 with similar scope and purpose received a performance rating of B2-Inadequate but potential demonstrated.¹⁷⁴ • Improve TB diagnosis in ECSA region: Initiated in 2019, \$2m out of \$6m has been disbursed and \$3m committed. The grant is for a regional laboratory initiative and aligned to what was intended.¹⁷⁵ The TRP recommended to strengthen sustainability planning, provide TA beyond just the proposed national network of

¹⁶⁴ QRA-H-HIVOS2. https://www.aidspace.org/gfo_article/global-fund-board-approves-new-country-and-multi-country-grants-valued-473-million

¹⁶⁵ <https://data.theglobalfund.org/investments/grant/QRA-H-HIVOS/>.

¹⁶⁶ QRA-H-CARICOM. <https://data.theglobalfund.org/investments/grant/QRA-H-CARICOM/1>.

¹⁶⁷ <https://network.org.ua/en/sustainability-of-services-for-key-populations-in-eastern-europe-and-central-asia/>.

¹⁶⁸ QMZ-H-AUA. <https://data.theglobalfund.org/investments/grant/QMZ-H-AUA/>.

¹⁶⁹ <https://data.theglobalfund.org/investments/grant/QMZ-H-ECUO/>.

¹⁷⁰ <https://frontlineaids.org/our-work-includes/global-fund-mena/>.

¹⁷¹ The Global Fund (2019) Focus on the Middle East Response.

¹⁷² QMZ-H-FA. <https://data.theglobalfund.org/investments/grant/QMZ-H-FA/1>.

¹⁷³ QPA-T-WHC. <https://data.theglobalfund.org/investments/grant/QPA-T-WHC/2>.

¹⁷⁴ <https://data.theglobalfund.org/investments/grant/QPA-T-WHC/1>.

¹⁷⁵ <https://data.theglobalfund.org/investments/grant/QPA-T-ECSA/2>.

		<p>laboratories, and to strengthen implementation and monitoring of effective biosafety protocols. A previous grant implemented between 2016 and 2018 with similar scope and purpose received a grant rating of A2-Meets expectations indicating that it met its objectives.¹⁷⁶</p> <ul style="list-style-type: none"> • WCA supranational reference lab network: Initiated in 2019, \$1m out of \$4.5m has been disbursed and \$2m committed. Our review suggests that the grant is for a regional laboratory initiative and aligned to what was intended.¹⁷⁷ The TRP recommended to strengthen governance and management capacity and sustainability planning. Performance information is not available. • Reduce barriers for KVPs in LAC region: Initiated in 2019, \$1m out of \$4.5m has been disbursed and \$3m committed. Our review suggests that the grant intends to promote the inclusion of civil society in NTPs and is aligned to what was intended.¹⁷⁸ Performance information is not available.¹⁷⁹ • Refugees in Eastern Africa: Initiated in 2019, \$2m out of \$7.5m has been disbursed and \$4m committed. The grant intends to provide TB services in refugee camps and settlements in Djibouti, South Sudan, Sudan and Uganda, and is aligned to what was intended.¹⁸⁰ The TRP recommended to strengthen M&E, integration and the focus on gender sensitive interventions. Performance information is not available.¹⁸¹ • Refugees in Asia: Initiated in 2019, \$2m out of \$5m has been disbursed and \$3m committed. The grant intends to provide TB/MDR-TB interventions among Afghan refugees, returnees and mobile populations in Afghanistan, Iran and Pakistan, and is aligned to what was intended.¹⁸² The TRP recommended to clarify the harmonized approach, strengthen M&E, and focus on addressing human rights barriers. Performance information is not available.¹⁸³ • Elimination among migrants in Greater Mekong subregion: Initiated in 2019, \$5m out of \$10m has been disbursed. The grant intends to provide timely diagnosis and treatment of TB of migrants in the region and is aligned to what was intended.¹⁸⁴ The TRP recommended to strengthen M&E, and focus on addressing gender barriers, stigma and discrimination and the continuum of care. Performance information is not available.¹⁸⁵ • Improving DR-TB detection and treatment outcomes in EECA: Initiated in 2019, \$3m out of \$5m has been disbursed. The grant is designed to strengthen health systems to advance people-centered quality TB care and aligned to what was intended.¹⁸⁶ The TRP recommended to strengthen M&E and the linkage between interventions and intended outcomes. A previous grant implemented between 2016 and 2018 with similar scope and purpose received a grant rating of B1-Adequate indicating that it was broadly on track to meeting its objectives.¹⁸⁷
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¹⁷⁶ <https://data.theglobalfund.org/investments/grant/QPA-T-ECSA/1>.

¹⁷⁷ <https://data.theglobalfund.org/investments/grant/QMZ-T-PNT/1>.

¹⁷⁸ https://www.aidspace.org/gfo_article/global-fund-board-approves-new-country-and-multi-country-grants-along-interventions-ugd.

¹⁷⁹ <https://data.theglobalfund.org/investments/grant/QRA-T-PIH/1>.

¹⁸⁰ <https://igad.int/divisions/health-and-social-development/health/2165-igad-and-unhcr-sign-a-grant-agreement-on-multi-country-tb-interventions>.

¹⁸¹ <https://data.theglobalfund.org/investments/grant/QPA-T-IGAD/1>.

¹⁸² <https://igad.int/divisions/health-and-social-development/health/2165-igad-and-unhcr-sign-a-grant-agreement-on-multi-country-tb-interventions>.

¹⁸³ <https://data.theglobalfund.org/investments/grant/QMZ-T-UNDP/1>.

¹⁸⁴ <https://igad.int/divisions/health-and-social-development/health/2165-igad-and-unhcr-sign-a-grant-agreement-on-multi-country-tb-interventions>.

¹⁸⁵ <https://data.theglobalfund.org/investments/grant/QMZ-T-UNDP/1>.

¹⁸⁶ <https://data.theglobalfund.org/investments/grant/QMZ-T-PAS/2>.

¹⁸⁷ <https://data.theglobalfund.org/investments/grant/QMZ-T-PAS/1>.

Malaria elimination: Southern Africa	<ul style="list-style-type: none"> • Budget: \$20m across 8 countries • More: To sustain the scale of Global Fund investments to address malaria elimination. • Improved: Activities are intended to strengthen regional alignment and targeted activities to support elimination goals. 	<p>More/improved: Operationalized through two grants, performance has been mixed:</p> <ul style="list-style-type: none"> • Malaria Elimination Eight Initiative: Initiated in 2019 across 8 countries, \$6m out of \$12m has been disbursed and \$8m committed. The grant is designed to harmonize policies, expand testing and treatment among KVPs and strengthen surveillance to create an enabling environment for countries to reach elimination.¹⁸⁸ As such, while the small investment amount is unlikely to support implementation of activities at scale, it is aligned to the objective of strengthened regional alignment. The TRP recommended to strengthen governance and coordination, justify the selection of activities, focus on addressing barriers to access and plan for. The TERG review of Malaria Elimination in Southern Africa recommended that the grant be modified based on a robust understanding of strategic priorities.¹⁸⁹ A previous grant implemented between 2016 and 2018 with similar scope and purpose received a grant rating of B1-Adequate indicating that it was broadly on track to meeting its objectives.¹⁹⁰ • MOSASWA cross-border initiative: Initiated in 2020 in border areas between Mozambique, South Africa and Eswatini, \$4m out of \$27m has been disbursed and \$12m committed. The grant is designed to coordinate, collaborate, harmonize policies and approaches to target mobile/migrant populations and others at risk in border areas, and to improve surveillance to reach elimination.¹⁹¹ As such, it is aligned to what was intended. The TRP recommended to strengthen governance, coordination and M&E, justify the selection of activities, focus on addressing barriers to access and plan for sustainability. The TERG review of Malaria Elimination in Southern Africa recommended that the grant be continued.¹⁹² A previous grant implemented between 2017 and 2019 with similar scope and purpose received a grant rating of A1-Exceeds expectations indicating that its objectives were exceeded.¹⁹³
Malaria elimination: Mesoamerica	<ul style="list-style-type: none"> • Budget: \$6m across 9 countries • More: To sustain the scale of GLOBAL FUND investments to address malaria elimination. • Improved: Activities are intended to strengthen regional alignment and targeted activities to support elimination goals. 	<ul style="list-style-type: none"> • More/improved: Operationalized through one grant across 9 countries, the Regional Malaria Elimination Initiative, the full \$6m has been disbursed. The grant is designed to harmonize policies and improve coordination of approaches, as defined through identification of gaps in national strategies, to reach elimination.¹⁹⁴ As such, while the small investment amount is unlikely to support implementation of activities at scale, it is aligned to the objective of strengthened regional alignment. The TRP recommended to strengthen governance, ensure alignment of approaches to global WHO strategies and guidance, and to strengthen approaches to human rights and gender. In 2018 the grant was rated of A2-Meets expectations indicating that its objectives are on track, although no more information is available online.¹⁹⁵
Malaria: Greater Mekong sub-region: Elimination to address	<ul style="list-style-type: none"> • Budget: \$119m, including country allocations for 5-6 countries = \$239m • More: To support the scale up of activities to 	<ul style="list-style-type: none"> • Improved/more: Operationalized through one grant across 9 countries, the Regional Artemisinin Initiative 2 Elimination (RAI2E), \$162m out of \$239m has been disbursed and \$190m committed. The grant, which reflects a significant commitment by countries towards a common goal, is designed to increase malaria service coverage for remote populations in border areas and other at-risk

¹⁸⁸ <https://data.theglobalfund.org/investments/grant/QPA-M-E8S/2>.

¹⁸⁹ HMST, Health Focus (2018) TERG Thematic Review on Elimination of Malaria In Southern Africa.

¹⁹⁰ <https://data.theglobalfund.org/investments/grant/QPA-M-E8S/1>.

¹⁹¹ <https://data.theglobalfund.org/investments/grant/QPA-M-LSDI/2>.

¹⁹² HMST, Health Focus (2018) TERG Thematic Review on Elimination of Malaria In Southern Africa.

¹⁹³ <https://data.theglobalfund.org/investments/grant/QPA-M-LSDI/1>.

¹⁹⁴ <https://www.plataformalac.org/en/2018/05/successful-experiences-in-the-lac-region-within-the-framework-of-the-malaria-elimination-initiative/>.

¹⁹⁵ <https://data.theglobalfund.org/investments/grant/QRA-M-IDB/1>.

multi-drug resistance	<p>eliminate malaria and drug resistance.</p> <ul style="list-style-type: none"> • Improved: Activities are intended to strengthen regional alignment and targeted activities to support elimination goals.¹⁹⁶ 	<p>populations, as well as case management through health volunteers and strengthening of national surveillance systems to accelerate elimination.¹⁹⁷⁻¹⁹⁸ As such, it is aligned to what was intended. In 2018 the grant was rated of B1-Adequate indicating that it is broadly on track to meet its objectives.¹⁹⁹ The TRP recommended to strengthen governance, community-based service delivery, HMIS and M&E, and reduce program management costs. A previous grant implemented in 2017 with similar scope and purpose also received a grant rating of B1-Adequate.²⁰⁰</p>
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Strategic Initiatives

- Strategic Initiatives were developed to facilitate cross-cutting global coordination in specific areas of strategic importance where further action was required but could not be addressed through country allocations/grants. As such, in theory, investments in these areas meet the criteria for one or more of the following: ‘improved’, ‘unique’, ‘new’ and/or ‘innovative’.
- Our analysis – summarized in Table 11 below – suggests that the design of most Strategic Initiatives meets the criteria for being catalytic, however, for some Strategic Initiatives there is not a clear case on why additional funds are required over and above what could be supported through the core allocations and/or through the mandates of other agencies.
- Our analysis, which is based on weak M&E data, also suggests that around half of Strategic Initiatives are meeting expectations, and half are below expectations. This is in line with the OIG’s findings that weaknesses in the contracting, monitoring and management of Strategic Initiatives has negatively affected efficiency and effectiveness.²⁰¹

Table 11: Assessment of catalytic nature of Strategic Initiatives

Strategic Initiative	Catalytic by design	Catalytic in implementation
TB: Addressing barriers to find missing cases, esp. in KVPs	<ul style="list-style-type: none"> • Budget: US\$ 10m allocated to 13 countries accounting for the majority of missing TB cases. It is implemented by WHO, StopTB and other competitively selected vendors. • Improved/innovative: Designed to strengthen the integration of community-based TB activities into the work of existing NGOs and other CSOs working in TB-relevant sectors, based on the work and engagement of CRG to identify barriers to finding missing cases. 	<ul style="list-style-type: none"> • Improved/innovative: As of end-2019, 100% of funds have been committed, and 80% disbursed. A range of activities have been implemented, such as developing 11 field guides; conducting 11 CRG assessments²⁰²; 4 patient cost surveys; piloting new approaches²⁰³; sharing learning through high level summit of 30 high burden countries, annual review meeting of 13 Strategic Initiative countries and newsletter and e-learning platform; provision of TA on scaling interventions and planning for next grant cycle; roll out of One Impact platform for community monitoring in 8 countries. Quantitative data suggests that case finding has increased, with Secretariat reporting and some key informants suggesting that at least part of this progress is due to catalytic funding helping to ‘generate tremendous

¹⁹⁶ The Global Fund (2019) FOCUS ON Regional Artemisinin-resistance Initiative (RAI). Eliminating Malaria in the Mekong.

¹⁹⁷ WHO (2018) THE MEKONG MALARIA ELIMINATION PROGRAMME. Countries of the Greater Mekong are stepping up to end malaria

¹⁹⁸ <https://raifund.org>.

¹⁹⁹ <https://data.theglobalfund.org/investments/grant/QSE-M-UNOPS/3>.

²⁰⁰ <https://data.theglobalfund.org/investments/grant/QSE-M-UNOPS/2>.

²⁰¹ OIG (2019) Advisory Report: Managing Strategic Initiatives

²⁰² WHO (2018) Baseline assessment of community based TB services in 8 WHO ENGAGE-TB priority countries.

²⁰³ For instance, latent TB e-health monitoring tool, scaling up patient cost surveys, people centered framework to support data driven NSP development, revised engage TB training package.

Strategic Initiative	Catalytic by design	Catalytic in implementation
		momentum globally'. An independent assessment of the Strategic Initiative is underway.
Malaria elimination: Cross-cutting support	<ul style="list-style-type: none"> Budget: US\$ 7m allocated to 21 low burden countries. It is implemented by WHO. Improved/new: To conduct 'malaria elimination situation rooms' and develop: elimination roadmaps and scoring process in 21 countries; surveillance assessments in 17 countries; implement a case-based online data tracking system in all 5 WHO regions; improv global strategic guidance, including SOPs for elimination certification; develop tools for risk assessments; and conduct assessments of health outcomes. (Ranked as only moderately catalytic as mostly unclear why this could not be funded by other sources) 	<ul style="list-style-type: none"> Improved/new: As of end-2019, 100% of funds have been committed, and 82% disbursed. We have not seen a report of progress against workplan but are aware of some outputs being achieved (e.g. trainings in South Africa, a cross-border meeting between EMRO and EURO countries and a pilot of a new surveillance assessment tool in Bhutan). Quantitative data suggests that significant progress is being made against health outcome and impact targets, with the Strategic Initiative on track to meet its objectives.
Malaria: Catalyzing market entry of new LLINs to counter the threat of insecticide resistance	<ul style="list-style-type: none"> Budget: US\$ 2m across 6-9 countries. It is implemented by Secretariat staff and competitively selected vendors. Innovative: Designed to facilitate and evaluate introduction of new LLINs through pilots and achieve commodity price reductions. 	<ul style="list-style-type: none"> Innovative: As of end-2019, 64% of funds have been committed, and 49% disbursed. MoUs have been signed with all 9 pilot countries with 2m nets distributed in Burkina Faso, 0.9m in Rwanda, and 11.4m under procurement. A volume guarantee has been concluded to reduce prices, which alongside more funding, has enabled wider roll out.
Malaria: Piloting introduction of the RTS,S malaria vaccine	<ul style="list-style-type: none"> Budget: US\$ 15m in 3 countries. Implemented by WHO and co-funded by Gavi and Unitaaid. Innovative: To generate evidence on safety, impact and feasibility to inform vaccine introduction decisions in 3-5 years' time. 	<ul style="list-style-type: none"> Innovative: As of end-2019, 100% of funds have been committed, and 69% disbursed. Despite delays requiring a no-cost extension, all countries have now implemented the introduction of the vaccination with more than 180,000 children (60%) receiving the first dose at end-2019. Systems for mortality surveillance, safety monitoring and other protocols are in place.
RSSH: Sustainability, transition and efficiency	<ul style="list-style-type: none"> Budget: US\$ 2m implemented by WHO, UNICEF, OECD, World Bank and other competitively selected vendors. Improved: Designed to accelerate the implementation of the Sustainability, Transition, and Co-Financing Policy through support for planning on: <ul style="list-style-type: none"> ○ <i>Sustainability:</i> Health financing strategies, establishment of regional networks on fiscal 	<ul style="list-style-type: none"> Improved: As of end-2019, 79% of funds have been committed, and 56% disbursed. The Secretariat report that despite its complexity, the Strategic Initiative is on track to utilize the budget and meet objectives, noting its utility advancing the Secretariat's work on sustainability, domestic financing, efficiency, and transition. To date: <ul style="list-style-type: none"> ○ <i>Sustainability:</i> Work on health financing strategies is advancing in 7 of 12 countries and various trainings/events held on fiscal

Strategic Initiative	Catalytic by design	Catalytic in implementation
	<p>sustainability of health systems, resource tracking and advocacy for greater domestic health financing.</p> <ul style="list-style-type: none"> ○ <i>Transition</i>: Planning, readiness assessments, TA to support specific transition challenges (e.g. social contracting) and capacity building among national stakeholders. ○ <i>Efficiency</i>: Development of tools to monitor efficiency and assessments. <p>(Ranked as only moderately catalytic as mostly unclear why this could not be funded by other sources)</p>	<p>sustainability. 22 of 33 countries received TA from WHO on SHAs and a number of policy briefs/notes were developed, and some trainings, to advance the advocacy work.</p> <ul style="list-style-type: none"> ○ <i>Transition</i>: Majority of focus on AELAC region with 20 readiness assessments funded, and TA delivered to a range of countries. Some pilot initiatives launched to address transition challenges (e.g. WB and GAVI collaboration on capacity building). ○ <i>Efficiency</i>: Allocative efficiency modelling conducted in a range of countries. Technical efficiency TA limited to a few countries only. Cross-programmatic efficiency analysis has been conducted in 10 countries with other work on integration, including workshops, also implemented.
RSSH: Technical support, South-to-South collaboration, peer review and learning	<ul style="list-style-type: none"> • Budget: US\$ 14m. It is implemented by WHO, UNICEF, RBM and other competitively selected vendors. • Improved: Designed to support South-to-South collaboration, sharing of best practice by peers, as well as technical support by global and regional providers to ensure investments are underpinned by the guidance and knowledge base requisite to deliver the necessary impact at country level. (Ranked as only moderately catalytic as mostly unclear why this could not be funded by other sources) 	<ul style="list-style-type: none"> • Improved: As of end-2019, 100% of funds have been committed, and 91% disbursed. A range of outputs have been achieved: 30 countries were supported to strengthen NSPs, including development of guidance on linking NSPs to health sector plans; mock TRPs have been held; TA has been provided on a range of topics (e.g. to address bottlenecks, financing, transition, integrated service delivery, integrated community case management, AGYW, mass campaigns) with workshops in some areas; development of FRs; etc.
RSSH Data: Systems, data generation and use for programmatic action and quality improvement	<ul style="list-style-type: none"> • Budget: US\$ 21m across 15-20 high impact and priority countries. It is implemented by WHO, PAHO, Unicef, University of Oslo, APMG and other competitively selected vendors. • Improved: Designed to develop innovative tools, guidance, capacity and ensure quality data systems, data generation and use for policy, planning, funding and programmatic action. (Ranked as only moderately catalytic as mostly unclear why this could not be funded by other sources) 	<ul style="list-style-type: none"> • Improved: As of end-2019, 93% of funds have been committed, and 56% disbursed. A range of outputs have been achieved, with more countries integrating datasets within a single national HMIS and WHO standard reporting packages and dashboards installed in >20 countries. TA has been provided for 15 countries to develop HMIS aspects of funding requests for the next grant cycle, in coordination with Gavi, and work to strengthen analytical capacity is ongoing in 11 countries. Despite delays, program evaluations are complete in 49 countries and ongoing in a further 28. Thematic reviews are also on track. TA on M&E has also been widely provided in 38 countries. There is progress against KPIs 6d (functionality of HMIS) and 6e (reporting of disaggregated data).

Strategic Initiative	Catalytic by design	Catalytic in implementation
RSSH PSM: Diagnosis and planning	<ul style="list-style-type: none"> Budget: US\$ 20m across 16 countries with high disease burden.²⁰⁴ It is implemented by Deloitte, John Snow, Pharma Systems Africa, MSH and other competitively selected vendors. Improved: Designed to develop and implement strategies for supply chain systems and assess their functioning. (Ranked as only moderately catalytic as mostly unclear why this could not be funded by other sources) 	<ul style="list-style-type: none"> Improved: As of end-2019, 57% of funds have been committed, and 40% disbursed. Performance is below target, having conducted 20 diagnostic assessments but implementation having been substantially started (indicated as having a 6-month review) in 9 out of 16 intended countries. Performance against KPI 6b on supply chain performance, is nonetheless improving.
RSSH PSM: Innovation challenge fund	<ul style="list-style-type: none"> Budget: US\$ 6m across 20 countries with high disease burden. It is implemented by the Secretariat with competitively selected TA providers. Innovative: Designed to support research, development and testing of innovative, efficient, cost-effective and well- structured supply chain systems models. 	<ul style="list-style-type: none"> Innovative: As of end-2019, 60% of funds have been committed, and 15% disbursed. Performance is below target, but some activities have been implemented – e.g. completed lab optimization needs assessments in 12 WCA countries; testing of innovative last mile approaches in Madagascar; scoping GS1 introduction to increase patient safety and supply chain security for the next grant cycle; and waste management landscape analysis. Progress is now reported to be accelerating.
RSSH PSM: Developing local resources	<ul style="list-style-type: none"> Budget: US\$ 10m across 9/10 countries. Implemented by PAHO, Unicef, and other competitively selected vendors. Improved: Designed to support capacity building and cross-country collaboration to develop and implement national strategic guidance and best practices in procurement and supply chain management. 	<ul style="list-style-type: none"> Improved: As of end-2019, 40% of funds have been committed, and 20% disbursed. Performance is below target, with 7 out of 10 focus countries receiving TA support, and implementation plans for other countries at risk due to COVID. There have been some programmatic achievements (e.g. drone academy pilots, capacity tools developed and in eLMIS) and support provided to non-focus countries. Also strengthened coordination between partners for capacity building.
RSSH PSM: Pre-qualification of medicines and IVDs	<ul style="list-style-type: none"> Budget: US\$ 12m implemented by WHO. More: Designed to enable WHO to carry out medicines and IVD dossiers evaluations, manufacturing site inspections and post marketing surveillance of pre-qualified medicines and IVDs. This is intended to contribute to increasing availability of quality assured medicines and IVDs. 	<ul style="list-style-type: none"> Improved: As of end-2019, 90% of funds have been committed, and 47% disbursed. There is progress in launching ERPs for pharmaceuticals, 3HP, diagnostics, syphilis RPR and a HIV self-test, leading to an increase in the number of pharmaceutical and diagnostics products available. However, a number of areas of work have been delayed or not yet started.
CRG	<ul style="list-style-type: none"> Budget: US\$ 15m. It is implemented by competitively selected vendors. 	<ul style="list-style-type: none"> Improved: As of end-2019, 91% of funds have been committed, and 84% disbursed. Performance has met expectations with TA

²⁰⁴ South Africa, India, Malawi, Niger, Nigeria, Cameroon, Mali, Côte d'Ivoire, Uganda, Burkina Faso, DRC, Chad, Liberia, Togo, Haiti, Ethiopia, Bangladesh, Pakistan, Sudan, Tanzania and Ghana.

Strategic Initiative	Catalytic by design	Catalytic in implementation
	<ul style="list-style-type: none"> Improved: Designed to support capacity-building of KVP networks on Global Fund processes (US\$ 5m); provide TA (US\$ 6m) and enable Regional Civil Society and Community Communication and Coordination Platforms (US\$ 4m). 	<p>completed in 4 countries, and in progress in 20 others. 5 CSOs and 6 KVO consortiums fully implemented their workplans. Regional platform communications have reached >30k CSOs and platform engagement has increased. A survey conducted by regional platforms participating in the initiative found that it was serving to increase knowledge, capacity and coordination to meet CRG objectives, particularly for HIV.²⁰⁵ An external evaluation will provide further evidence of programmatic results at end-April 2020.</p>
CRG: Human rights: breaking down barriers	<ul style="list-style-type: none"> Budget: US\$ 2m across 20 countries. Implemented by competitively selected vendors. Improved: Designed to support planning for human rights programming in 20 countries, provide TA to support implementation and conduct mid-term assessments in 15 countries. 	<ul style="list-style-type: none"> Improved: As of end-2019, 90% of funds have been committed, and 15% disbursed. Performance has met expectations with a TA provider orientation meeting held; 17 multi-stakeholder meetings executed; 6 plans developed and 12 others in development; TA provided in 6 countries; and mid-term assessments ongoing in 3 countries.

²⁰⁵ EANNASO, APCASO, RAME, EHRA, Via Libre, ITPC-MENA (2019) Strengthening Community Engagement in Global Fund Processes through the Community, Rights and Gender Strategic Initiative.

ANNEX 4.IX.A: MAPPING OF MODULAR FRAMEWORK TO MATCHING FUND INVESTMENT AREAS

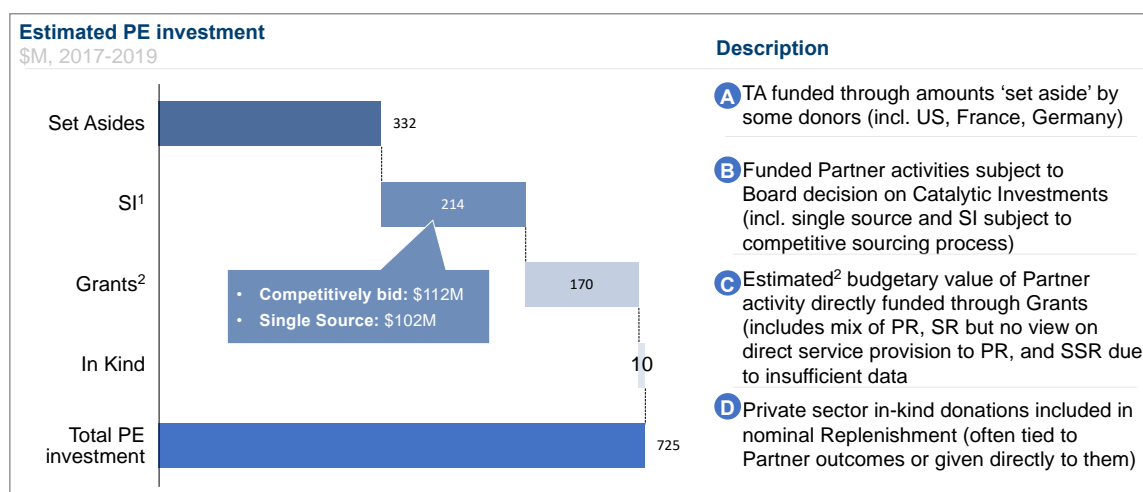
Table 12: Catalytic investment profile

Catalytic investment	Module	Intervention	Impact indicator	Outcome indicator	Coverage indicator
KVP impact (Matching Funds)	Comprehensive prevention programs for men who have sex with men	Community empowerment for men who have sex with men	HIV I-3b; HIV I-9a	HIV O-4a	KP-1a; KP-3a; KP-6a
	Comprehensive prevention programs for sex workers and their clients	Community empowerment for sex workers	HIV I-3c; HIV I-10	HIV O-5	KP-1c; KP-3c; KP-6c
	Comprehensive prevention programs for people who inject drugs and their partners	Community empowerment for people who inject drugs	HIV I-11	HIV O-6; HIV O-9	KP-1d; KP-3d; KP-4; KP-5
	Comprehensive prevention programs for transgender people	Community empowerment for transgender people	HIV I-9b	HIV O-4.1b	KP-1b; KP-3b; KP-6b
	Comprehensive programs for people in prisons and other closed settings	Community empowerment for people in prisons and other closed settings			
	Prevention programs for other vulnerable populations		HIV I-12	HIV O-7	KP-1e; KP-3e
Human rights (Matching Funds)	Programs to reduce human rights-related barriers to HIV services				
Adolescent girls and young women (Matching Funds)	Prevention programs for adolescents and youth, in and out of school				YP-1; YP-2; YP-3; YP-4
Finding missing cases (Matching Funds)	TB care and prevention	Case detection and diagnosis	TB I-3	TB O-1a	TCP-1
		Engaging all care providers (TB care and prevention)	TB I-3	TB O-1a	TCP-1; TCP-7a; TCP-1; TCP-7b; TCP-1; TCP-7c; TB/HIV-5
		Community TB care delivery	TB I-3	TB O-1a	TCP-1
		Collaborative activities with other programs and sectors (TB care and prevention)	TB I-3	TB O-1a	TCP-1
	Multidrug-resistant TB	Case detection and diagnosis: MDR-TB	TB I-3	TB O-1a	TCP-1
		Engaging all care providers (MDR-TB)	TB I-3	TB O-1a	TCP-1; TCP-7a; TCP-1; TCP-7b; TCP-1; TCP-7c; TB/HIV-5
		Community MDR-TB care delivery	TB I-3	TB O-1a	TCP-1
		Collaborative activities with other programs and sectors (MDR-TB)	TB I-3	TB O-1a	TCP-1
	TB/HIV	TB/HIV collaborative interventions	TB I-3	TB O-1a	TCP-1; TB/HIV-5
		Engaging all care providers (TB/HIV)	TB I-3	TB O-1a	TCP-1; TCP-7a; TCP-1; TCP-7b; TCP-1; TCP-7c; TB/HIV-5
		Community TB/HIV care delivery	TB I-3	TB O-1a	TCP-1; TB/HIV-5
		Collaborative activities with other programs and sectors (TB/HIV)	TB I-3	TB O-1a	TCP-1; TB/HIV-5
Integration of Service Delivery and Health Workforce Improvements (Matching Funding)	Integrated service delivery and quality improvement	All	SD-1; SD-3		
	Human resources for health, including community health workers	All excluding 'Retention and scale-up of health workers, including for community health workers'	HW-1; HW-2; HW-3; HW-4; HW-5		

Catalytic investment	Module	Intervention	Impact indicator	Outcome indicator	Coverage indicator
Data systems, data generation and use for programmatic action and quality improvement (Matching Funds)	Health management information system and monitoring and evaluation		M&E-1; M&E-2; M&E-3		

ANNEX 4.X: PARTNERSHIPS (SRQs 19, 21)

Figure 28: Where funding is involved, estimated value of PE investment at app. US\$ 725M in 2017-2019 allocation cycle across Global Fund funding mechanisms



¹ Includes \$33M in Matching investment treated as SI for Malaria | ² Based on current budgetary framework, these amounts exclude Partners as direct service provider to grant implementor, sub-sub-recipient activities (SSR), and other categories of PE activities beyond TA Fees/ Consultants and TA Per Diem/Travel (e.g., advocacy, surveys, data collection, salaries for program management)

Source: GF Treasury Team, Hyperion, SI Coord. Office, Purchase Order Extracts, GFS Detailed Grant Budgets as of March 22, 2019

1

The main report presents enabling and hampering factors for partnerships at country level through a forcefield analysis framework. The factors listed are detailed here for reference.

Enabling factors:

- Aligned agendas or interests:** For example, all country HIV programs seem well aligned across the need for and use of the UN 90-90-90 targets, and there seems to be good clarity around the use of various models and country data to calculate where each country is. The development of sustainability and transition planning in countries close to/approaching transition (Ukraine) have benefited from joint technical support from partners and the Global Fund to develop their plan. Efforts in Viet Nam to develop a plan for moving forward on social contracting for civil society is being led by UNAIDS but aligns well with other partners and national program actors at country level, as reflected in the recent establishment of a new national working group on the topic.
- Well-coordinated, inclusive, participatory platforms:** The experience and maturity of country platforms—such as the CCMs or the supporting technical working groups is a positive factor when they are well led and well managed (and a hinderance when they are not). Evidence at country level, particularly in Kenya, Cameroon and Eswatini suggest the Global Fund's insistence on inclusivity and participation by KVPs and their representatives is not only well established in the formal 'Global Fund-related' platforms such as the CCM, but also is now embedded in national practice in NSP development. Strong health sector coordination platforms in Ethiopia and Ukraine also appear to be working well for overall health sector management, although Global Fund engagement in those forums is more limited.
- Enhanced planning within MoH or disease programs:** Good planning and clear communication between the partners, both within their own coordination mechanisms and on the national platforms, improves timely technical support. For example, in Kenya and Viet Nam have both seen efforts by PEPFAR, Global Fund partners, and others to improve decision-making for PSM; Viet Nam has several partners such as Expertise France involved in strengthening the health insurance capacity and management in the transition of all HIV and TB treatment to the Social Health Insurance.

- **Provision of long-term TA:** Evidence that long-term TA to programs (provided by France, Germany and USG in many countries) is a critical enabler for the achievement of the Strategic Objectives although impact is hard to prove definitively. But it is described by stakeholders as smoothing or enabling good relations at national program level, reducing duplication (often through improved communication) and supporting technical areas which can be prone to delays or bottlenecks for grants and thus use of long-term TA prevents these or solves them quickly: technical advisors for TB, and advisors for RSSH coordination in Ethiopia are in place to support programs as well as resolving bottlenecks to implementation.
- **Relations and personalities:** Finally, several cases revealed evidence of the positive influence of individual relationships, between partners or between Country Teams and partners, and how these continue to strongly effect the state of partnership. This carries with it risk when there is Country Team, senior government/MoH turnover, LFA, or even change in partner or implementer turnover.

Hindering factors:

- **Lack of Global Fund country presence:** There was recognition that the Global Fund's regular visits to countries (approximately 2–6 visits per year but this varies considerably across the cases) were helpful but overall, there was still a perception that the lack of a full time Global Fund presence hinder partnership engagement and collaborations at country level. For example, in Ethiopia, several bilateral and multilateral donors expressed a desire for more country presence by the Global Fund; particularly now, given the country's political transition. GAVI's presence in Ethiopia is visible through UNICEF, one of its Alliance members, which is centrally funded and acts as a focal point and ears/eyes and GAVI representative; a mechanism considered to be working well from the perspective of development partners.
- **Partners mandates unaligned:** The positioning of partners/mandate and capacity issues (and sometimes the lack of Secretariat country presence) makes it difficult for the Global Fund to support certain agendas; and conversely can allow other partners to dominate certain policy shifts. For technical partners, this can be explained more generally through 'Principle-Agent Problem' theory, where agents (i.e. partners) are able to make decisions and/or take actions on behalf of, or that impact, the principle (i.e. the Global Fund Board/Secretariat) but are able to act to fulfill their own self-interest. An example given through the case studies for this Review in Kenya, Eswatini, and Viet Nam was the push by PEPFAR for the change in first line drugs for HIV. KIs reported this change as 'too rapid', given WHO guidance was incomplete, and studies of side effects in pregnant women unavailable. This change in first line drugs has happened but the speed meant agendas were misaligned in 2018–2019.
- **Weak transparency, coordination and oversight of partner investments:** The lack of planning, lack of TA needs assessments and coordination at national levels for technical assistance is commonplace with implications for transparency and oversight of partner investments. Evidence suggests neither the Secretariat, the CCMs, the technical working groups nor the national programs always know what partners are planning to provide; and this is not openly (in most cases) matched or co-jointly planned with the funding available in the grants for TA. Efforts to coordinate TA at global level (for example through the joint TA plans for HIV as coordinated by UNAIDS, with other partners), do not appear to extend to national levels. The preparation of 'One Plan' for TA per grant (like that espoused by GAVI's Partnership Engagement Framework) is rarely done at the disease level or the ministry or CCM level. An exception may be the recent development of a national TA plan in Benin.
- **Weak leadership/sustainability issues:** Some KIs described how weak development partner coordination has implications for services and sustainability, for example the system or level of top ups remains an issue in Cameroon and other places where Global Fund top ups are close to or set by government rules, while PEPFAR's are slightly more generous. Part of this reflects somewhat weak leadership within national systems, or poor coordination within CCM (Viet Nam's CCM leadership and ToR are now changing following TA provided by several

partners to help the CCM identify skills gaps). Country level variation in capacity and skills within partners offices is a well-known, fairly frequently referenced challenge to TA and to partnership in general. This can lead to poor relationships between Country Teams and partners at country level.

- **Weak/systemic health/PSM systems** provide barriers to functioning partnerships and affect country level grant implementation. While the partnership model of the Global Fund expects technical partners to step up to support grant implementation, it is often impossible for the partners to resolve the problem when the problems are themselves part of the weak health systems infrastructure or institutions. For example, in Kenya, the co-financing agreement in the current TB grant has a condition that the TB laboratory technicians throughout Kenya would be transferred away from Global Fund funding to Government of Kenya/MoH funding during 2019/2020. This process was delayed (at time of case study) and neither the Program Director (TB) nor the partners consulted for the case study knew how to solve this issue which reflected the current status of decentralization of health services to the counties, but was clearly going to affect the functioning of the laboratories in many of those same counties, with potential to impact on the grant itself.

ANNEX 4.xi: ANALYSIS OF DOMESTIC RESOURCE MOBILIZATION (SRQ17)

For the years 2012-2020, financial data was obtained on investments (in US\$) for all countries in which the Global Fund currently has grants. The overall trend for the three diseases has been one of a gradual decline in Global Fund investments while domestic resources have consistently increased.

As shown in Figure 29, between 2002 and 2017 domestic health expenditures as a percentage of overall government expenditures increased from slightly more than 2% to approximately 2.4% in countries with Global Fund grants. While this may appear to be a small increase, it should be noted that this is an average measure; thus, there were much larger increases in some countries (and a few countries with decreases). Further, because this is a measure of the change in health expenditures as a percent of overall government expenditures, the relatively small increase could be much larger in absolute terms. As shown, in Figure 30, the average GDP in Global Fund countries went from approximately \$20 billion in 2002 to approximately \$100 billion by 2018; a nearly five-fold increase. Thus, even though, government expenses and domestic resources for health did not increase significantly in percentage terms, the absolute figures would correspond to the five-fold increase.

Figure 29: Domestic Health Expenditures

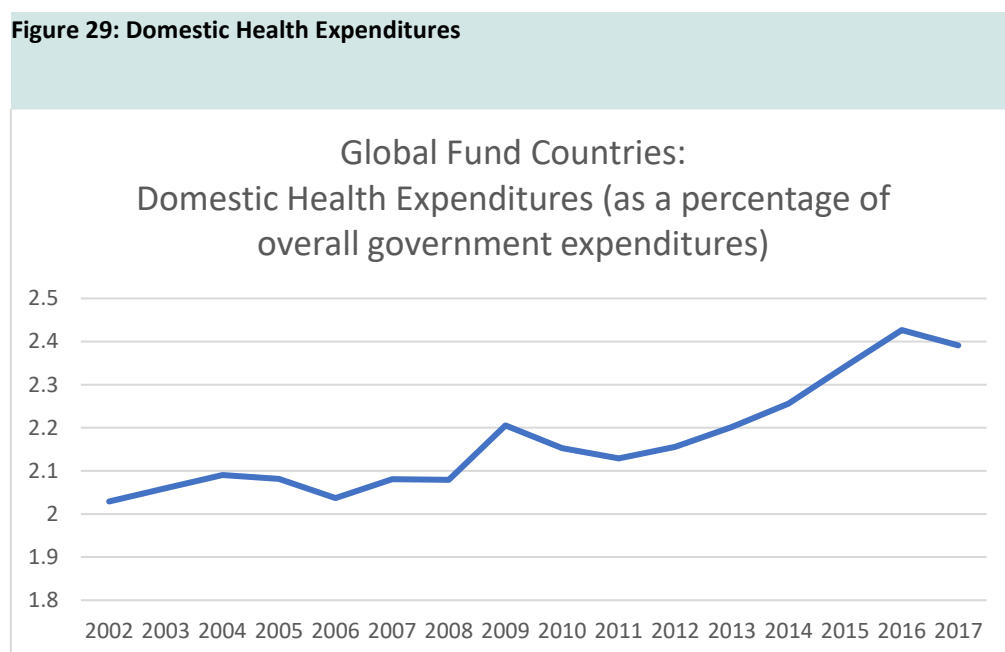
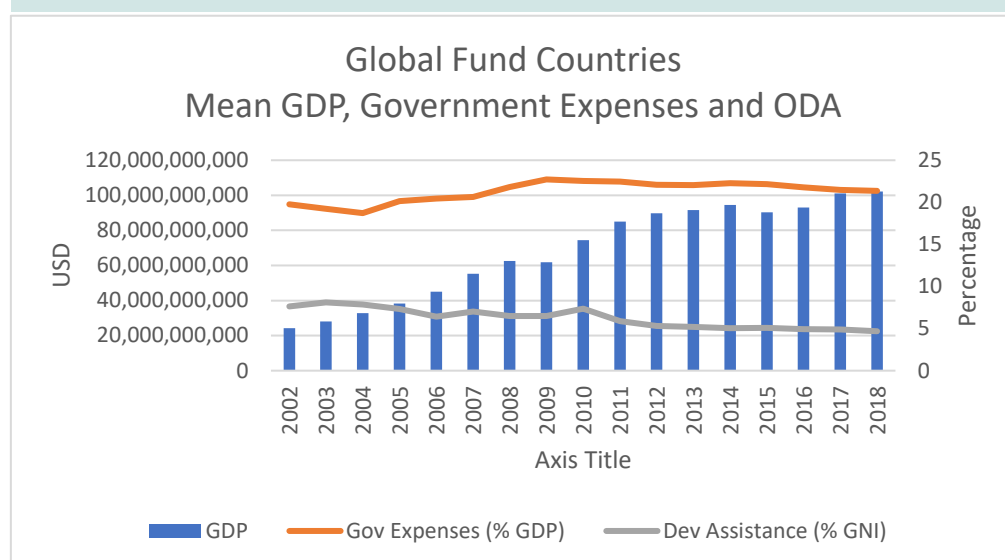


Figure 30: Mean GDP, Government Expenses and ODA

This is also reflected in the trends for the three individual diseases; though, while HIV has shown a more steady and measured decrease in Global Fund investments for the years under review, TB had a dramatic drop between 2013-2014, before plateauing and then beginning its steady decline in 2017. Similarly, malaria had a consistent decrease between 2012-2015 before increasing until 2017 and then demonstrating a substantial drop in funding in recent years. This may be due simply to progress in malaria elimination, thus, reducing the need for funding. Finally, unsurprisingly, the proportion of funding coming from external sources for the three diseases is highest in the African region and lowest in EECA; though, it should be noted that the Global Fund does provide a substantial percentage of the external funding for the MENA region in comparison to other development partners.

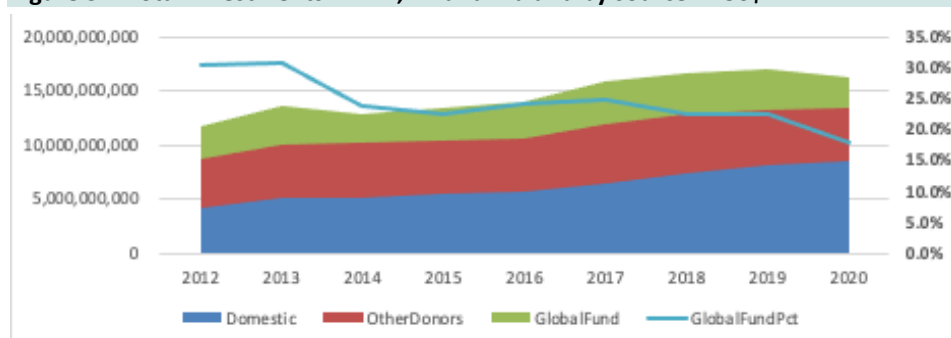
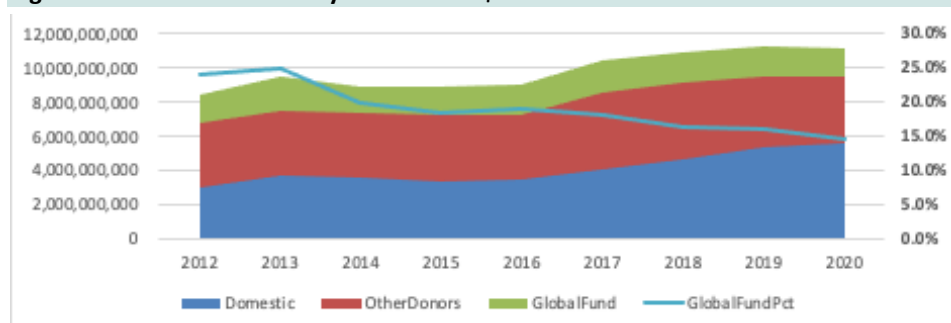
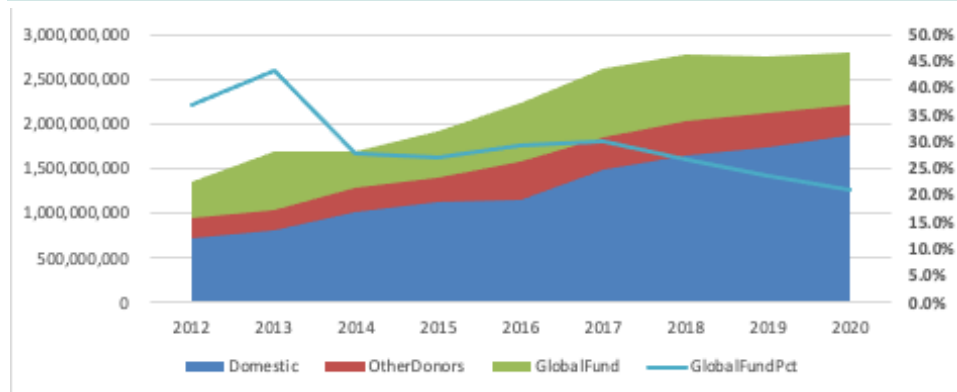
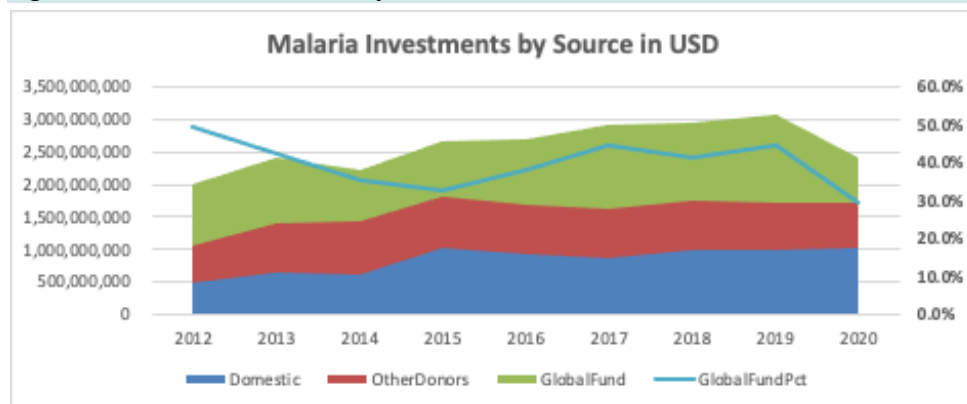
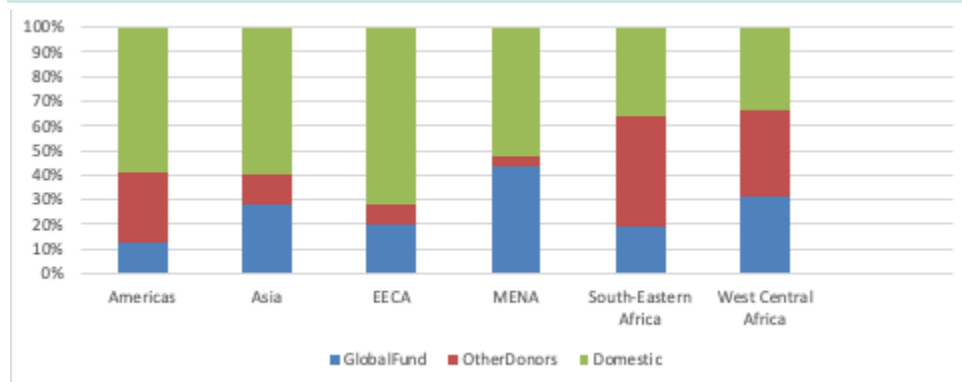
Figure 31: Total investments in HIV, TB and malaria by source in US\$**Figure 32: HIV investments by source in US\$**

Figure 33: TB investments by source in US\$**Figure 34: Malaria investments by source in US\$****Figure 35: Overall investments by region 2012 - 2020**

ANNEX 4.XII: ANALYSIS OF RSSH INVESTMENTS (SRQ14)

For 2017-2019, only 5 out of 107 countries decided to reallocate a portion of their disease funding to standalone RSSH grants. The table below shows the portion of funding reallocated from the initial disease allocation as per the allocation letter²⁰⁶.

Table 13: RSSH standalone grants

Country	Total Allocation for the 3 diseases	RSSH standalone	Percentage (in brackets suggested based on 2014-16 Allocation Letters)	Change from disease allocation taken to support RSSH stand alone
Benin	€ 67,021,483	€ 10,053,222	15.0% (9.9%)	H – 11%, T – 15% M – 18%
Ethiopia	US\$ 375,608,887	US\$ 24,000,000	6.3% (10%)	T/H – 2.4% M – 14%
Sierra Leone	US\$ 90,924,651	US\$ 17,524,651	19.0% (28.3%)	H – 25.5% T + 19% M – 19.5%
Tanzania	US\$ 579,593,776	US\$ 43,459,547	7.5% (9.3%)	T/H – 10% M – 0%
Angola	US\$ 58,088,940	US\$ 5,304,365	9.1% (12%)	T/H – 6.5% M – 18%

Most of the funding for standalone Funding Requests (FR) was taken from the malaria allocation (apart from Tanzania, others ranged from 14-19% taken). Apart from Benin, which had a larger share, other countries appear to be requesting less for RSSH than in the previous allocation period (2014-2016). Most other countries spent on RSSH but in most cases lower than the suggested recommended percentages; even when separate PAAR funding for RSSH was achieved through Portfolio Optimization it rarely reached the recommended percentage.²⁰⁷

Global Fund investments mostly target health ‘systems support’ rather than ‘systems strengthening’ efforts

From the country case studies, it was observed that irrespective of the stage at the development continuum the country sits, there is common though varied progress towards alignment with or adoption of country systems, often supported with RSSH investments through the grant. Our review of two data sets²⁰⁸ of RSSH investments indicate that on average 15% is spent on supporting and strengthening health systems, particularly those systems that are directly supporting the disease programs. An additional 30% of RSSH investments are found in the PAAR. These are usually expansions of pilots undertaken with grant funding. With additional funding after portfolio optimization, mostly going to care and treatment, the percentage of RSSH investment tends to decrease further.

In terms of investment requests, countries do request for different RSSH elements. This depends both on where they sit along the (health systems and general) development continuum, but also whether some of the health systems elements are supported by other development partners; the latter is not always clear in the Global Fund FRs or awards. As observed in Table 14 below, there is no clear pattern to the distribution of RSSH investment category. All countries ask for HMIS support, yet in the same category of investment some countries are still working with paper-based systems while others are requesting to establish interoperable digital health systems. Some countries ask for

²⁰⁶ 2017-2019 Allocation letters for the 5 countries.

²⁰⁷ Review of 77 FRs of the 2017-2019 allocation period, during the TRP/RSSH, the TERG/RSSH, the TERG/STC and the SR2020 reviews

²⁰⁸ As included in FRs during the 2017-2019 allocation period. Two sets: one of the 12 Country Case Studies for SR2020, the other the combination of country case studies from the TRP/RSSH, TERG/RSSH, TERG/STC, and TERG/SR2020 reviews, a total of 77 FRs, including allocation, PAAR and Matching Fund modalities.

limited support since they may receive support from other partners, while others (e.g. Ukraine, Kenya, Ethiopia and Eswatini) request multiple RSSH elements to support health sector reform. While not so much an issue among the country case studies, the larger data set saw significant requests for large investments in HRH (salaries, top-ups for CHWs and selected health workers). Many countries also ask for Community Response and Systems (CRS) and Procurement and Supply Management (PSM) support, but this is often at a much less costs in US\$ terms.

Table 14: RSSH Modules Investment requested in Funding Requests

Country	DIS/RSSH	Income Class	Portfolio Categorization	PSM	HMIS	HRH	ISD	FM	NHS	CRS	PM
Benin	RSSH	LI	Core	✓	✓	✓	✓		✓		✓
Nepal	Malaria	LI	Core		✓						✓
Nepal	HIV	LI	Core	✓	✓	✓	✓			✓	✓
Nepal	TB	LI	Core		✓		✓			✓	✓
Ukraine	TB/HIV	LMI	Core/COE	✓	✓	✓	✓	✓		✓	✓
Pakistan	HIV	L-LMI	High impact/COE	✓	✓						✓
Pakistan	Malaria	L-LMI	High impact/COE	✓	✓						✓
Pakistan	TB	L-LMI	High impact/COE	✓	✓			✓			✓
Ethiopia	RSSH	LI	high impact	✓	✓	✓	✓	✓			
Ethiopia	Malaria	LI	high impact		✓					✓	✓
Vietnam	HIV	L-LMI	high impact	✓	✓				✓	✓	✓
Vietnam	TB	L-LMI	high impact	✓	✓						✓
Kenya	Malaria	L-LMI	high impact		✓						✓
Kenya	TB/HIV	L-LMI	high impact	✓	✓	✓	✓	✓		✓	✓
Dom Rep	HIV	UMI	focused		✓					✓	
Dom Rep	TB	UMI	focused								✓
Cameroon	TB/HIV	L-LMI	Core	✓	✓				✓		✓
PNG	TB/HIV	U-LMI	Core	✓	✓		✓			✓	✓
Philippines	HIV	U-LMI	high impact	✓	✓					✓	✓
Philippines	TB	U-LMI	high impact	✓	✓						✓
Philippines	Malaria	U-LMI	high impact		✓				✓		✓
Eswatini	TB/HIV	U-LMI	Core	✓	✓	✓	✓			✓	✓

The following graphs show the average percentage by RSSH element for the 12 country case studies, the larger FRs data set (both from the 2017-2019 allocation period), and also the W1/2020-22 that covers the RSSH requests for 30 countries.

There is a common pattern with the main support request for HMIS and PSM, less for Financial management and national health strategies). Despite the recommendation in the 2020-22 allocation letters for increased consideration of community systems and integrated service delivery, the W1 graph shows there is little difference for the previous allocation; the new category lab support used to be under integrated service delivery).

Figure 36: RSSH investment review 12 country cases – 30 FRs

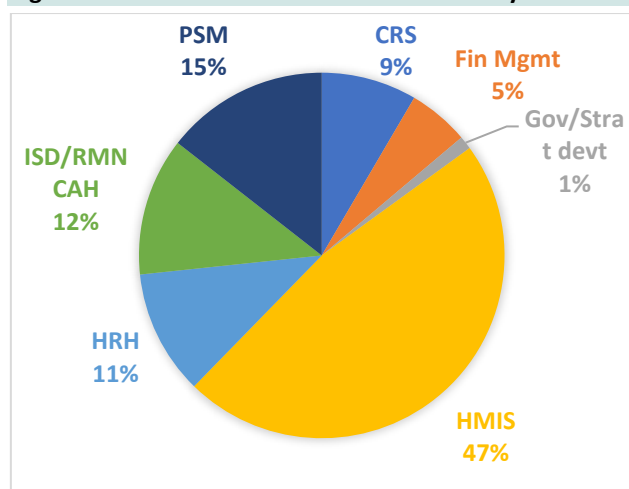
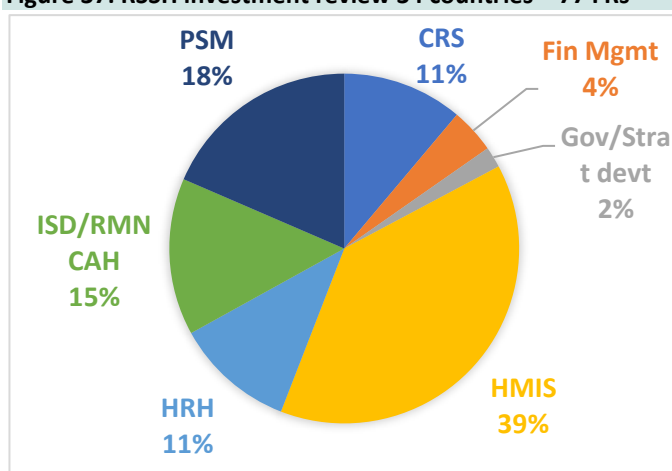
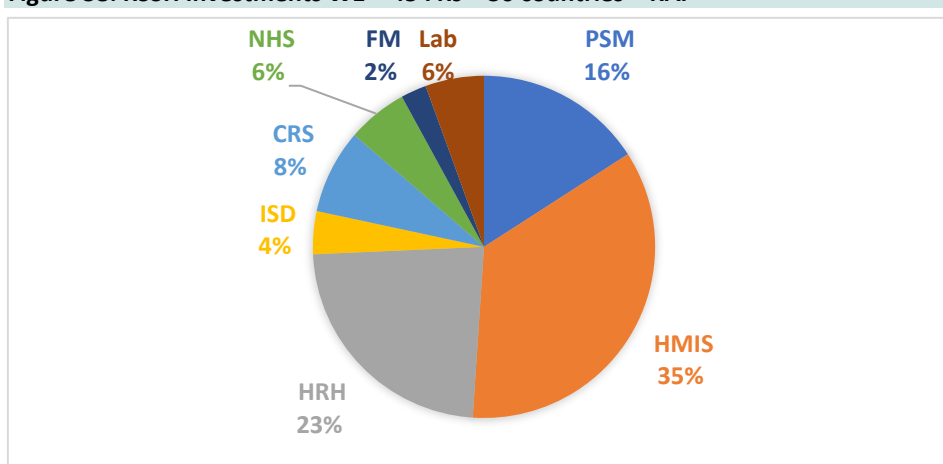


Figure 37: RSSH investment review 34 countries – 77 FRs**Figure 38: RSSH investments W1 – 45 FRs – 30 countries + RAI**

Upon further granular review of the cost categories of these RSSH investments in the FR budgets it was found that 65% of RSSH funding is for health systems support, i.e. payment for recurrent costs of the MoH, PR, disease programs: salaries, support supervision, meetings, travel, TA from technical partners, while the remainder of the investment would be used to strengthen health systems, ensuring that the country achieves more equitable and sustained improvements across health services and health outcomes²⁰⁹.

Table 15 below shows the detailed funding ratios of support vs strengthening systems for investments in the combined RSSH elements.

²⁰⁹ https://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1

Table 15: Funding for RSSH support vs strengthening

Country	DIS/RSSH	Income Class	Portfolio Categoriz	Total Amount	RSSH portion	RSSH %	RSSH Sup	RSSH Str
Benin	RSSH	LI	Core	12,063,866	8,678,268	72%	80%	20%
Nepal	Malaria	LI	Core	4,208,547	248,750	6%	100%	0%
Nepal	HIV	LI	Core	21,164,144	1,724,385	8%	76%	24%
Nepal	TB	LI	Core	16,138,548	2,545,361	16%	50%	50%
Ukraine	TB/HIV	LMI	Core/COE	119,482,531	18,884,694	16%	67%	33%
Pakistan	HIV	L-LMI	High impact/COE	34,956,107	555,469	2%	84%	17%
Pakistan	Malaria	L-LMI	High impact/COE	24,931,610	4,277,041	17%	77%	24%
Pakistan	TB	L-LMI	High impact/COE	130,163,215	11,470,228	9%	95%	5%
Ethiopia	RSSH	LI	high impact	24,000,000	24,000,000	100%	89%	12%
Ethiopia	Malaria	LI	high impact	111,849,218	11,919,721	11%	84%	17%
Vietnam	HIV	L-LMI	high impact	56,638,005	4,493,127	8%	89%	12%
Vietnam	TB	L-LMI	high impact	47,281,094	3,740,909	8%	58%	43%
Kenya	Malaria	L-LMI	high impact	60,097,090	3,820,600	6%	68%	33%
Kenya	TB/HIV	L-LMI	high impact	295,780,282	39,391,575	13%	76%	25%
Dom Rep	HIV	UMI	focused	15,994,956	2,208,229	14%	63%	37%
Dom Rep	TB	UMI	focused	4,493,840	0	0%	0%	0%
Cameroon	TB/HIV	L-LMI	Core	98,924,430	7,468,183	8%	73%	28%
PNG	TB/HIV	U-LMI	Core	21,076,614	2,221,059	11%	62%	39%
Philippines	HIV	U-LMI	high impact	8,483,242	1,414,286	17%	100%	0%
Philippines	TB	U-LMI	high impact	88,543,887	4,800,057	5%	82%	18%
Philippines	Malaria	U-LMI	high impact	10,662,817	4,538,085	43%	61%	39%
Eswatini	TB/HIV	U-LMI	Core	47,210,126	5,483,667	12%	56%	44%

So from a perspective of moving towards strengthening systems so countries position themselves to take over Global Fund (and other DPs investments) to become sustainable in the future, this still seems some ways off, even for a country like the Dominican Republic that with its UMI status could be transitioning soon.

Lastly our detailed review of the country case studies showed that program management costs are still a significant investment element: 19% (range 1-57%, with the larger percentages for additional security costs in countries such as Afghanistan or International PRs with a higher overhead). Program management costs are not a RSSH element. While evidence is available on the performance of the INGO PRs (usually good A and B ratings), there is little evidence that capacities are being built in recipient government counterpart institution and thus long-term sustainability continues to be at risk. For a number of countries (especially those under the ASP modality, where Global Fund choses the PR)) there do not seem to be concrete plans to shift from international NGOs to domestic institutions as PR/SRs.

In conclusion with a considerable level of investment to support rather than strengthening i.e. 65% and a significant high level of program costs, i.e.19% (or 72% and 11% respectively for the larger data set), there is little progress towards strengthening of health systems in Global Fund supported countries and therefore minimal progress on SO2.

ANNEX 4.XIII: INTEGRATED SERVICE DELIVERY (SRQ16)

For this Review, integrated service delivery (ISD) is understood and analyzed in two distinctly different ways: health systems integration and program services integration. For the purposes of understanding the data and progress made to date on ISD, we tease-out the difference between the two noting that both are intrinsically linked to each other and to SO2's seven operational objectives.²¹⁰

Integrating health systems

The Secretariat has made significant progress in articulating the need for integrated health system functions and how the Global Fund can contribute to this objective through the RSSH Roadmap. The RSSH Roadmap presented to the Board Strategy Committee in October 2018 laid-out five key points to “operationalize strengthening actions in a manner that advances the fight against the three diseases and helps build resilient and sustainable systems for health”:²¹¹

- build RSSH voice and capacity in NSP development
- proactively advance integration
- prioritize RSSH investments along the development continuum
- deepen collaboration with partners
- improve measurements of RSSH investments.

In addition to presenting a strategy for achieving progress on RSSH, the Roadmap also spells-out what systems integration means for key RSSH areas.²¹²

There is very little evidence to suggest that progress is being made to integrate health systems functions. The historical legacy of massive investments in targeted disease programs since 2002 has fortified vertical disease programs and the equally vertical way in which grants are written and administered. This Review does not criticize that history; it simply notes the net effect of this investment and how it complicates shifting to a more horizontal or ‘diagonal’ approach (i.e. a greater degree of integration) as well as the difficulty of retrofitting M&E systems to track progress in this effort. There are currently inadequate mechanisms to track the results of investments to strengthen health systems and enhance integrated health system functioning. For example, data collected to count the amount of investments in laboratory systems strengthening informs how much is being invested but does not provide any indication that integration is happening, although key informants (including Secretariat and country stakeholders) insists that considerable progress is being made. The RSSH team is currently seeking to better understand health systems strengthening, and by extension, health systems integration, through the RISE model—Results, Innovation, Systems Thinking and Equity.²¹³ The RISE model calls for, among other good ideas, the reincorporation of both Household Surveys (HS) and Health Facility Assessments (HFA) to better understand where integration is actually occurring for the direct betterment of client satisfaction.

Program service integration

The Global Fund collects data on ‘packages of health services’ delivered—a sort of proxy measure for program integration—but there is not a clearly defined link between program integration and packages of health services delivered. More detailed analysis is presented in the sub-annex below. There are anecdotal examples of program integration across disease components and good guidance

²¹⁰ (1) Strengthen community responses and systems; (2) Support reproductive, women’s, children’s, and adolescent health, and platforms for ISD; (3) Strengthen global and in-country procurement and supply chain systems; (4) Leverage critical investments in human resources for health; (5) Strengthen data systems for health and countries’ capacities for analysis and use; (6) Strengthen and align to robust national health strategies and national disease-specific strategic plans; and (7) Strengthen financial management and oversight.

²¹¹ RSSH Roadmap: Improving the quality and impact of RSSH investments. Presentation to Strategy Committee, Geneva, 28-29 March 2019

²¹² I.e. Service delivery including laboratories; human resources for health (HRH); data improvement; domestic resource mobilization; community systems; procurement and supply chains; national health strategies; and financial management.

²¹³ RSSH Training: RISE to the challenge. November 28, 2019

notes to this effect²¹⁴ (highlighted in more detail below), but there are very limited directions evident in the Modular/Performance Framework²¹⁵ for integrating service delivery as part of a ‘step-wise’ movement along a development continuum. There is one HIV prevention intervention dedicated to linking RMNCAH and HIV services in the Modular Framework Handbook of Oct 2019 but no ISD modules or interventions for TB or malaria in the same handbook. For RMNCAH, integration of PMTCT and HIV program services has greatly reduced vertical transmission of the disease. Over 60% of countries have fully integrated PMTCT and a further 30% have at least partially integrated. Even with this integration, low coverage of PMTCT services persists.

While program service integration is a recognized strategy for achieving greater efficiencies and effectiveness, not all program services should be integrated. Context is critical. In service delivery settings where stigma and discrimination are not a problem, ISD is a logical way to improve program efficiencies and effectiveness as expressed through one-stop or co-location service delivery points (e.g. MNCH clinic). It can provide opportunities for improved quality of services and client satisfaction. However, where stigma and discrimination against socially marginalized groups continue to exist, a differentiated service delivery (DSD) approach needs to be considered. The literature on ISD, particularly with respect to HIV and SRH strongly suggests that programs consider a DSD approach, built upon community-level assessments of need, and takes into consideration the multiple and very different types of population groups and the ongoing challenges related to stigma and discrimination related to sexuality and drug use.

There has been improved WHO guidance on defining packages of health services relevant to specific populations and, in this light, the quality of services has improved to the benefit of specific populations. There are good examples of packages of HIV services being delivered to KVP groups, but there are fewer examples where combined ‘packages of services’ demonstrate greater program efficiency and effectiveness where multiple population groups receive services at a single point of service delivery. In addition, it doesn’t seem as if the Global Fund is systematically analyzing data on coverage of these packages that, in turn, drives more nuanced ISD efforts. Creating one-stop or co-location points of service delivery may seem logical in terms of efficiency, but it is often not practical to mix widely divergent population groups in one setting.²¹⁶ Aside from advances in HIV-TB integration, there is little data to examine the extent to which cross-programmatic service consolidation and/or the combination of services targeting multiple population groups is taking place across the portfolio and generating better VFM.

For HIV-TB, combined applications in 28 high burden countries appear to be ‘pushing’ both systems-level and program integration between the two traditionally vertical programs. If funding requests can be an indicator of movement towards integration, the joint TB-HIV review highlights some successes. For example, the proportion of HIV grants that addressed TB/HIV increased from 80% in NFM 1 to 96% in NFM 2 and the proportion of TB grants that addressed TB/HIV increased from 96% in NFM 1 to 100% in NFM 2²¹⁷. There is some indication of integration of HIV and TB *systems*, as indicated by increased harmonization of grant cycles allowing for easier joint-reviews. But it is still unclear whether, at this point, implementation is being rolled out in an economical, efficient and sustainable manner. As of NFM 1, 28 high burden countries submitted joint HIV-TB applications. Guidance documents exist to support combined funding requests, and initial indices from the joint HIV-TB review suggest that some integration is happening (i.e. M&E and supervision alignment, PR consolidation), but there appear to be no significant incentives or requirements to integrate systems and services more broadly.

²¹⁴ Technical Brief: Strategic Support for Strengthening Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), September 2019.

²¹⁵ TGF. Modular Framework Handbook, October 2019

²¹⁶ Multiple KIIs with FPMs and country cases study interviews.

²¹⁷ TGF. Review of joint TB-HIV grant applications, September 2019

Initial progress on HIV-TB program integration is best seen through two performance indicators: HIV testing among TB patients; and ART initiation among TB patients co-infected with HIV. These two indicators have been steadily increasing from 2010, with some countries reaching the global targets of testing all TB patients for HIV (100%) and ART initiation to $\geq 90\%$ of TB/HIV co-infected patients.²¹⁸ Despite these positive numbers, the HIV/TB Thematic Review found that most countries still have separate HIV and TB clinics (although these can be within the same facility) where each provide HIV testing and TB screening/diagnosis but refer patients for treatment services to their respective clinics. Only Eswatini had a one-stop, co-location service whereby TB and HIV services are provided by the same staff in the same clinic. In Zambia, HIV clinics provide all TB services and TB clinics provide all HIV services, so in practice these are also one-stop services. In Mozambique the TB clinic offers all HIV services, but the HIV clinic refers TB patients to the TB clinic for treatment. Finally, in Kenya, HIV clinics offer all TB services, but HIV positive TB patients are referred for ART to the HIV clinic.

Some progress is being made to integrate service delivery at the primary health care (PHC) level by providing defined packages of essential health services along with a functional referral system (RMNCAH, iCCM, AGYW). The RISE model provides a particular focus on equity which seeks to promote the design of integrated programs aimed at reaching the poorest people and working closely with communities to provide these services through PHC systems. This includes geographic targeting – focusing on areas where the poor and under-served reside and finding ways to reduce user fees to access programs. Good examples of putting this into practice are conditional cash transfer, decentralized facility financing or PBF (good examples in DRC) and contracting with NGOs/CSOs to explicitly target poor populations. These best practices can be found in the Sahel initiative on SMC where NGOs for being contracted for performance-based delivery under the assumption that by letting NGOs do the delivery, poor kids will have access to the other services that NGOs provide.

Despite the lack of quantitative data, the anecdotal information is encouraging. For example, in malaria, the Global Fund is contributing to iCCM integration into PHC systems, often in collaboration with PEPFAR, that targets child mortality and treats childhood presentation of symptoms (fever) in MNCH settings in Benin, Mali, Cote d'Ivoire, Niger and Burkina Faso. This goes hand in hand with a greater emphasis on building capacities to deliver health services through primary health care centers. In all of these countries, there is a focus on expanding the role and capacities of CHWs and/or health extension workers through investments in HRH. In Togo and Chad, the Global Fund is investing in integrated antenatal and postnatal care, using skills and competency based in-service training, standards-based audits and collaborative learning at facility level. This “allows for essential packages of interventions, including those for HIV, TB and malaria, to be delivered to mothers and newborns during antenatal and postnatal care”.²¹⁹

Review analysis suggests that there is also some progress in those regions (EECA, LAC, SE Asia) that are further along the development continuum and targeted for transition. For example, in Lao PDR, there is a move away from vertical programming and a strengthening of PHC services, while in countries such as Azerbaijan, Moldova, and Armenia there is progress in the integration of HIV and TB services into mandatory health insurance schemes, and PHC/UHC reform in Ukraine and Moldova. In Jamaica and the Dominican Republic, the Global Fund has initiated the discussion of the integration of HIV services by completing a recent review of potential opportunities and barriers.

AGYW is successfully demonstrating how upstream investments in coordination and planning across multiple sectors results in positive outcomes for AGYW health in 13 high disease burden countries in sub-Saharan Africa. Different from the community-up approach, the AGYW engagement in 13 high disease burden countries begins by establishing buy-in from the Global Fund country teams including their department line-reports outside of GMD (e.g. M&E, finance, legal, etc.) all the way through to

²¹⁸ TGF. Review of joint TB-HIV grant applications, September 2019.

²¹⁹ RSSH Guidance Note 2020.

facilitating country-level negotiations between a wide range of government Ministries, international partners, community leaders and the private sector. This often involves innovative accounting to justify and pay for services (transportation, school fees, livelihood support, etc.) not traditionally covered in HIV prevention programs.²²⁰

The best examples of synergy and efficiency we have found, in looking primarily at the cross-programmatic intersection of SRH and HIV, come from the work on integrating iCCM into community-based systems of primary health care, CRG community systems engagement that focus planning on women's health care needs, and the cross-sectoral coordination underpinning the success of the AGYW work (i.e. integrating relevant non-health sectors such as education, youth and sports, labor, social services and transportation).

The iCCM focus on PHC settings with linkages between malaria programs and RMNCAH²²¹ and the CRG focus on community planning on women's health care needs both demonstrate the importance and value of centering interventions at the community-level. Both favor a client-centered approach which is an effective model for addressing the wider Global Fund concerns about equity in access and creating synergies where they are most valuable—at service delivery. To address gender equity concerns that particularly effect adolescent girls and young women, the CRG unit has been focusing their energies on community-based planning and understanding the 'health ecosystem' of a given community which includes a sort of mapping exercise to (a) identify what partner agencies are present, (b) what services they are offering and (c) how these factor into the overall health community system of care. On the other hand, the AGYW work is a good example of cross-sectoral planning at the interface between national programs, the Global Fund and other partner agencies.

While the Review in general suggests that payment for results models might be expanded across the portfolio, this is one area where caution should be exercised given past experiences in RMNCAH where clinics have 'pushed' more profitable family planning services (i.e. IUDs and implants) at the expense of cheaper alternatives (pill, condoms, etc.).²²²

It is not clear whether ISD approaches are being used efficiently with the objective of providing an adequate level of patient-centered quality of care. The RISE model suggests the use of health facility assessments (HFAs) and household surveys (HHSs) to track and monitor outcomes related to affordable, client-focused service delivery where integrating service delivery addresses equity, efficiency and greater sustainability. As countries progress along a development continuum where greater domestic investments lead to the development of stronger health care infrastructure and a subsequent movement towards universal health coverage (UHC), primary health care service delivery becomes an increasingly important model to achieve greater equity in the distribution of limited health resources.

Finding lessons learned on cross-programmatic synergies is also a challenge. In the absence of any meaningful quantitative data, this Review attempted to understand synergies and cross-programmatic efficiencies through an examination of relevant documents and through the voices of key informants at both global and country level (i.e. through 11 case studies). The literature review and interviews explored, in particular, the intersection of HIV and SRH where these two traditionally siloed programs search for ways to be more integrated and efficient. Review analysis points to the direction that progress is being made where partner groups or consortiums focus their investments on community-level planning and **let the community drive the program agenda.** This was evident in the progress being made at the intersection of HIV and SRH in several west Africa countries as well as the integration of iCCM between malaria programs and MNCH clinics.

²²⁰ Report: iKPI (e) – Number of Target Countries with a Comprehensive Package of Prevention Programs for AGYW in Global Fund Grant Agreements. January 2019.

²²¹ RMNCAH continuum of care model https://www.who.int/pmnch/about/continuum_of_care/en/

²²² KII with UNFPA and WRC.

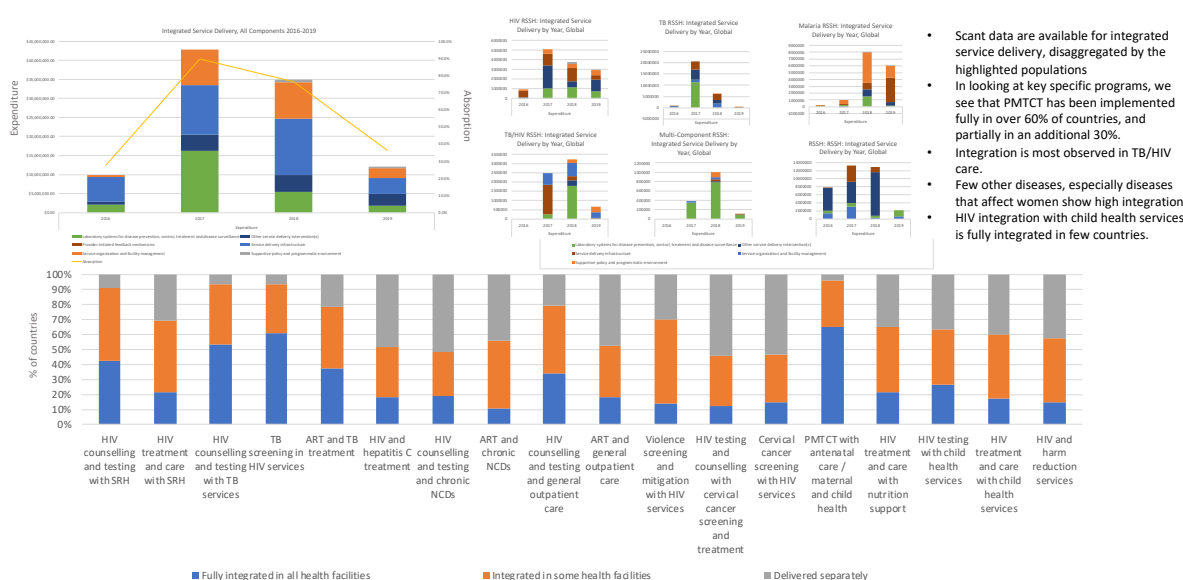
Finally, there is an evolving and dynamic field of knowledge and expertise around ISD, especially between HIV and SRH. UNAIDS holds periodic expert consultations on ISD, maintains a pool of integration experts and there is an evolving literature and practice on how best to integrate HIV, SRH and RMNCAH programs. It is not clear the degree to which the Global Fund takes advantage of this resource aside from inputs by UNAIDS to HIV-related technical guidance. UNAIDS currently tracks a number of integrated HIV services with respect to TB, SRH, RMNCAH, NCDs, Hepatitis C, (and others) across 130 countries. These data demonstrate a high degree of integration between HIV counselling and testing with SRH, TB services and PMTCT with antenatal care.

ANNEX 4.xiii.A: TRACKING PROGRAM INTEGRATION

The Global Fund is not tracking program integration; it collects data on ‘packages of health services’ delivered but there is not a clearly defined link between packages of health services delivered and integration of services. There are many anecdotal examples of program integration across disease components found across all of our country case studies, but none describe program integration as a ‘step-wise’ movement along a development continuum. There is no quantitative way to track progress on service integration relative to a movement along a development continuum primarily because the development continuum is an allocation formula and not a measure used to track program progress. The ‘development continuum’ has limited operational or evaluative use outside of the allocation formula.

Figure 39: Strategic objective 2: Build resilient and sustainable systems for health.

SO 2b: Support reproductive, women’s, children’s and adolescent health, and platforms for integrated service delivery



- Scant data are available for integrated service delivery, disaggregated by the highlighted populations
- In looking at key specific programs, we see that PMTCT has been implemented fully in over 60% of countries, and partially in an additional 30%.
- Integration is most observed in TB/HIV care.
- Few other diseases, especially diseases that affect women show high integration
- HIV integration with child health services is fully integrated in few countries.

Despite the lack of quantitative data, there is a lot of good anecdotal information about program integration. For example, in malaria, the Global Fund is contributing to iCCM integration into PHC systems, often in collaboration with PEPFAR, that targets child mortality and treats childhood presentation of symptoms (fever) in MNCH settings in Benin, Mali, Cote d'Ivoire, Niger and Burkina Faso. This goes hand in hand with greater emphasis on building capacities to deliver health services through primary health care centers. In all of these countries, there is a focus on expanding the role and capacities of CHWs and/or health extension workers through investments in HRH. In addition, Togo and Chad have prioritized Global Fund investments to improve integrated antenatal and postnatal care, using skills and competency based in-service training, standards-based audits and collaborative learning at facility level. This allows for essential packages of interventions, including those for HIV, TB, and malaria, to be delivered to mothers and newborns during antenatal and postnatal care.

With respect to delivering more appropriate ‘packages’ of health services, there has been improved WHO guidance on defining these packages of health services relevant to specific populations and, in this light, the quality of services has improved to the benefit of specific populations. There are good examples of packages of HIV services being delivered to key and vulnerable population groups, but there are fewer examples where combined ‘packages of services’ demonstrate greater program efficiencies and effectiveness where multiple population groups receive services at a single point of

service delivery. In addition, it doesn't seem as if the Global Fund is systematically analyzing data on coverage of these packages that, in turn, drives more nuanced ISD efforts. Creating one-stop or co-location points of service delivery may seem logical in terms of efficiencies, but it is often not practical to mix widely divergent population groups in one setting. There is little data to examine the extent to which cross-programmatic service consolidation and/or the combination of services targeting multiple population groups is taking place across the portfolio and generating better value for money.

In Global Fund Guidance Notes, there is a detailed scope and description of 'intervention packages', but this does not translate "up" to cross-modular integration. Health systems integration data note an investment category spread along a TRP-defined table of 4 investment areas, or 4 S's: Start-up, Support, Strengthening, and Sustainability (see below). While this overall categorization of systems strengthening activities is useful to differentiate and track investment type, there is no guidance or accepted formula that defines a continuum of progress where country X should be investing at Y point along a continuum of health systems strengthening.

Figure 40: Existing frameworks including the TRP's 4S will help guide the RSSH strategic investment approach along the development continuum

9th Strategy Committee Meeting, 28-29 March 2019, Geneva, Switzerland

Existing frameworks including the TRP's 4S will help guide the RSSH strategic investment approach along the development continuum

➤ Such frameworks will be referred to as a guide and used in a flexible manner, rather than as a rigid and prescriptive approach

Parameter	System start-up (establishment)	System Support	System Strengthening	System Sustainability
Scope	Emergency, early development of systems	May be focused on single diseases or intervention	Activities have impact across health services and outcomes	Systems are integrated, and resources are fully incorporated into the overall health sector
Longevity	Short term, depending on country situation	Effects limited to period of funding	Effects will continue after activities end	Effects are continuing without external/additional support
Approach	Input heavy for all systems	Provide inputs to address identified system gaps impacting service delivery	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner	Systems are adjusted to adapt to changes and resources are continuous, relevant and available domestically

Source: TRP Report on RSSH Investments in the 2017-2019 Funding Cycle, 8th Strategy Committee, October 2018

Investment Synergies and Efficiencies with Other Sector Investments (16a)

Few organizations, including the Global Fund, write-up examples of dysfunctional health service delivery where in-country actors duplicate services or create significant gaps in services, poor coordination, inefficiency or ineffective programming. There are anecdotal stories shared by key informants but even in interviews, people tend not to elaborate and to focus instead on positive stories of collaboration to the exclusion of highlighting negative situations.

In a review of dozens of technical briefs, the word 'synergy' rarely comes up and when it does, it's in the form of general statements asking grant applicants to look for synergies in an effort to align with other programs and avoid duplication of services. Comments on 'synergies' in guidance notes are

mostly ‘generalized’ statements to health systems integration. TRP members look for and comment on synergies in their review of FRs and keep tracking notes of where countries need to improve on avoiding duplication of services and areas where finding synergies would improve the outcomes or impact of the grants.

A logical place to find examples of anticipated cross-programmatic synergies or collaborations would be in funding requests and, more likely still, in national strategic plans. However, a word search of ‘synergies’ and ‘investment pathways’ of all FRs across the 11 country case studies showed zero matches. A less thorough check among NSP equally showed a lack of focus on ‘synergy’ and ‘complimentary investment pathways’. The absence of these terms is not necessarily an indication that synergies are not being sought or that applicants don’t look for and find complimentary investment pathways. It’s more likely that ‘synergy’ and ‘complimentary investment pathways’ have simply not yet taken root in the lexicon of Global Fund terminology and briefing notes.

Certainly, good coordination, efficiency and effectiveness are well established principles that drive funding request development and program implementation. Constant improvements in guidance notes help shape better funding requests for the three diseases and RSSH, but they are still weak in helping guide countries on how to construct budgets that encourage cross-sectoral programming with the objective of finding greater impact. The in-country process for developing a funding request requires the involvement of multiple partners but is still, most often, highly verticalized around the three diseases and, to a lesser extent, RSSH. Although the CCM is a multi-stakeholder body, and its FRs are, in general, built upon a NSP, the vertical nature of the FRs themselves do not lend to cross-program synergies.

Key informant interviews were less informative or conclusive on the role of synergies and investment pathways. People tend not to want to talk about situations of poor coordination, program overlap, or duplication of services and how to improve these. While these situations certainly exist, especially in country settings where multiple partners are involved across related health fields (i.e. SRH-HIV, or MNCH and malaria), key informants would not elaborate. Even when asked to identify positive stories of program synergies, key informants essentially focused their responses on the very personal examples of good stewardship or leadership and/or generalized policy examples of progress being made at integration across related fields of interest.

One potential window into understanding how synergies and/or efficiencies may or may not be found is by looking at how some health service packages are determined according to which donor(s) pays for what service or commodity despite there being nationally determined packages of services. In many countries where the Global Fund and PEPFAR are present, countries tend to divide up the country by province or district in order to spread-out who pays for what²²³. Sometimes this can work out well, like in Cameroon²²⁴, but in other cases it can create potential areas of duplication, inequity in access or program instability and disruption when PEPFAR offers more (or less) services and/or transitions out of a country, as in Vietnam and Kenya²²⁵. This patchwork of donor-determined inputs can complicate consistently applied service delivery across a country, region or district²²⁶ and seriously hamper efforts at program ‘synergies’ not to mention advancing program sustainability.

²²³ Which countries?

²²⁴ “The PEPFAR and Global Fund programs complement one another with minimal overlapping of geographical coverage and offer a synergy of services where there is a geographical overlap. In the five districts common to the two programs for prevention activities, the respective PRs signed a letter of intent defining their responsibilities, aligning their tracking systems by harmonizing their unique identification codes and ensuring access to a full package of services for all beneficiaries. [Secretariat Briefing Note – SBN] PEPFAR will increase coverage from 4 to 10 regions, with the aim of reaching HIV epidemic control by 2021. [Cameroon CPR 2019]

²²⁵ Ethiopia case study?

²²⁶ Evidence from case studies?

As a trend, it raises questions about national ownership and long-term program sustainability²²⁷. It can equally occur that national programs divide the national program pie by how much the domestic budget can cover and then parcels out 'the gap' for the Global Fund to cover²²⁸. While this phenomenon has not been studied in-depth, it raises questions of sustainability due to the potential precariousness of service delivery when one (or more) of the donor partners change the focus of their financing. The synergies or efficiencies in this type of partnership model are highly variable. In some countries there is excellent communication and coordination resulting in synergies and efficiencies; in others it's quite the opposite.

²²⁷ Eswatini case study

²²⁸ Country case study examples

ANNEX 4. XIV: ALIGNMENT OF GLOBAL FUND STRATEGIC PRIORITIES, POLICIES AND INVESTMENTS TO BROADER GLOBAL HEALTH GOALS (SRQ22)

Universal Health Coverage

There is significant overlap of concomitant goals between the UHC, SDG and the Global Fund's Strategy. The actual contribution of the Global Fund to these wider development agendas is greatly under appreciated. This is due in part to the Global Fund's inability to demonstrate direct contribution to these global agendas and the lack of documented progress being made in RSSH and addressing equity issues. UHC aims to ensure that all people obtain essential health services without suffering financial hardship when paying for them.²²⁹ The promise of UHC is to provide an affordable, minimum package of 16 health services of which HIV, TB, and malaria are included.²³⁰ There are many factors that shape a country's commitment and/or ability to provide these services in an equitable way, for all of its citizens. Chief among these factors is having the foundation of a sufficiently strong health system to deliver these services.²³¹

In theory, the Global Fund contributes to progress toward UHC—and helps countries move along a UHC development continuum—through its business model of raising and disbursing resources for the three diseases and strengthening health systems (all essential elements of UHC). In practice, Global Fund investments contribute to strengthening the very foundation upon which affordable and equitable access to HIV, TB and malaria services can be achieved. However, as this Review has highlighted, to make better progress and leverage better outcomes, the Global Fund needs to be more strategic in clarifying and focusing its RSSH investments to the right types of health systems strengthening interventions relevant to each country's situation. This includes ramping up its investments to improve equitable access for KVPs. While the Global Fund Strategy contributes to a movement toward UHC, both by addressing the three diseases and building strong, sustainable health systems, it struggles to demonstrate this contribution. There seems to be no M&E roadmap or dedicated person or team responsible for tracking and demonstrating this progress.

Global Fund investments in RSSH are small compared to global need but they are significant in relation to its overall portfolio, and current investments could be made more strategically and effectively. The WHO estimates that USD 371 billion are needed annually from now until 2030 in order to strengthen health systems to achieve UHC.²³² At present, the Global Fund invests just over USD 1 billion per year in RSSH—a far cry from actual need, and yet the Global Fund is the largest multilateral provider of grants to health systems strengthening.^{233,234} And as noted above, current RSSH investments are overly focused on *systems support* (i.e. recurring programs costs) as opposed to *systems strengthening* and sustainability investments. Clearly, the gap to meet the global need for health systems strengthening is far too wide for the Global Fund to fill alone, nor would reappportioning a larger percentage of its overall budget to RSSH be feasible. Interviews with global health leaders have noted deep and continuing resistance to larger RSSH investments due to dissatisfaction with how those funds are being invested and the perception that greater investments in RSSH take resources away from funding HIV, TB, and malaria.²³⁵ There is also a lack of normative guidance, a sort of 'UHC Marshall Plan', that guides health funding institutions on what, where and how country-level investments could contribute toward global progress on UHC.

Since the Global Fund is not currently tracking its contribution to the UHC agenda, at mid-cycle in the 2017–2022 Strategic Plan, it can only report on high-level expressions of intention rather than

²²⁹ <https://www.uhc2030.org>

²³⁰ [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

²³¹ [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

²³² <https://www.uhc2030.org>

²³³ Peter Sands, update to the 40th Board meeting

²³⁴ Email confirmation from Dianne Stewart, Head of Donor Relations at the Global Fund, 30 July 2020.

²³⁵ KII, global health leaders.

a demonstrable contribution to how Global Fund grants are making progress toward UHC. This does not mean that the Global Fund is not contributing; its contribution to impact on the three diseases and building resilient and sustainable health systems are directly relevant to UHC objectives. Analysis of M&E systems demonstrates that the Global Fund has simply not trained its data capture and analysis on outputs or outcomes that could reasonably speak to progress toward UHC goals.

Country case studies provided specific examples of how some countries are making progress toward UHC such as the National Strategic Plan commitments by Eswatini and Viet Nam's evolving health insurance coverage for all. Ethiopia's investments in PHC and the expansion of community health workers demonstrate progress toward more equitable distributions of health services to the poorest of the poor, i.e. vulnerable populations, while Kenya has a long-term goal of integrating the three diseases into PHC settings.

In 2015, a collaborative effort by WHO and the World Bank advanced consensus on what constitutes basic benchmarks for progress toward UHC (i.e. a minimum package of affordable health services) and constructed an index that demonstrates it.²³⁶ The index expresses equity in coverage on essential services including HIV, TB, and malaria. There is also a financing component that expresses UHC to out-of-pocket expense burden at 10% and 25%. All three of these measures could be used to track Global Fund contributions to UHC progress. However, this Review did not find any use of this UHC index.

Building RSSH is a critical element in making progress toward UHC and is a key pillar of the current Global Fund Strategy, thus demonstrating further commitment to this global agenda. However, **the Global Fund is not channeling its RSSH investments in the right types of systems strengthening and sustainability efforts (e.g. human resources for health, systems financing, governance, etc.) that can leverage better health systems outcomes, demonstrate real contributions to impacting the three diseases and providing greater equity in access to KVPs.** While much progress has been made to advance the needs of KVPs by strengthening human rights, reducing stigma and discrimination and addressing structural barriers to gender discrimination, the Global Fund has paid less attention to efforts that would more deliberately address equity in access to health services as a principal outcome of strengthening health systems.

Sustainable Development Goals

The Global Fund's Strategy is generally aligned with and designed to ensure investments contribute toward the SDGs. The 2017–2022 Strategy specifically states that the 'financing provided through the Global Fund will be a major contributor to enabling countries to meet [Sustainable Development] Goal 3 and the associated target that seeks to end the epidemics of AIDS, TB, and malaria by 2030.'

There are 11 goals under SDG3, 3.3 being of principal importance to the Global Fund Strategy: by 2030, end the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. Also, of relevance, 3.1 focuses on reducing maternal mortality and 3.2 on ending preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. Clearly, the Global Fund's Strategy, its funding model and financial resources are being directed to address SDG3.3, 3.2 and 3.1 and to some degree SDG5 (i.e. to achieve gender equality and empower all women and girls).

Similar to contributions to UHC, Global Fund financing contributes significantly to SDGs 3 and 5. In 2019, 12 international organizations came together and developed a Global Action Plan (GAP) to define how and who would contribute what in making progress toward the SDGs. The Global Fund has made progress in defining the scope of its contribution to the GAP, principally through the sustainable health financing accelerator—one of seven 'accelerators'—and putting this into practice

²³⁶ [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

through collaborative efforts with partners at both the global and country levels. In close collaboration with the Bill and Melinda Gates Foundation and other partners, the Global Fund works at the country level to develop sustainable financing tools and document best practices. The Secretariat reports regularly to the SDG GAP committee as well as reporting progress on the Sustainable Health Financing accelerator to the Board.

Similar to the UHC agenda, the financial resource needs to fully address the SDGs far exceeds what the Global Fund alone can provide and there is a need for continued, close collaboration with other development organizations. At the Financing for the Development Conference in Addis Ababa in July 2015, fully financing the SDGs was estimated to require trillions, not billions, in order to achieve its ambitious targets.²³⁷ They called for new approaches to financing that recognized that domestic resources, not external assistance, would be the ‘engines of progress’ both to get more results and to increase the total volume of financing.²³⁸ Despite this funding shortfall, the Global Fund is making significant progress, through its STC Policy, to encourage and make progress on increasing domestic financing in HIV, TB, and malaria. Finally, responding to the SDGs is a multi-organizational, international effort. The GAP outlines where organizations have a comparative advantage in their contributions to the SDGs. In this light, the Global Fund has focused its comparative advantage on sustainable health financing.

Emerging Issues in Health Security: Antimicrobial Resistance, Climate Change and COVID-19

In considering future directions for the Global Fund—as part of the scope of work for this mid-cycle Strategic Review—there was little evidence, apart from KII, upon which to evaluate and make definitive conclusions on whether the Global Fund should ‘take on’ the Antimicrobial Resistance (AMR) agenda or engage with health-related climate change issues. However, the rapid and unprecedented emergence of COVID-19, during the course of this Review, provided an unexpected opportunity to examine how a global pandemic can affect, in real time, virtually every aspect of implementing the Global Fund Strategy.

The Global Fund’s initial response to COVID-19 shows an organization capable of applying its historical, comparative advantage of responding well and rapidly in a crisis situation to deliver resources in a transparent and accountable way. The Global Fund business model has demonstrated an ability to adapt quickly and meet the unprecedented challenges threatening progress toward achieving impact against the three diseases and building RSSH.²³⁹ The COVID-19 response has been smart, swift and focused if not always for the greater good of addressing the global pandemic but for protecting and mitigating programmatic losses to the significant gains that have been made in addressing the three diseases during the first two years of this Strategic Plan.

The lockdown of human activity is having innumerable consequences on the day-to-day implementation of HIV, TB and malaria prevention and treatment activities. For example, in sub-Saharan Africa, where significant progress has been made in addressing the HIV/SRH needs of AGYW, COVID-19 is disrupting the very structural foundations upon which young women depend for sustenance, livelihood and protection.²⁴⁰ Young people depend on public transport for school, running small businesses, visiting a clinic for HIV prevention or going to a pharmacy. When transportation systems shut down, as they have in the pandemic, so do small women-owned enterprises. Livelihoods falter and the necessities in life to protect one’s SRH become unaffordable, out-of-reach or inaccessible.

²³⁷ Financing for Development Conference in Addis Ababa in July 2015 report.

²³⁸ <https://www.globalfinancingfacility.org/introduction>

²³⁹ The Global Fund. Mitigating the impact of COVID-19 on countries affected by HIV, tuberculosis and malaria. June, 2020. https://www.theglobalfund.org/media/9819/covid19/mitigating_impact_report_en.pdf (accessed July 2, 2020).

²⁴⁰ KII interviews, Secretariat staff.

Redirecting Global Fund resources to purchase personal protection equipment (PPE) for safe mosquito net distribution, ensuring continuity of antiretroviral therapy and supporting initiatives to adapt and sustain tuberculosis case finding and treatment have been essential reprogramming exercises to safeguard progress in grant implementation by protecting the well-being of essential personnel who deliver life-saving HIV, TB, and malaria health services.²⁴¹ The very nature and scope of community health care work is challenged in an environment of infectious diseases. Community health workers must physically go and be present within communities, visiting individuals and families. Without PPE, they are forced to choose between the unthinkable options of either stopping community visits or putting themselves at risk with substandard protective equipment. When transportation systems cease to run or are severely scaled-back, when communications systems and technologies are substandard especially in internet 'dead zones' or when the lack of PPE or the demands of 'social distancing' reduce the number of people who can be seen in a clinic, then the implementation of daily or routine service delivery is equally affected.

From a biomedical perspective, it is still too early to know the precise pathogenic ways in which COVID-19 could affect people living with HIV, TB, and malaria and what the health system response will be. Despite limited data of the biomedical impacts of COVID-19, national HIV/TB programs can anticipate that people living with HIV, who are already immunocompromised, may have significant challenges managing a COVID-19 infection. As a respiratory illness, one can surmise that COVID-19 will disproportionately affect people living with TB. For malaria, social isolation will make it difficult for parents to bring their sick children to health facilities. The Global Fund is already anticipating how the social and economic lockdowns will derail program implementation and therefore hinder access to essential, life-saving treatments. A recent Lancet article published in June 2020 estimates that 'in high-burden settings, HIV, tuberculosis, and malaria deaths over a 5-year period could increase by 10%, 20%, and 36%, respectively'.²⁴² From a health systems perspective, COVID-19 places significant new demands (e.g. purchase, distribution and use of PPE; heightened protection measures, service disruptions, etc.) and poses numerous challenges to already weak health systems to reach and serve the poorest of the poor and most vulnerable. A recently published Global Fund biweekly survey across the more than 100 countries suggests that 85% of HIV, 78% of tuberculosis, and 73% of malaria programs are being disrupted. Some 18% of HIV programs, 17% of tuberculosis programs, and 19% of malaria programs are experiencing high or very high disruption.²⁴³

From a business model perspective, the Global Fund Secretariat has been swift to respond with transparency and within a completely virtual operating environment. This has been no small feat when considering the multiple chains of command needed for decision-making, all executed virtually over Skype, Zoom, or Bluejeans. The Secretariat quickly developed a number of tools, guidelines, communications and funding protocols and mechanisms to address COVID-19. In March, the Global Fund leadership and its Board of Directors immediately made available up to USD 500 million from reprogramming unspent grant funds to be re-directed toward a COVID-19 response. Countries could reprogram up to 5% of their total grant amounts. On April 9, the Board approved a new funding channel called the COVID-19 Response Mechanism (C19RM) that could spend up to an additional USD 500 million USD on a COVID-19 response. By May 15, the Board had approved of USD 130 million in funds to 81 countries and six multi-country grants through C19RM. Impressively, the Secretariat committed to a grants processing turn-around time of five days.

The information to date on the Global Fund's response to COVID-19 is limited, but since mid-March, the SR2020 team has observed a Secretariat understandably struggling to maintain day-to-day

²⁴¹ HIV, tuberculosis, and malaria: how can the impact of COVID-19 be minimised? Lancet Global Health 2020. Peter Sands, July 13, 2020.

²⁴² Hogan AB, Jewell BL, Sherrard-Smith E, et al. Potential impact of the COVID-19 pandemic on HIV, tuberculosis, and malaria in low-income and middle-income countries: a modelling study. Lancet Glob Health 2020; published online July 13. [https://doi.org/10.1016/S2214-109X\(20\)30288-6](https://doi.org/10.1016/S2214-109X(20)30288-6).

²⁴³ The Global Fund. survey: majority of HIV, TB and Malaria programs face disruptions as a result of COVID-19. June 17, 2020. <https://www.theglobalfund.org/en/covid-19/news/2020-06-17-globalfund-survey-majority-of-hiv-tb-and-malaria-programs-face-disruptions-as-a-result-of-covid-19> (accessed July 2, 2020).

implementation and oversight activities while simultaneously switching from work-place settings to home-based ones. We also suspect that COVID-19 has seriously challenged traditional ways of working with respect to internal and external meetings with and among the Global Fund's Board, its various committee groups and other important Global Fund groups like the TERG, TRP and thematic work groups. Although we have not been able to assess country-level implications of COVID-19, we assume that virtual meetings for country-level activities, where feasible to arrange, are perhaps less productive than face-to-face meetings.

Finally, COVID-19 has also had a significant impact on global and national economies that may profoundly affect the level of funding commitments available in the immediate future. Massive layoffs and unemployment due to a virtual halt to all economic activity has put national treasuries in debt into the trillions of US dollars. And although major economies like France and Germany are beginning to 're-open', as of this writing, most economists predict that it will take years to reach pre-COVID-19 levels of GDP. Worse still, virologists and epidemiologists predict, in the absence of an effective vaccine, a second wave of COVID-19 infections that could be even worse in the Fall of 2020 and bring new orders for more economic and social lockdowns.

The Theory of Change that SR2020 used to guide its analysis hypothetically assumed that resources made available to address the three diseases and RSSH *would continue to rise in the future*. COVID-19 has forced us to re-evaluate that hypothesis. According to the Lancet article of July 13, the Global Fund Executive Director, Peter Sands, estimates that 'USD 28.5 billion is needed to fund an effective response to COVID-19 and prevent a potentially devastating impact on HIV, tuberculosis, and malaria in the highest-burden countries.'²⁴⁴ We now believe that the remaining two years of the current Strategy and, most likely, for the development of the next strategic cycle, the Global Fund should anticipate funding shortfalls and the most likely eventuality that it will not be able to reach previously anticipated resource mobilization and programmatic targets.

²⁴⁴ The Global Fund. Mitigating the impact of COVID-19 on countries affected by HIV, tuberculosis and malaria. June, 2020. https://www.theglobalfund.org/media/9819/covid19_mitigating_impact_report_en.pdf (accessed July 2, 2020).

ANNEX 4. XV: FUTURE STRATEGIC POSITIONING

This section presents findings from a forward-looking enquiry commissioned within SR2020 into how the Global Fund should position itself in the next strategic cycle. Twenty global health leaders (including, but not exclusive to Global Fund Board members) were asked to consider the future of the Global Fund based upon extensive knowledge of the organization. In order to provide data that support answers to SRQs 22, 23 and 24, particular areas of focus were in relation to how the Global Fund can strengthen implementation to meet its current Strategic Objectives, as well as complementarity between SDG, UHC and AMR objectives.

Given the wide range of individual opinions aired during the interviews, they have been organized around three composite themes. The aim of these themes was to illustrate the most prominent dimensions of strategic thinking about the Global Fund's future. While deliberately designed to show *contrasting* perspectives, no one theme is the exclusive preserve of a single constituency or respondent. The second part of this section draws on each of the themes *selectively* in order to develop a coherent narrative designed to help shape discussions about the next strategic cycle.²⁴⁵

These expert opinions and themes were used as a complimentary source of additional qualitative data to compare, contrast and triangulate against the evidence, findings and conclusions generated through the main body of work conducted under the SR2020.²⁴⁶

Overall messages for the three strategic themes

All respondents acknowledged the achievements of the Global Fund: as a vehicle for raising, managing and disbursing unprecedented funding for health and the consequent impact the Fund has achieved in reducing the burden imposed by the three diseases. The successful 2019 replenishment demonstrates continuing confidence in the partnerships the Global Fund has created and continues to nurture.

That said, the interviews revealed a sense of unease about the future even among strong supporters. Before looking at each of the strategic themes in more detail, three overarching messages emerged:

- **If not now, when?** There is a consensus that the Global Fund needs to change, but there remain deep and significant divisions as to the direction that change should take. These divisions – many of which are long-standing - make it difficult for the Global Fund to respond strategically to an evolving global landscape.

My answer to your question about how the Global Fund should change is that I am frustrated that it never will. It is trapped by inertia.

Can the Fund continue in this vertical way? Views are binary. I do not know if or when they will change.

- **An integral part of the global health architecture:** The Global Fund can no longer afford to see itself just as the central player in its own universe. Rather, the next strategy must define the Global Fund's role as part of a wider ecosystem of global health organizations at country and global level. Global health architecture in this sense should not be taken to indicate any kind of hierarchy or formal structure with strict divisions of labor. It is better understood as an increasingly dense and overlapping network of coalitions, relationships and alliances, which draw on the different strengths of the institutions involved.
- **Covid-19 has the potential to change everything:** The Global Fund has shown exemplary flexibility in its initial response to the pandemic and Covid-19 will continue to influence what

²⁴⁵ To avoid any doubt, the points made in the text that follows are not evaluation findings and are not based on strong triangulated evidence. They should be interpreted as a collection of emerging themes based on the views and opinions of global health leaders with expertise and knowledge of the Global Fund's work.

²⁴⁶ To support this process, the external consultant and SR2020 team have engaged to 'package' these themes and ensure alignment between the two bodies of work.

the Global Fund is asked to finance. In addition, there is already evidence of the damage caused as a result of Covid's impact on HIV, TB and malaria programs, which will require repair and rebuilding to avoid unnecessary losses. At a broader level, the current expenditure boom on health will, without doubt, be followed by financial consolidation affecting the economic position of *all* countries – donors and recipients. Equally, the pandemic has the potential to change how global organizations – in health and beyond – choose to work together to meet a systemic challenge of this magnitude.

At the time of writing (May 2020) there is still a massive degree of uncertainty about the eventual health, economic and political impact of the Covid-19 pandemic. It is equally clear that it will have a major influence on the process and content of the new strategy, and the period of implementation that follows. While this draft of the report will flag issues and implications where appropriate, a more detailed analysis will be needed later in the year.

The successful replenishment is not necessarily a good indicator of the future...the landscape is already changing and Covid-19 will change it further.

Theme 1: Clarify health systems strengthening

The role of the Global Fund in strengthening health systems is, and has always been, a divisive issue. It is seen as a prerequisite for long-term success and sustainability by some and as a distraction from the Global Fund's core mission by others. The only real point of consensus suggested by the interviews is that there is a need for greater clarity as to what the Global Fund does and how decisions on RSSH funding are reached.

The RSSH agenda has new urgency given Universal Health Coverage (UHC) has become the central strategic objective of many national health policies. While no respondents proposed that the Global Fund should take on the whole agenda, *"the Global Fund does not have the money to do HSS properly"*, stronger and more resilient health systems are central to the achievement of UHC and are of great concern to implementing countries.

Supporters argue that the Global Fund should therefore do more in health systems strengthening. Specifically, they argue that given the resources allocated to RSSH the Global Fund has a *"higher responsibility"* to countries beyond focusing on AIDS, TB and malaria (ATM). Others point out that if the Global Fund genuinely supports the Right to Health, then it is illogical to focus on three diseases alone. Taken to their conclusions both these positions would raise the profile of RSSH in the hierarchy of future strategic objectives.

Recognizing the divisiveness of the issue, however, most respondents support a compromise in which investing in RSSH is seen *primarily* as a means of achieving better ATM outcomes, with whatever externalities in terms of benefits to other programs and the health system as a whole can be achieved.

As the argument turns to what should be funded many supporters of the RSSH agenda are critical of the current situation. They suggest that headline figures of allocations to health systems strengthening give a misleading impression - noting, for instance, that most RSSH grants are actually spent on the supply of commodities. In addition, there remains a major gap between intent (as expressed for example in the Road Map and Information Document on RSSH) and current realities on the ground. The main part of the review and recent analyses by the TERG and TRP reinforce these views. RSSH interventions are planned with limited attention to context and the need for monitoring achievements. While over one-quarter of resources are spent on RSSH, reports suggest that even in the current funding cycle around two-thirds of grants provide systems support, mainly to disease specific programs, as opposed to systems strengthening. Further, around 80% of support for Human Resources for Health is actually requested for different forms of salary support for staff working on Global Fund supported programs.

There is no dichotomy between a broader approach to health systems strengthening and closer partnership with others. The dichotomy is between what is said and what is actually done in RSSH [and the partnership agenda].

The case against expanding work on RSSH has several elements. First, it is argued that the lack of clear metrics for measuring success reduces the Fund's accountability for results. Achievements in RSSH – it is said - can never be as clear cut as those in relation to reducing disease burden. This argument seems to have gained some momentum as a result of the debate about the Global Fund's role in UHC. Several respondents felt that the meaning and boundaries of what constitutes UHC are unclear and "woolly". If RSSH is one means by which the Global Fund *contributes* to the achievement of UHC, by extension, its meaning and boundaries will also be unclear and difficult to measure. Second, it is argued that the Fund was designed as a funding instrument and has neither the systems nor level of expertise in health systems strengthening, especially in areas in which sustained interaction with partners in country is required. A third line of argument is that more work on health systems is a distraction from the Global Fund's main purpose and detracts from its main value proposition in the eyes of its donors. The RSSH agenda in this view is seen as a zero-sum game rather than as a necessary means to achieving the Fund's strategic objectives.

The key question is whether we have achieved what we set out to do. To which the answer is no – particularly with regard to prevention.... The risk in broadening the agenda is not just the loss of focus on the three diseases per se, but also weakening the attention given to key populations.

.... there are lives at stake and broadening the focus puts all this at risk

The final line of argument is that it is widely assumed that an expansion of the RSSH/health systems strengthening agenda would result in a major loss of financial contributions to the Global Fund. In a sense this is the most compelling argument and explains why many respondents that might otherwise support a more ambitious RSSH agenda are prepared to compromise. Absent the potential loss of income, it would be reasonable to expect the Global Fund to revisit its strategy with regard to health systems strengthening in the light of new challenges at country level. Instead, the risk is that work on the new strategy merely rehearses familiar arguments while an effective gridlock inhibits a genuinely strategic response.

In conclusion, it appears unlikely that the divide about the Global Fund's role in health systems strengthening will be resolved in the next cycle. This suggestion may be proved wrong if Covid-19 exposes weaknesses in health systems even more starkly than other recent epidemics. It might also be proven wrong were the Global Fund to suffer a major loss of income (for which, in the words of one respondent, "*there is no Plan B*"). On a more positive note, however, several respondents point to the way forward given limited room to maneuver: greater clarity in terms of scope and outcome; a focus on major bottlenecks to service delivery; acknowledge the Fund's areas of greatest expertise; and work towards integration, at least across the three diseases. We return to these issues in Part 3 of the report.

Theme 2: Contingency, Context and Country Ownership

The second theme that emerges from interviews is that the Global Fund could do much better with the resources at its disposal. This issue was framed in different but complementary ways. For some it is seen as a need for a more agile, expert, data-driven and contingent approach to the design of interventions. This would entail a more granular understanding of disease epidemiology; a more rigorous analysis of context; better understanding of bottlenecks and obstacles to service uptake and delivery; stronger links between planning and disease control departments; and a more pragmatic approach to working with private entities (an issue on which the current strategy is silent). Others expressed the problem in terms of "*gaps*" in the current portfolio: doing more in the area of

community systems; increasing the focus on “weaker” countries; leveraging work on HIV/AIDS in support of noncommunicable diseases (NCDs); and better integration with reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services.

It is tempting, but misleading, to see this as a technical agenda linked only to efficiency of resource use. Many of the gaps and areas for improvement that were highlighted by respondents show an equal concern for reducing inequities in access and health outcomes; for doing far more in the cause of gender and human rights; and making greater use of the Global Fund’s comparative advantage in supporting key and vulnerable populations. Many noted, for instance, that one of the most immediate impacts of Covid-19 is to expose how health systems fail to address the needs of migrants and refugees.

There is an overlap with the health systems agenda, but most respondents see RSSH as a means to an end. Others go further and argue that the Global Fund would be better off just acknowledging its strengths in the procurement and supply of commodities.

Maybe the Global Fund is best at just providing inputs leaving strengthening to others. But it does need to be more honest about what it does and doesn’t do.

An element common to several respondents is the idea that the Global Fund should be more “prescriptive”. Support for “professionalizing” the Global Fund would, in this view, require hiring more technical specialists able to take part in country level program design and negotiation. Pursuing this logic would decrease reliance on traditional technical partners. A more contingent and context-specific approach suggests the role of the Technical Review Panel (TRP) as a judge of proposals could become redundant and even re-opens the question of the Global Fund’s country presence.

The TRP is part of the problem. If there is a proper dialogue in country it becomes redundant as it depends on the limited in-country knowledge of TRP members²⁴⁷.

The thread that binds this theme together is concern about the process through which proposals are developed and decisions are made as to what is funded. The main review highlights issues around value for money, gaps in the current portfolio, and other technical areas in which improvements are needed. However, if anything is going to change in the next strategic cycle a closer examination of the process and incentives that drive proposal development appears to be essential. The main thrust of a critique shared by many respondents is that the process is risk averse, inherently conservative and resistant to change. Completion of all the steps to secure a grant is complex and labor intensive. As a result, “no-one wants their proposal knocked back by the TRP”. Inevitably, fear of rejection favors “safe” proposals, similar in design to those that have received funding in the past (as pointed out in previous sections of this report).

The critique extends both to Country Coordinating Mechanisms (CCMs) and the Secretariat.

Despite current reforms, respondents stress that an insufficient number of CCMs are in a position to represent broader strategic interests as opposed to more specific departmental concerns in relation to the three diseases. Similarly, pressures on Global Fund staff to ensure that funds are disbursed – “to get the money out the door” remain strong and may increase given growing concerns about absorptive capacity.

Changing how the Global Fund works at country level is difficult. One of the Fund’s strengths is the ability to disburse money at country level and there is little appetite for making processes more complex or slowing down the flow of resources. It is also the case, as examples in the main part of the report have shown, that there are governments with a clear vision and the will to use resources as they think fit. However, they are the exceptions.

²⁴⁷ By contrast, another respondent defended the role of an offshore body like the TRP. From a CSO perspective an external arbiter was seen as being the only way of overcoming strong vested interests on the part of government CCM members.

The Global Fund is a machine. Examining how it works is hard and will be resisted. Few countries have the political will to stipulate what they really want.

Departing from accepted ways of doing business and opening the process of developing proposals in ways that are more responsive to country needs entails greater risk. The founding principle of the Global Fund was that it would respond to country-defined needs in ways that departed from most development practice in the late 1990s. It remains dedicated to the principle that countries should become increasingly self-reliant and in charge of their own destiny. A critique voiced by several respondents is that the current way of working is unduly risk averse and that discussions at Board level focus “too much on fiduciary risk, not enough on country context and programmatic issues”.

Everyone praises country ownership; all we do is [said to be] in alignment with country priorities. But is it really? We have no independent evaluation.

There are risks that we should never accept, but there are some risks we must take. We are being driven by donors who want to stick to the vertical as it reduces fiduciary risk.

Country ownership is a powerful principle but there is a risk that it is being devalued. An evident concern is that country ownership is used by the Secretariat to justify whatever is being done. “*The country ownership concept actually gives more power to the Secretariat*”. There is also an unspoken sense that some of the suggestions about the fund needing more professional staff and being “*more prescriptive*” come from a perspective that would seek to promote strategies and solutions determined by *external* expertise. From the comments made about the importance of self-determination clearly this would be counterproductive.

To conclude this theme, there is strong agreement that country ownership should remain a fundamental principle for the next strategy. A more data-driven, contingent and context-sensitive approach, drawing on the best available evidence and expertise, need not be inconsistent with ownership. Indeed, it needs to be seen as a way, not of undermining country ownership, but promoting and enhancing it. However, for the kind of changes that have been suggested here it will be necessary to address the political, institutional and financial incentives that drive current practice in the development and negotiation of proposals.

Several respondents acknowledged that the Global Fund’s leadership and governance recognized the challenge – but needed to bring the Secretariat with them. Change, it was suggested, will need a more fully independent evaluative function. As many noted the current system works well on its own terms and change will provoke resistance. Whether the shocks caused by the Covid-19 pandemic offer an opportunity for more fundamental reform or suggest even more reason for caution; time will tell.

Theme 3: Partnership revisited

The partnership model is fundamental to the Global Fund’s way of working. In most contexts, the Global Fund’s partners are defined as those organizations and agencies that help it achieve its objectives. This understanding of partnership is consistent with the idea that the Global Fund was designed purely as a financing body to raise and disburse funds and that implementation would become the responsibility of partners, chief among whom were national governments.

This expression of the partnership model has been the subject of extensive review including in SR2020. Reform has focused on strengthening the relationship with technical partners through contractual or quasi-contractual means such as memoranda of understanding, which reinforce accountability to Global Fund at the center of the network. While some respondents spoke positively about current arrangements, for others it remains a source of frustration both to the Global Fund

itself (“our biggest weakness is our partners”) and to some partner organizations (“the Global Fund doesn’t trust partners”).

Over time as the Global Fund has changed. Like many other organizations that started purely as funders, it has taken on many attributes of a program in its own right. Theme 3 is based on the idea that the Global Fund is also a partner and collaborator with other agencies and development partners in support of shared agendas and challenges. The most prominent examples are universal health coverage and global health security (most urgently, the response to Covid-19), but the list also includes anti-microbial resistance and climate change and the Global Fund’s contribution to the achievement of other Sustainable Development Goals (SDGs). In this expression of partnership, the Global Fund shares a broad analysis of global health challenges and a vision for their solution but acts as an independent agent as part of the overlapping coalitions and networks that make up the institutional architecture of global health. In other words, UHC does not become an objective in the next strategy *but acting within its own defined mandate* in partnership with others the Global Fund makes a significant contribution to countries efforts to achieve UHC.

The key strategic issue is for the Global Fund to strengthen its work on health systems but to do so as part of a more integrated approach alongside the other agencies involved in the Global Action Plan²⁴⁸.

We can’t deal with Domestic Resource Mobilization (DRM) as separate institutions.... change can happen as it has in the Bretton Woods Institutions. Health is behind the curve...but partnerships cannot be based on relationships in Geneva and Washington.... they must be at country level and led by countries.

The Global Fund-centric and the Global Fund-in coalition expressions of partnership are both necessary, but the former tends to win out at the expense of more collaborative behavior. The Global Fund is perceived in many countries as being primarily concerned with the design and disbursement of its own grants rather than being willing to invest the time and energy in working more closely with others. This was described by some respondents as a cultural issue and - linked to the way institutional incentives operate (as discussed in Theme 2) - is obviously not an exclusive characteristic of the Global Fund. There is also a growing body of work at country level (in part linked to the Global Action Plan) that shows new and practical approaches to collaboration at country level (notably between the Global Fund and World Bank). To date, however, these countries are the exception.

After all these years we should be talking about one or two places that are doing exceptionally badly, not one or two places that are doing well.

Collaborative partnership is particularly important in relation to sustainability, transition and co-financing. While the Covid-19 pandemic will impact on the Global Fund’s approach to transition, respondents note (as in the quote above) that the transition from external to domestic financing for health should not be tackled on an agency by agency basis or program by program. Rather, transition needs to be seen in terms of the financing (and financial management) of the entire health sector.

Managing transition and ensuring sustainability will be more challenging as a result of the pandemic. As part of the immediate response to the Covid-19 we are seeing an unprecedented willingness to spend large amounts on health. At the time of writing, much of this new and re-purposed expenditure is being spent on supporting efforts to reduce the impact of the disease on

²⁴⁸ The Global Action Plan is an initiative of 12 multilateral agencies led by WHO that play significant roles in health, development and humanitarian responses. Its objective to enhance collaboration among the 12 agencies to accelerate country progress on the health-related SDG targets.

population health. It is equally evident, however, that the collateral damage to health in many low-income countries – through foregone care, absence of staff and services, fear of infection, hunger and reduced mobility under lockdown – is going to be as, or even more serious, than the impact of Covid-19 itself. Moreover, countries are going to have to face the challenge of rebuilding damaged health care systems and services at a time when the current expenditure boom is superseded by a serious revenue crunch. In past crises when fiscal contraction occurs governments cut health and social welfare first. To help countries navigate the coming turmoil solidarity, clarity of purpose and partnership among all development partners is going to be essential.

Towards the next strategic cycle overview

While respondents raised many critical points, it is important at the outset to reiterate that the Global Fund has been a major force for good in global health. It has raised resources on an unprecedented scale thereby augmenting the efforts of national authorities, civil society and other development partners in reducing the burden of the three diseases. The Global Fund retains the confidence of those donors who see it as a safe investment and an efficient way of securing value for money from scarce aid budgets.

The landscape for global health is changing. The 2019 replenishment was successful but depended in the words of one respondent “*on the usual suspects*”, implicitly raising the issue of how to broaden the donor base and how to accommodate the demands of any new contributors in the way the Fund operates and is governed. Even among existing constituencies, the enquiry points to long-standing tensions about the need for change, and frustrations that a more strategic response to new challenges remains elusive.

The way ahead for countries and international health organizations is fraught with uncertainty. What the pandemic means for the work of international partnerships is still unclear: a major shock to the whole system or a reason for more cautious and evolutionary change? The enquiry does however suggest that the changes needed to make the Global Fund a more effective and collaborative partner may be easier to bring about than overcoming deep-set divisions about the Global Fund’s role in strengthening health systems.

This part of the report draws on the three themes to construct a narrative to help guide the development of the next strategy. Each part of the narrative is divided into points of principle followed by practical steps. At this stage, the practical steps are purely illustrative, and do not constitute recommendations.

Health security and universal health coverage

Principles

- **The next strategy needs to consider the role of the Global Fund as an integral part of an ecosystem of global health organizations.** The Fund is a significant actor in a wide range of overlapping partnerships, coalitions and alliances. In the face of the direct and collateral damage resulting from the Covid-19 pandemic, effective global and national partnerships to help countries achieve universal health coverage and health security will be vital.
- **Health security is not just about preventing pandemics. It is about preventing pandemics from increasing mortality from all other causes.** From its experience of AIDS, TB and malaria – health crises with profound economic and political consequences, the Global Fund has the potential to be a thought leader bridging divides in thinking about universal health coverage and health security.
- **The Global Fund is a major contributor – working within its own areas of expertise - in helping countries achieve universal health coverage and health security.** In this regard health security and UHC do *not* become strategic objectives in their own right but neither does this principle

argue for business as usual. Rather, it requires the work of the fund within its specific mandate to respond more effectively to a set of higher-level strategic goals and objectives linked to UHC and health security as defined by countries.

Practical steps

Maintain the primary focus on AIDS, TB and malaria outcomes, but review interventions through the UHC lens of financial security, access to needed services, and, particularly, leaving no-one behind. Continue to shift the focus of the Global Action Plan and the Health Financing Accelerator to country level – with a strong feedback loop to agency headquarters to encourage learning and adaptation. Expand current work on joint financing and the use of common performance indicators started with the World Bank and set out in the recent Global Fund-World Bank memorandum of understanding. Support domestic resource mobilization and transition from external funding in collaboration with other partners as a sectoral rather than disease or program-specific issue. Use the global voice and experience of the Fund to caution against further fragmentation of support to countries, particularly in the response to the pandemic (another area for thought and policy leadership)

Health systems strengthening

Principles

- **The primary objective of the RSSH agenda should be to support the achievement of AIDS, TB and malaria outcomes in ways that respond to country-defined needs.** The agenda should focus on core Global Fund strengths and program, not seeking to be open-ended or cover all aspects of health system strengthening.
- **Countries have different needs and there is strong support for a more contingent and context-specific approach in the area of health systems strengthening.** However, the *default* mode for RSSH interventions should be to promote the integration of disease-specific programs into resilient, integrated national systems.
- **Communicate the RSSH agenda in ways that better acknowledge the Fund's focus, expertise and achievements.** A major effort is required to bridge the gap between what is said and what is done by the Global Fund in the field of health systems strengthening. Greater clarity in this regard opens the space for other partners and helps countries define needs that are currently not being adequately addressed.

Practical steps

Define and make public a limited set of RSSH focus areas in which the Global Fund has particular strengths and expertise (e.g. procurement and supply management; community systems; reaching key and vulnerable populations, management information, community systems). In line with a more contingent approach, support outside focus areas may be needed, particularly if carried out in collaboration with other partners and monitored in terms of overall system performance. In line with the partnership agenda continue to identify ways in which the Global Fund contributes to the global effort to combat AMR and to make health systems environmentally sustainable.

Responsiveness and collaboration

Principles

- **Country ownership should remain a fundamental operating principle of the Global Fund.** However, the concept of ownership needs to be re-assessed: to ensure that countries are genuinely in control and that the needs of disease-specific programs are understood in their wider political, economic, social and institutional context.
- **The process through which proposals are developed and funding decisions are made needs to be more open to scrutiny and independent evaluation.** A more data-driven, expert and

contingent approach to achieving better and more equitable outcomes needs to be seen as a way of strengthening and not undermining country ownership.

- **A more responsive and collaborative Global Fund needs to revisit the trade-off between the management of operational and fiduciary risk.** At present Board discussions are stacked too often in favor of minimizing fiduciary risk in order to maintain the confidence of financial contributors.

Practical steps

Several respondents noted that this agenda underpins the success of the other two and that the changes required are more “*cultural*” than technical. SR2020 offers many insights into both the strengths and shortcomings of the current business model. To advance this agenda, the processes (structures, systems and incentives) that act at country and Secretariat level, and which determine what is funded and how the Global Fund is perceived as a collaborator, must be more open to scrutiny and independent evaluation.

ANNEX 5: THEORY OF CHANGE TABLES BY MODULE

The ToC is underpinned by a series of underlying assumptions that we have considered using the Context Mechanism Outcome (CMO) framework. The following tables set out the various mechanisms (i.e. resources, policies and processes, partnerships) of relevance to each module, and the contextual factors required to be in place for the intended outcomes to be achieved.

MODULE 1: IMPACT

This module does not have a CMO table as this is considered as the end point in the TOC. Rather, the hypotheses from each the other modules seek to test whether, why and how impact is being achieved.

MODULE 2: EFFICIENCY AND EFFECTIVENESS

Module 2: Economy/efficiency		In scope
The Global Fund Partnership enables the implementation of grants that balance VfM (i.e. economy, efficiency, effectiveness, equity & sustainability) considerations		
Context		
<ul style="list-style-type: none"> Funding environment remains stable, with donors and countries fulfilling funding commitments Political economy, governance and country capacity enable countries/partners to efficiently implement programs as per the Grant Agreement/NSP leading to effective disease response The Global Fund Secretariat is committed to enhancing efficiency including country experiences of accessing and implementing Global Fund resources 		<ul style="list-style-type: none"> Yes, inc. via Mod3 Yes Yes, inc. via Mod3
Assumptions linking context to mechanisms		
<ul style="list-style-type: none"> Governance, systems capacity and economics are supportive of VfM in purchasing within and outside PPM, and this is likely to be sustained post-transition (SRQ 11, 18) Countries select the best VfM disease interventions & accompanying technologies - optimally distributing resources at an impactful yet sustainable scale across a range of interventions, population groups and sub-national geographies (i.e. taking equity into consideration) to maximize health impact (SRQ 10, 21, 6R) There is VfM in use of technologies at the service delivery level (SRQ 11, 13 & 20, 14) Initiatives to increase grant absorption have increased absorption and led to higher quality and impactful programs in countries 		<ul style="list-style-type: none"> Yes Yes Yes Yes
Mechanisms		
<ul style="list-style-type: none"> The MSS's 7 implementation tools are deployed appropriately Partnership arrangements are in place to co-ordinate supply side interactions When health technologies are procured with domestic finance (including as part of co-payment and/or transition planning) mechanisms are in place to identify risks, mitigate risks (e.g. Strategic Initiatives), and manage risks to sustaining market shaping efforts and VfM The evidence, tools, normative guidance and partner advice – as well as Global Fund mechanisms (e.g. CCM, partner and CT dialogue, TRP, Strategic Initiatives) – support optimal intervention choice, scale, population/geographic targeting, in particular for: i) trade-offs when budgets are insufficient to cover all potentially cost-effective interventions and/or technologies; and ii) decisions on piloting or scaling up new technologies and to transition to new technologies where appropriate, considering budget constraints, equity and sustainability Quality medicines are available at service delivery level (e.g. supply chains functioning) and cost-optimized machines are well utilized (maintenance, cartridges, renovation costs are 		<ul style="list-style-type: none"> Yes Yes, inc. via Mod5 Yes Yes, inc. via Mod5 Yes

Module 2: Economy/efficiency		In scope
budgeted for and available. Machines are rationally placed, sample transport is functioning) • Effective LLINs are utilized (LLINs are aligned with user preferences and are used. Type of LLIN is aligned with pyrethroid resistance patterns to ensure impact). IRS is appropriately deployed. • (NB: SRQ14 can also provide information on whether and how investment choices in human resources, data and lab systems have been funded for optimal impact.) • Mechanisms to enhance absorption include: qualitative adjustment process applied to the allocation methodology, which adjusted for country absorptive capacity; differentiated funding request and grant making processes; more detailed analysis of absorption through PU/DR reporting; more frequent reprogramming; introduction of portfolio optimization; strategic reporting of absorption through KPI 7; more active balancing of financial and programmatic risk considerations; engagement of partners, including through disease situation rooms, to identify and address bottlenecks to program implementation; targeting of RSSH support to financial management capacity building; program management arrangements; etc.		• Yes • Yes, inc. via Mod4&5
(Intermediate) Outcomes		
A. Global Fund grants offer VfM, which makes a meaningful contribution to the achievement of the long-term outcomes and impact (i.e. the Strategic Objectives)		A.
Assumptions linking mechanisms to (intermediate) outcome A		
• Global Fund initiatives to enhance grant absorption lead to higher quality and impactful programs in country. • Global Fund grants are designed, based on best available evidence and in unison with other program resources, to optimally distribute resources across a range of interventions, population groups and sub-national geographies to maximize health impact, in practice and according to country context. • The Global Fund's procurement and market shaping efforts contribute to the VfM of Global Fund investment and these gains are likely to be sustained post-transition.		• Yes • Yes, inc. via Mod3 • Yes

MODULE 3: FUNDING MODEL

Module 3: Funding Model		In scope
Hypothesis: The mobilization of international funding and the differentiated Funding Model's policies and processes ensure resources are allocated and disbursed to countries appropriately. The design and implementation of grants enables increasingly efficient and effective investments		
Context		
• The funding environment for the three diseases remains stable, with donors and countries fulfilling funding commitments • The Global Fund Secretariat is committed to enhancing efficiency including country experiences of accessing and implementing Global Fund resources		• Yes • Yes
Assumptions linking context to mechanisms		
• Global Fund resource mobilization is successful in securing funding for AIDS, TB and Malaria • Global Fund Secretariat resources and capacities enable continuous improvements to operational policies and processes		• No • Indirectly
Mechanisms		
• Secretariat define cross-country allocation for optimal distribution across the portfolio • Secretariat defines ceiling amounts in a country allocation letter and suggests in-country disease split, differentiated by need • Catalytic funding is available to incentivize country allocations in support of the Strategic Objectives including RSSH, human rights, gender equality and KVPs • National-led inclusive country dialogue processes (as part of funding request development) support alignment of Global Fund resources with country need, based on national health		• Yes • Yes • Yes • Yes

Module 3: Funding Model	In scope
<ul style="list-style-type: none"> and disease plans, and the meaningful participation of disease, key populations, RSSH and gender constituents Global Fund guidance and TRP review processes support funding request development in line with Strategic Objectives (including RSSH, human rights and gender equality) Country Team engagement during the country dialogue, funding request development process and grant making, support the Strategic Objectives and drive impact Differentiated processes exist for funding request, TRP review, approval and grant making processes, and for COE countries Policies and processes (e.g. Grant Making, TRP review, GAC approval) are in place to ensure funds are available to ensure timely grant start up Annual funding decisions are made during implementation, based on grant ratings Grant revisions and portfolio optimization facilitate the recalibration of grants during implementation 	<ul style="list-style-type: none"> • Yes, inc. Mod 2 • Yes • Yes • Yes • Yes, inc Mod 4 • Yes, inc Mod 2
(Intermediate) Outcomes	
<ul style="list-style-type: none"> The role of partners facilitates and enables grant implementation Global Fund grants offer VfM, which makes a meaningful contribution to the achievement of the long-term outcomes and impact (i.e. the Strategic Objectives) 	<ul style="list-style-type: none"> • Mod 5 • Mod 2
Assumptions linking mechanisms to (intermediate) outcomes	
<ul style="list-style-type: none"> The Global Fund's country allocation and suggested disease split is appropriate Countries are motivated to leverage catalytic funding and design/implement catalytic interventions including for RSSH, KVPs and human rights and gender Country dialogue processes involve disease, KVPs, RSSH, human rights and gender constituents which ensure appropriate interventions are reflected in grant design funding requests are evidence-based and reflect country priorities and needs based on relevant national plans funding requests use available guidance and Global Fund review processes to ensure the most appropriate interventions are implemented to support the Strategic Objectives, address structural barriers and drive impact Differentiated approaches ensure countries spend less time getting to grant signature and more time implementing grants, enabling scaled up service delivery and impact Annual funding decisions based on grant ratings free up funds to be reallocated Grant revisions and Portfolio Optimization enable rapid and continuous reinvested of grant resources to support high impact interventions, Strategic Objectives, and country outcomes. Partners provide appropriate support to grant design processes and grant implementation. 	<ul style="list-style-type: none"> • Yes • Yes • Yes • Yes • Yes, via Mod 2 • Yes, via Mod 2 • Yes • Yes, via Mod 2 • Yes, via Mod 5

MODULE 4: GRANT OVERSIGHT, M&E AND RISK MANAGEMENT

Module 4: Grant oversight, M&E and risk management	In scope
Hypothesis: Where there is sufficient stakeholder commitment and capacity, appropriate M&E, oversight and programmatic assurance systems and processes work to enable and ensure efficient and effective Global Fund investments	
Context	
<ul style="list-style-type: none"> Countries are willing and able to meet Global Fund M&E reporting requirements, and have sufficient capacity to meet oversight and assurance requirements The Global Fund Secretariat is committed to generating and using quality M&E data to inform strong oversight and assurance functions 	<ul style="list-style-type: none"> • No • Yes
Assumptions linking context to mechanisms	
<ul style="list-style-type: none"> Global Fund investments in RSSH are successful in building capacity to meet M&E, oversight and assurance requirements 	<ul style="list-style-type: none"> • No • Yes

Module 4: Grant oversight, M&E and risk management		In scope
<ul style="list-style-type: none"> Global Fund Secretariat has capacity to inform, and countries are willing to allow, program revisions and/or course correction based on analysis of M&E data and through other oversight and assurance processes 		
Mechanisms		
<ul style="list-style-type: none"> The suite of KPIs are designed to accurately and comprehensively report on progress towards the Global Fund Strategic Objectives Service coverage targets are designed and set to be realistic (i.e. in light of resource availability and country capacity to implement) but also to incentivize performance The M&E data generated through program monitoring and evaluations/reviews is used to enable effective oversight and program assurance functions The systems, processes and stakeholders in place to monitor, oversee and assure grant implementation are appropriate and fully functioning across all countries within the Global Fund portfolio Programmatic assurance measures and processes seek to consider any trade-off decisions between mitigating fiduciary and programmatic risk to enable the maximization of impact Clear guidance is provided to country stakeholders on what M&E and other data is required and when, as well as on how to collect, collate and report this information Global Fund Partners engage to support M&E, oversight and assurance functions, in line with Global Fund policies, processes and guidance Annual funding decisions are made during implementation, based on grant ratings The generation and use of M&E data support and enable a culture of learning within the Secretariat 		<ul style="list-style-type: none"> Yes Yes Yes Yes Yes No Yes, via Mod 5 Yes Indirectly
(Intermediate) Outcomes		
<ul style="list-style-type: none"> Global Fund grants offer VfM, which makes a meaningful contribution to the achievement of the long-term outcomes and impact (i.e. the Strategic Objectives) 		Mod 2
Assumptions linking mechanisms to (intermediate) outcome		
<ul style="list-style-type: none"> Data quality and currently available tools are sufficient to enable accurate reporting against grant targets across different country contexts (e.g. COEs), such that this can be accurately aggregated up to report on progress towards Strategic and Operational Objectives at the global level Service coverage targets act as strong incentives to perform well at the country level and are appropriate relative to total disease program resources The burden of reporting M&E data on country stakeholders is manageable (i.e. not prohibitively high) Sufficient information is available to the Secretariat to make informed decisions on how best to balance fiduciary and programmatic risk considerations. 		<ul style="list-style-type: none"> Yes Yes Yes, via Mod 2 Yes

MODULE 5: PARTNERSHIPS

Module 5: Partnerships		In scope
Hypothesis: Global Fund partners are motivated to provide appropriate quality and quantity of technical support for grant design, implementation and the achievement of the Strategic Objectives		
Context		
<ul style="list-style-type: none"> Ambitious global targets and recent unprecedented volumes of financial resources generated for ending the epidemics requires a significant effort by the Global Fund partnership to support programs that deliver maximum impact Ending the epidemics within the broader (SDG3) environment requires new collaborations and partnerships 		<ul style="list-style-type: none"> Yes Yes
Assumptions linking context to mechanisms		
<ul style="list-style-type: none"> Partners have capacity to step up support to translate funding into high impact programs The Global Fund leadership and Board is supportive of evolving the partnership further to address the epidemics in the context of SDG3 		<ul style="list-style-type: none"> Yes Yes, via Mod 7 Indirectly

Module 5: Partnerships		In scope
<ul style="list-style-type: none"> The Global Fund Secretariat has capacity and is committed to managing partner inputs/ contributions in support of the Strategic Objectives 		
Mechanisms		
<ul style="list-style-type: none"> Strategic Cooperation Frameworks between the Secretariat and some technical agencies set out scope of partnership responsibilities with action-oriented matrices. Partnership Engagement Initiative also exists to strengthen aspects of the Global Fund Partnership Strategic Initiatives for TA work to address gaps and support the operationalization and achievement of the Strategic Objectives Disease situation rooms at global level exist to coordinate partner support to NSPs, funding requests, bottlenecks in funding and implementation of grants Global Fund partners support the development, implementation and monitoring of national disease and/or health plans Global Fund partners engage in country dialogue and funding request development processes and support evidence-based design of grants aimed at achieving the Strategic Objectives (including RSSH and human rights and gender equality) and maximum impact Global Fund partners engage to support the STC Policy, processes and guidance (e.g. transition preparedness) and to leverage domestic resources and other commitments necessary for financial and programmatic sustainability Global Fund partners engage to support the integration of the three diseases into equitable and sustainably delivered health services Global Fund partners engage to support capacity building of country entities in policy, technical, programmatic areas CCMs, technical working groups, PRs, Country Teams and other partners support the oversight and implementation of grants and the achievement of Strategic Objectives and country outcomes 		<ul style="list-style-type: none"> Yes Yes Yes Yes Yes, via Mod 2/3 Yes, via Mod 6 Yes, via Mod 6/7 Yes Yes, via Mod 4
(Intermediate) Outcomes		
<ul style="list-style-type: none"> Global Fund grants offer VfM, which makes a meaningful contribution to the achievement of the long-term outcomes and impact (i.e. the Strategic Objectives) Strengthened country commitment to sustainable epidemic responses and successful transition towards full domestic financing Countries are moving towards integrating HIV, TB and malaria services into equitable and sustainably delivered packages within health services 		<ul style="list-style-type: none"> Mod 2 Mod 6 Mod 7
Assumptions linking mechanisms to (intermediate) outcomes		
<ul style="list-style-type: none"> Partnership Strategic Cooperation Frameworks and Initiatives based on mutual accountability and centered on achieving country outcomes work as intended at global and country levels Partners are motivated to support the design, oversight and implementation of grants to deliver maximum impact Partners have the required capacity to delivery and sustain high quality and relevant support aimed at furthering the Strategic Objectives and country outcomes Partners coordinate/collaborate to ensure support is country driven and harmonized Opportunities for collaboration and synergies with partners and other entities centered on country outcomes are maximized 		<ul style="list-style-type: none"> Yes Yes Yes Yes Yes

MODULE 6: SUSTAINABILITY, TRANSITION AND CO-FINANCING

Module 6: Sustainability, Transition and Co-Financing		In scope
Hypothesis: STC Policies, procedures, and practices sufficiently support countries to strengthen financial and programmatic sustainability, including enhancing domestic resources for health and the three diseases, across the Global Fund portfolio (including in transition and non-transition contexts)		
Context		
<ul style="list-style-type: none"> Global economic prosperity and sustained growth continues, including in Middle Income Countries (MICs) and Lower Income Countries (LICs) 		<ul style="list-style-type: none"> No Yes

Module 6: Sustainability, Transition and Co-Financing		In scope
<ul style="list-style-type: none"> The three diseases remain relevant priorities (epidemiological and political) for host country counterparts Countries are willing and able to increase domestic funding for health and the three diseases 		<ul style="list-style-type: none"> Yes
Assumptions linking context to mechanisms		
<ul style="list-style-type: none"> Global Fund policies, processes, practices, and guidance leverage countries to prioritize the three diseases The Global Fund Secretariat has sufficient capacity to engage at the country level with relevant counterparts Global Fund investments in RSSH are successful in building capacity and systems to enable programmatically sustainable responses 		<ul style="list-style-type: none"> Yes No Yes, via Mod 1,3
Mechanisms		
<ul style="list-style-type: none"> Clear guidance is provided to country stakeholders on what the STC Policy and other related policies, processes and guidance requires/requests of countries, over what time horizon, and as the Global Fund transitions out of countries The Funding Model encourages/incentivizes countries to use Global Fund/other resources to invest in activities that improve prospects for sustainability and transition Funding requests include RSSH and other support to build country systems and capacity, and clear commitments by countries related to sustainability and transition Global Fund partners engage to support the application of the STC Policy and related policies, processes and guidance (e.g. through Transition Readiness Assessments) The Global Fund Secretariat and partners engage with a range of stakeholders in country (e.g. parliament/legislative bodies, ministries of finance, etc.) to leverage domestic resources and other commitments to build and ensure long-term sustainability 		<ul style="list-style-type: none"> Yes Yes, via Mod 3 Yes, via Mod 3 Yes, via Mod 5 Yes
(Intermediate) Outcomes		
A. Global Fund grants offer VfM, which makes a meaningful contribution to the achievement of the long-term outcomes and impact (i.e. the Strategic Objectives)		<ul style="list-style-type: none"> Mod 2
B. Countries are able to improve their capacity to sustain programs, partners and systems over time		<ul style="list-style-type: none"> Mod 6
Assumptions linking mechanisms to (intermediate) outcome A (i.e. Module 2)		
<ul style="list-style-type: none"> Trade-offs between achieving short-term impact and longer-term sustainability are considered by stakeholders when designing and implementing Global Fund grants Data quality and currently available tools are sufficient to enable accurate reporting on progress towards sustainability and transition objectives 		<ul style="list-style-type: none"> Yes Yes, via Mod 4
Assumptions linking mechanisms to (intermediate) outcome B (i.e. Module 6)		
<ul style="list-style-type: none"> Countries have sufficient capacity to manage risks and sustain programs, partners and systems as they transition away from Global Fund support As countries transition away from Global Fund support, funding streams specific to the three diseases are integrated into the broader health system Support for non-state providers of health services is maintained following Global Fund transition Services for KVPs are maintained following Global Fund transition 		<ul style="list-style-type: none"> Yes Yes Yes Yes

MODULE 7: SYNTHESIS AND FUTURE POSITIONING

Module 7: Synthesis and Future Positioning		In scope
Hypothesis: Sufficient country resources, policies, procedures and capacity are in place to ensure that countries strike the right balance of investments between disease-specific programs and strengthening health systems as countries move along a health systems development continuum towards UHC.		
Context		
<ul style="list-style-type: none"> Evolving and competitive funding environment among health and development organizations Competing donor, partner and country expectations about how to move along a development continuum towards UHC. 		<ul style="list-style-type: none"> Yes Yes
Assumptions linking context to mechanisms		

Module 7: Synthesis and Future Positioning		In scope
<ul style="list-style-type: none"> • The Global Fund Funding Model is fit-for-purpose with respect to funding RSSH and a movement towards UHC • Global Fund resource mobilization efforts are successful in securing an appropriate level of funding and multi-stakeholder engagement for strengthening health systems to integrate HIV, TB and malaria services. • Countries are willing and able to implement strategies that prioritize integration of services. 		<ul style="list-style-type: none"> • Yes • Yes • No
Mechanisms		
<ul style="list-style-type: none"> • National-led country dialogue processes identify and allocate Global Fund resources to strengthen health systems and maintain the meaningful participation of key populations and gender constituents during proposal development and grant implementation. • Global Fund guidance, TRP review processes and Country Team engagement ensure that sufficient resources are allocated to health systems strengthening including, among others, integrated service delivery within the three diseases and with other related areas such as RMNCAH and SRH. • Differentiated processes (funding request, TRP review, approval and grant making processes) provide the necessary flexibility for countries to tailor their RSSH activities along a national plan built to achieve UHC. • Global Fund policies, procedures and partner support enhance the efficiency and effectiveness of disease-specific investments while simultaneously striving towards greater integration and strengthening of services and health delivery systems. 		<ul style="list-style-type: none"> • Yes • Yes • Yes, inc via Mod 3 & 6 • Yes, inc via Mod 3
(Intermediate) Outcome		
<ul style="list-style-type: none"> • Efficient, effective and equitable integrated service delivery improves program outcomes and provides lessons on how to strike the right balance between disease-specific investments and health systems strengthening. 		Yes
Assumptions linking mechanisms to (intermediate) outcomes		
<ul style="list-style-type: none"> • The Global Fund's country allocation methodology and global disease split adequately considers health system needs, with sufficient funds available to pursue the necessary strengthening to allow for the integration of services, including SRH. • Sufficient evidence is available to countries on what works to allow for informed and evidence-based decision making for health systems development investments. • The country dialogue process adequately incorporates long-term sustainability planning for disease-specific health services integration. • Global Fund Partners provide strong technical advice on sustainability and integration objectives • Community systems for prevention, treatment and care are adequately resourced and included in national plans for UHC. • Country experience demonstrates smooth integration of disease programs into comprehensive service delivery packages while maintaining the achievement of strategic objectives. 		<ul style="list-style-type: none"> • Yes, inc via Mod 3 • Yes, inc via Mod • Yes, inc. via Mod 6 • Yes, inc via Mod 6 • Yes, inc via Mod 3

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ANNEX 7: COUNTRY SUMMARY REPORTS

The country summary reports have not been published.