End-Term Strategic Review (2017-2022)

Country Case Studies Appendix

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CONTENT

This appendix includes 14 case study reports conducted as part of SR2023: Bolivia, Chad, Côte d'Ivoire, India, Kenya, Kyrgyzstan, Nigeria, Mozambique, Pakistan, Philippines, Sierra Leone, South Africa, South Sudan and Zambia.

Methods for the country case studies are described in the SR2023 Report Appendix C.2.

1. BOLIVIA CASE STUDY REPORT

1.1. INTRODUCTION

1.1.1. Key country characteristics and HTM context

Bolivia is a country located in Central South America, southwest of Brazil, with just over 12 million people (in 2023), and a multi-ethnic population including people of indigenous, mixed (mestizo), European and African origins. Bolivia is classified as a low-middle income country, with a GDP per capita of US$3,133.1 (in 2021)[1]. Between 2017 and 2022, the country experienced a series of challenging political events including contested general elections in 2019 and a change of government. This led to political instability, exacerbated by an economic recession due to declining revenues from falling natural gas prices and the effects of the COVID-19 pandemic.

Over the last two decades, there have been modest increases in government investment in health. During the 2017-2022 period, domestic general government health expenditure increased from 4% GDP to 6% (2021), equivalent to a rise in US$ 146 per capita to US$ 197 (2021).[2] Efforts have also been made to consolidate the National Health System (SNS) capacity, which is currently structured on three-tiered basis (local, departmental and central), with a capacity of 4,212 health facilities, 3471 health facilities from de public subsector, 258 from the Social Security subsector and 483 from the private subsector.[3] To consolidate its operations and promote a more comprehensive vision in the management of endemic and epidemic stakeholders, the Ministry of Health and Sports (MoH) restructured the General Directorate of Epidemiology by bringing TB, HIV (part of the National Program for Infectious Diseases) and Malaria services (part of the Program for Vector-borne Diseases) under a new Disease Prevention and Control Unit.[4]

Despite these efforts, progress on the three diseases, HIV, TB and Malaria has been limited, especially for TB. The country has one of the highest TB incidences in the Americas, only surpassed by Haiti and Peru in 2020.[5] The disease incidence is 109 per 100,000 with a mortality of 15 per 10,000 for 2021, with 7,071 new cases of TB reported and 4,811 successfully treated.[6] Bolivia faces a concentrated HIV epidemic, with a low prevalence (0.30%), incidence (0.12 per 1000) and mortality (4 per 100,000) in the general population of as of 2021, but much higher figures among key populations (e.g., prevalence was 25.7% in men who have sex with men (GB-MSM) groups and 30.8% in transgender women in 2021). Malaria incidence is of 272.4 per 100,000 in 2021, and 9,959 cases treated for the same period.[7] In the country, malaria particularly affects the population of the Amazon, in the departments of Beni, Pando and the north of La Paz, with circulation of Plasmodium falciparum and Plasmodium vivax.

1.1.2. Summary of Global Fund support

Boliva is classified as a Global Fund Focused country. At present, two Global Fund grants totalling US$20.3 million are active in Bolivia (GC6) (for malaria and HIV/TB), a decline from GC5 (US$31 million) and GC4 ($29 million).[8] The United Nations Development Program (UNDP) is the PR for both the malaria and HIV/TB grants. Differentiated ART service delivery and HIV care are the largest investments in HIV/TB, while active case detection and investigation constitutes the largest investment in malaria.

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[1] Global Fund (2022). Funding Request HIV/TB and internal documents (confidential)

[2] WHO Global Health Expenditure Database. https://apps.who.int/nha/database/ViewData/Indicators/en. Latest data available.

[3] Bolivia Plurinational State National Health Information System, SNIS, 2023.

[4] Ministerio de Salud y Deporte de Bolivia (2023). Sistema Nacional de Información en Salud-Vigilancia Epidemiológica. https://snis.minsalud.gob.bo/. Consulted September 25, 2023.

[5] Based on Global Fund internal documents (confdintial)

[6] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State).

[7] Communication from National Malaria program

[8] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State).

HIV/TB. Bolivia's HIV response is implemented through nine Departmental STI/HIV/AIDS Programs that are responsible for 11 Departmental and Regional Surveillance, Information and Reference Centres (CDVIR/CRVIR), which offer diagnosis and treatment services. Community services supporting primarily specific services for key populations, are financed entirely by the Global Fund; these incorporate primary and secondary prevention actions aimed at different key populations (gay, bisexual, and men who have sex with men (GB MSM), transgender people (TG) and sex workers (SW)). Services supported through the Global Fund HIV/TB grant include differentiated ART service delivery and HIV care (21% of the HIV/TB budget), behaviour change (16%), routine reporting (15%) and TB care and prevention (10%).

Malaria. Bolivia entered the malaria pre-elimination phase in early 2019, and GC6 (2020-2022) malaria allocation was increased compared to GC5 to support pre-elimination efforts. Global Fund support particularly focuses on strengthening of community-based interventions, including revitalization of the volunteer network (discontinued in 2019), and a pilot technical-operational unit in the priority area of Riberalta, which will conduct epidemiological surveillance, micro-stratification for decision-making, and develop a basic package of activities to support the volunteer network.[9] LLINs, facility based treatment and IRS are included in the GF-supported grant. The activities financed by the Global Fund cover approximately 25% of the needs throughout the country and have been implemented within the framework of complementary resources to the national malaria strategy.[10]

The majority of Bolivia's HIV, TB and malaria response is domestically financed with heavy reliance on the Global Fund as the major external funder for the three diseases.[11] Nearly all external malaria and tuberculosis funding and 74% of external HIV financing is through Global Fund support.

1.2. KEY FINDINGS

1.2.1. Relevance of Global Fund investments

Global Fund investments are said to be highly relevant in Bolivia and greatly contributing to strengthening the country HTM response, especially in a limited donor landscape and funding constraints. Stakeholders consider Global Fund investments support evidence-based interventions which are relevant and responsive to address national needs and priority actions to progress against HIV, TB and malaria. Although domestic funding has made up the majority of investments for HTM in the country over the last decades, funding from the Global Fund still represents considerable support for essential service delivery especially for malaria, as outlined above. The absence of other significant donors for the three diseases further increases the importance and relevance of Global Fund investment in the country.

Several stakeholders mentioned that Global Fund investments have allowed the implementation of interventions that would have been difficult to implement without this funding, especially given current funding constraints in the country. Examples highlighted included the implementation of the Information System SIMONE, described as highly relevant to enable better follow-up of HIV treatment schemes, support for activities which would not be funded in the absence of the Global Fund such as combination prevention actions in KPs including access to HIV screening tests and prevention supplies.[12] For TB, support in strengthening laboratory diagnostic tests, and malaria support with community volunteers for follow-up were highlighted as particularly relevant. Stakeholders shared that these interventions are focused on areas where it is possible to have a high impact, and although no specific cost-effectiveness study was mentioned, the Country Coordination Mechanism (CCM) referred these as being on a list of prioritized needs to be addressed, developed as part of the country dialogue process. In addition, Global Fund interventions are focused on regions with high concentration of cases for each of the diseases (Santa Cruz, Cochabamba and La Paz for HIV and TB, and Riberalta and

[9] Based on Global Fund internal documents (confidential)

[10] Based on Global Fund internal documents (confidential) 1

[11] Malaria expenditure over 2014-2021 was US$ 44 million, of which 64.7% was from domestic resources (including 1.5% OOP) and the remaining 35.3% from external sources (mostly Global Fund). For HIV external funding represented 23% of the total HIV expenditure over 2014-2021 (US$ 162.3 million), and 77% was from domestic sources.

[12] Global Fund (2022). Funding Request Form_HIV/TB

Guayamerin for malaria) to maximise impact.[13],[14] In addition, stakeholders shared that the support of the Global Fund has been of special relevance in areas such as the development of guidance and standards to strengthen the National Health Program (NAP for its name) technical capacity.

Some stakeholders highlighted room for improvement to better contextualise interventions and increase efforts to tackle regulatory and social barriers to introduce and scale up high impact interventions. For example, stakeholders reported persistent challenges in providing and expanding PrEP services, which are still not routinely part of national health policies in Bolivia.[15] This was also reported as a concern in Global Fund documentation, which highlighted the "limited ambition to introduce and expand PrEP and HIVST" as there has been little progress in addressing existing barriers, including a lack of national estimates of the population in need, no clear proposal to address identified gaps and no request for funds to support PrEP interventions (neither through allocation requests nor through the PAAR[16]).[17] Stakeholders also mentioned issues affecting the implementation of KP activities including the "casas trans" (trans shelters) or food support, to which the MoH had resistance and were difficult to sustain. The need for balance between innovative and established approaches was also recognized. In some cases, national norms may push for the use of free software for programming of some processes.

1.2.2. Progress and results achieved

HIV

There has been noticeable progress on HIV in Bolivia over the last strategic period, with HIV prevalence halving over the last decade (~0.2 to 0.1% from 2011 to 2021) and declining from ~15 to 4 per 100.000 in mortality from 2011 to 2021.[18] Stakeholders highlight a joint effort between the Global Fund and the national government, which has significantly ramped up its domestic financing for HIV over the years (i.e., covering 72% of HIV program costs in 2020 compared to 48.2% in 2014).[19] As of 2021, Bolivia has achieved 76%, 74% and 80% against the 95- global targets for HIV.[20]

Global Fund investments have contributed significantly to strengthen CSOs and community capacity and driving community-led interventions to address stigma and discrimination. A notable example is the successful peer educator promoters strategy funded by the Global Fund and primarily implemented by communities to address stigma and discrimination for PLHIV and KPs. Stakeholders and documented evidence highlight this initiative as a key factor contributing to the improvement seen in adherence to ARV treatment, reduction of treatment abandonment and increased return to treatment after dropping out. Other highlighted examples of contribution from Global Fund investments include scaling up HIV screening through community-centres and mobile units, implementing partner-assisted notification for couples, training and support to CSOs etc.

However key challenges remain especially regarding unequal progress across the population with the persisting high prevalence among KPs. There is a significant difference in HIV prevalence among KPs compared to the rest of the population (e.g., 25.7% in MSM, 30.8% in transgender women against 0.30% in the general population), highlighting the importance of strengthened efforts and targeted interventions to ensure access to services in these groups. The lack of data on HIV prevalence in female sex workers is also highlighted as a persisting issue. Available data suggest a

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[13] Global Fund (2021). BOL_C_FOC_FundingRequestForm_20220318_En_1

[14] Global Fund (2021). BOL_M_FOC_FundingRequestForm_20210607_En_1

[15] Murphy et al (2023). PrEP policy implementation gaps and opportunities in Latin America and the Caribbean: a scoping review. *Therapeutics Advances in Infectious Diseases 2023, Vol. 10: 1–19*

[16] To note that PAAR activity at line 36 has mistakenly been translated to "PrEP" when it refers to community ART and comprehensive support for PLHIV in ART.

[17] Based on Global Fund internal documents (confidential)

[18] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State)

[19] Global Fund (2022). Funding Request Review and Global Fund internal documents (confidential)

[20] Note discrepancy in 95- indicators between funding request estimates and published UNAIDS 2022 estimates for Bolivia 95-targets which are 'undefined'-52%-43%'.

prevalence of 0.57% among Sex Workers (SW) but are over a decade old (from 2010). [21] An Integrated Bio-Behavioral Surveillance (IBBS) was planned for the 2017-2019 allocation period and performed in 2021 but did not include Sec Workers (SW) at the time (an IBBS that will cover Female Sex Workers (FSW) is currently under preparation and will be implemented in 2024).[22] The HIV epidemic is also geographically concentrated, with 85% of people diagnosed with HIV living in three departments (La Paz, Cochabamba and Santa Cruz).[23]

There is also an opportunity to improve key activities such as retention to treatment and prevention services especially for KPs. For 2021, 19,736 people living with HIV who know their status were reported in the country, but only 14,568 are on anti-retroviral (ARV) treatment.[24] Stakeholders have also highlighted the need to advance combined preventive actions such as PrEP, the implementation of duo tests for HIV and syphilis to reduce the gap between HIV tests and syphilis tests, especially in prenatal services for pregnant women, and use of self-test so that more people from key populations know their HIV status and receive timely treatment. To achieve a greater impact, stakeholders recommended increasing training and capacity building for HRH, continuing to strengthen civil society and to scale up community based interventions for follow up of PLHIV, along with evaluating the implementation of the joint TB-HIV grant to identify opportunities for strengthening.

TB

The country has made noticeable progress on TB over the last decade, with TB prevalence steadily declining over the last 10 years, as per an estimated yearly reduction of 3.3% between 2010 and 2020 according to the WHO[25] and a low incidence rate of 52 per 100,000 population in 2020.[26] Global Fund investments have also supported the strengthening of laboratories and training of personnel, and implementation of GeneXpert technology which has helped to decentralise testing and improve coverage and timely access to results.[27]

However, there are considerable gaps remaining in diagnosis and treatment coverage as well as high geographic disparities and uneven progress across the population. In 2021, only 53% of the new reported cases of TB were notified, and only 80% of notified cases were successfully treated (2020).[28] In addition, the country has a concentrated incidence with 80.4% of all forms of TB cases in the country belonging to only 3 departments (Santa Cruz, La Paz and Cochabamba) and 1.4 times higher incidence in urban than rural areas.[29] There are also reported gender and age-related differences (i.e., male-female ratio in people with TB is 1.7:1, 15-34 age group has 1.3 times higher incidence than the national average). In addition, documented progress reports highlight two-fold increase in MDR-TB from 2013 to 2019, as well as very low coverage of TB preventive treatment (TPT) in people living with HIV (only 10% in 2021), inadequate identification of children with TB; and a lack of TB interventions in key populations.

Stakeholders have highlighted the importance of sustaining funding for TB and increasing coordination between local stakeholders to enhance the results of interventions. Whilst domestic public funding for TB has increased by an average of 6% from US$ 2.2 million in 2014 to US$ 4.2 million in 2021, the share of external funding for the same period decreased from 33.4% to 27.4% of all TB funding, in part due to funding restrictions and reprioritisation during COVID-19. As such, stakeholders have highlighted the need to focus resources on the most impactful actions, increase efficiency in spending and enhance complementary between national and Global Fund interventions (e.g., national

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[21] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State).

[22] Global Fund (2022). Funding Request Review and Global Fund internal documents (confidential)

[23] Global Fund (2022). Funding Request Form_HIV/TB

[24] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State).

[25] Reported incidence by NTCP over the same period followed the same trend with a slight discrepancy, 2.9% decrease rate per year. The discrepancy between estimated and reported could be due to gaps in either the population's access to health services, poor resolution capacity of health services, diagnostic algorithm with low sensitivity, problems in the case notification system or overestimation by WHO. Global Fund (2022). Funding Request Form_HIV/TB

[26] Global Fund (2022). Funding Request Review and Global Fund internal documents (confidential)

[27] Global Fund (2022). Funding Request Form_HIV/TB

[28] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State)

[29] Global Fund (2022). Funding Request Form_HIV/TB

infectious diseases program could take charge of diagnosis and treatment whilst the Global Fund could focus on funding prevention services) in alignment with national and sub-national/municipalities operational plans.

Malaria

There has been a steady decline in malaria in Bolivia over the last decades, with Bolivia reaching zero cases of transmission due to Plasmodium falciparum in 2015, a 50% reduction of cases due to Plasmodium vivax, and overall decrease in malaria cases in the country until 2018, when recorded cases reached 5,354 cases.[30] This was reportedly the result of increased investment in improving early diagnosis, specific and timely treatment, adherence to treatment and increased preventive and control actions, including the distribution and use of mosquito nets and indoor residual spraying, with significant contribution from Global Fund investments according to stakeholders.

However, recent reports indicate a worrying backsliding trend in recent years and flag areas for improvement in key activities such as the distribution of mosquito nets. Progress on malaria have been reversing in recent years, with the number of P. vivax cases rising back from 5,354 cases in 2018 to 9,357 (2019), 12,187 (2020), 9,959 (2021) and most recently 10,330 in 2022.[31,32] Progress reports also highlight the high percentage of relapses, up to 20.7% of malaria cases, and a reemergence of Plasmodium falciparum, especially in peri-urban areas.[33] The discontinuity of the network of community volunteers (by the National Malaria Program in 2019), is said to have weakened community surveillance and contributed to reversing gains on malaria in the country.[34] In addition, the disease remains highly concentrated, with 99% of malaria cases in Bolivia found in the Amazon region (especially Pando, Beni and La Paz) and the remaining 1% mostly found in the Extra-Amazon region. Performance against key indicators has also been sub-optimal in recent years with only 67% of the estimated new malaria cases being treated and only 77% of the ITN & LLIN distribution target met in 2021.

RSSH

Global Fund investments have supported key health systems strengthening interventions, contributing to ongoing national efforts to consolidate health system infrastructure including for information systems and community systems. Stakeholders have highlighted that Global Fund investments have supported the strengthening of the information systems across the three diseases, allowing the systematization of data collection across key indicators and consolidating performance measurement. Stakeholders highlighted that Global Fund investments have also supported community systems and civil society strengthening and CSO capacity building efforts across the three diseases, an area that is less prioritised by the state. CSO and community-led interventions have been responding to priorities identified by the country (through Funding Request development) including areas like stigma, discrimination and gender equality. The participation of civil society organizations in HIV and malaria has reportedly increased, though it remains lower for TB.

However, the fragmentation of information systems is highlighted as a critical issue by stakeholders, as data collection and monitoring systems for HIV, TB and malaria are not fully integrated in the National Health Information system (SNIS), especially the HIV M&E system (SIMONE) which is completely separate. This prevents optimal use and effective triangulation of data[35], as further elaborated in the discussion on Monitoring and Evaluation below.

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[30] Global Fund (2022). Funding Request Form_Malaria

[31] Global Fund (2022). Funding Request Form_Malaria

[32] 2021 and 2022 p.vivax data communicated by National Malaria program

[33] Global Fund (2022). Funding Request Form_Malaria

[34] Based on Global Fund internal documents (confidential)

[35] Global Fund (2022). Funding Request Form_HIV/TB

1.2.3. Funding model and business processes

Funding Model

Stakeholders reported that the CCM model enables greater participation across stakeholders as well as supporting effective funding request development, although malaria and TB CSO representation has been weaker than that of HIV, highlighting the need to adequate representation of interests across HTM. Stakeholders consider that grant proposals developed through the CCM have been well aligned with national health plans and take into account national and international guidelines. They highlighted that the CCM provides a good platform to facilitate participation across stakeholders and that the Secretariat support has been very helpful despite the limited resources available to them. In addition, stakeholders raise the need to ensure an optimal balance remains in the composition and participation of stakeholders the CCM, in light of ongoing changes with the CCM leadership passing over to the MoH (recommended to be changed every 2 years as per CCM guidelines) as well as changes in CSO representatives (including KP representatives). HIV CSOs have also been more represented compared to malaria and TB civil society overall, highlighting the need to strengthen CS capacities across the other two diseases to improve effective engagement and adequate representation of interests across HTM. They highlighted the importance of continuing to foster equal participation and inclusivity, to ensure proposed activities remain in line with national plans and community needs.

The funding model generally works well for Bolivia and allows effective prioritisation of activities - although there could be more flexibility and better contextualisation of processes to the Bolivian context. Stakeholders perceive that Global Fund processes and the funding model are effective both for the preparation of funding requests and implementation of interventions. They highlighted as example that the funding request process allows good prioritisation of interventions as was the case for the prioritisation of prevention activities, highly relevant in light of the limited funding available for these activities.

However, stakeholders flagged a key issue of need for greater sensitivity to the local context to facilitate the implementation of interventions. Examples highlighted included limited flexibility to allow reprogramming of unused budgets, especially considering the challenges in the Bolivia public administration, which was considered to have hindered implementation. Besides the COVID-19 pandemic, Bolivia experienced highly disruptive socio-political events including a restructuring of the MoH (including departments responsible for infectious diseases programming) and high turnover of personnel within the MoH including seven ministers in the last four years. At an internal level, stakeholders recognized the need to increase coordination and communication between internal stakeholders for the preparation of funding requests and implementation of interventions, including the need to better align procurement activities with existing supply chain and storage capacity in-country (as recurrent challenges have been flagged), promote the inclusion of civil society proposed activities in funding requests, and further increase transparency of the CCM actions (although they emphasised the CCM currently operates adequately).

The recent PR transition in GC6 represent an opportunity for learning as stakeholders highlight a successful transition process, though caution against potential trades off and challenges. The country underwent a transition of PR in GC6 leading to the pooling of HIV and TB grants under one PR (previously separated in GC5 with HIVOS serving as PR for HIV, and UNDP for malaria and TB).[36] This change was made at the request of the Global Fund and the new joint grant PR (UNDP) was elected following decision by an independent commission formed by the CCM, with adequate time and support for the process.

However, some stakeholders expressed concerns about potential delays in starting activities by the new PR especially for HIV/TB interventions, including for the distribution of medicines that could be delayed in the absence of a logistics operator. They also mention challenges in managing the joint grant, especially in the coordination of HIV and TB components. Specifically, although there was an integration of TB and HIV programs at the national level under the National Program for infectious and contagious diseases, at the departmental level, they remained mostly separated, thus raising the need for effective coordination and communication to align activities and avoid fragmentation and duplication between the two components. It is also worth flagging that the HIV M&E system (SIMONE) was developed

[36] Based on Global Fund internal documents (confidential)

and owned by the former GC5 PR[37] (HIVOS) although no particular challenges were highlighted during its transition over to UNDP and the MOH.

Sustainability, Transition and Co-financing

The Government has been increasing its co-financing for HTM responses and gradually taking over Global Fund-financed interventions, better positioning itself to sustain responses in the long run. There has been important progress in co-financing by the government, including financing of ART drugs for HIV, first- and second-line drugs for HIV and TB treatment, as well as cartridges for GeneXpert in TB, and taking over HRH salaries. For malaria, the government is co-financing the purchase of medications and rapid diagnostic tests. Stakeholders shared that the Government plans to continue this gradual take-over process and highlighted it as an important step to mitigate "Global Fund-dependency" in the long run and foster sustainability of HTM responses.

However, stakeholders flag the need to devise a clear transition plan to inform ongoing efforts and enable an effective transition process. Whilst recognising the recent progress made, stakeholders pointed the lack of a transition plan outlining clear steps and specific milestones to guide this process in a more coordinated manner (It is noted that a transition plan was developed back in 2019 and work is ongoing to update it). They emphasised the need for a common understanding on what a full transition would imply, not only in terms of costs but regarding required infrastructure and capacity including internal processes, technical capacity, governance and accountability mechanisms. As such, a transition plan would enable the Global fund and the government to identify existing gaps and barriers that can be gradually addressed to ensure an effective transition and sustainability of interventions going forward.

They also highlighted the importance of strengthening coordination and alignment during this gradual take-over process, particularly when implementation depends on co-financing from the government. For example, they shared experiences of delay on funding disbursement from the government due to slow administrative processes which impacted the implementation of activities by civil society organizations and other PRs/SRs (e.g., delays to implement TB case finding alongside HIV service provision).

M&E

There has been good progress to strengthen information systems in Bolivia however the system remains highly fragmented for HTM services. Bolivia has had an important development in its National Health Information System (SNIS) which has undergone several reforms to consolidate its regulatory and operational processes. The SNIS collects information on programmatic services and epidemiology across all disease programs including some HIV related data such as HIV testing in the general population, and laboratory-confirmed cases of HIV and other STIs, though it does not capture patient-level services.[38] A separate stand-alone system for HIV M&E (SIMONE) is funded by the Global Fund to collect programmatic and performance indicators. Stakeholders have flagged that SIMONE is a particularly efficient and comprehensive system, enabling tracking of a range of key indicators including new HIV cases, treatment prescription and adherence, and allowing better community monitoring for HIV. However, its operation outside of the SNIS poses a number of challenges in terms of overall data oversight for HIV as well as limited integration and triangulation of data between disease programs and across the overall health system.

There are also a number of challenges regarding TB monitoring and evaluation, which is done through a hybrid model with most TB data collected through the SNIS[39] but some are collected through a manual system described as outdated increasing chances of manual errors and potential issues for integration. Monitoring for malaria is reported to overall effective, done mostly through the PR (UNDP) which has its own M&E system although process for integration in the SNIS is unclear. It is worth flagging the recent efforts to reduce fragmentation led by the Global Fund including additional support through a Strategic Initiative (SI) in partnership with PAHO, to consolidate routine collection and use of data across HIV, TB and malaria, strengthen national and sub-national capacity for data use to guide the decision-making.[40]

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[37] Global Fund (2022). Funding Request Review and Global Fund internal documents (confidential)

[38] Ibid.

[39] Global Fund (2022). Funding Request Form_HIV/TB

[40] Based on Global Fund internal documents (confidential)

Risk management

Stakeholders consider that Global Fund risk management processes have been adequate and effective overall. Within stakeholders interviewed that were most familiar with existing risk management processes, there was a general agreement that the risk management procedures were effective, not particularly burdensome and adequate to the Bolivian context. Examples of current processes in place include the use of a Local Fund Agent, evaluation of secondary recipients prior to disbursements and regular risk assessments through audits.

Of note amongst key informants interviewed for this case study was the lack of general awareness of the risk management processes across stakeholders interviewed (i.e., those not directly involved in implementing them). Bolivian Global Fund stakeholders could potentially benefit from broader awareness raising - as appropriate in this area to foster increased understanding of Global Fund approaches to risk and thus decisions.

1.2.4. C19RM

Bolivia was significantly affected by COVID-19, with a reported 1,206,420 cases and 22,399 deaths as of August 2023.[41] **Global Fund support to Bolivia for COVID-19 responses totalled US$12.5 million** (of which US$0.3M was from grant flexibilities and $US10.9 million awarded through C19RM 2021). The first grants for C19RM 2021 (US$9.3 million) supported COVID-19 control and containment activities (US$5.4 million), health and community systems (US$1.2 million), mitigation for TB programs (US$0.1 million) and program management (US$0.6 million).[42] Activities mentioned in the Funding Request include the acquisition of protective equipment for health personnel and vulnerable populations, malaria interventions (strengthening of SCO and communities, and addressing barriers to care), and food support for HIV affected and vulnerable populations.[43] There remains an active portfolio of US$2.7 million for 2024 (from the approved C19RM 2021 funds) implemented through UNDP.

C19RM support was considered useful both to fight COVID-19 and mitigate impact on HIV, TB and malaria services, however some barriers affected the effectiveness in implementing interventions. Stakeholders view C19RM was a significant support during the pandemic, that it complemented domestic funding for COVID-19 specific responses and enabled HIV, TB and malaria activities to continue, and was suitably adapted to emerging needs over the course of the pandemic. C19RM investments supported vulnerable populations with specific activities (food baskets, trans houses, delivery of ARVs), implementation of laboratories, provision of PPE, as well as strengthening CSO-led and community-led interventions. Implementation challenges cited included that community interventions (e.g. distribution of food baskets) were difficult to implement due to public health restrictions in place during the pandemic. Respondents also cited delays in procurement due to limited capacity of providers and supply chain challenges during the COVID-19 pandemic. Other interventions such as procurement and supply chain activities were also reportedly impacted both due to pandemic restrictions as well as a lack of required infrastructure in country to support these operations.

1.2.5. Catalytic investments

Bolivia received a number of catalytic investments over the last funding cycles. This includes a small number of multi-country (MC) grants, and two Strategic Initiatives (SIs): the Sustainability, Transition and Efficiencies (STE) SI to strengthen civil society, as well as support from the Data SI. Examples of multi-country grants include:

- The Positive Leadership Alliance and Key Populations (ALEP), aimed at strengthening civil society organizations to improve quality of care and address human rights barriers for PLHIV especially KPs. The project promotes access to comprehensive and differentiated care, works with States to offer quality services and improve budgeting activities for HIV responses.[44]

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[41] Pan American Health Organization (2023). COVID-19 regional dashboard. https://who.maps.arcgis.com/apps/dashboards/c147788564c148b6950ac7ecf54689a0. Consulted September 26, 2023

[42] Global Fund (2021). C19 RM secretariat investment committee, September 16, 2021.

[43] Global Fund. C19RM funding requests

[44] Hivos América Latina. Alianza Liderazgo en Positivo y Poblaciones Clave. https://america-latina.hivos.org/program/alianza-liderazgo-en-positivo-y-poblaciones-clave/. Consulted September 26, 2023.

- The TB social observatory, which serves as a platform for social surveillance, political advocacy and social monitoring of the national response against TB. This MC also contributes to strengthening monitoring the ENGAGE-TB indicators related to the detection of TB cases and support treatment.[45]

The Multi Country CIs are seen as having practical added value to HIV and TB interventions in Bolivia though stakeholders cited the need to avoid overlaps and duplication with existing interventions in the country. The overall perception across stakeholders is that these CIs have been useful to complement actions, in coordination with investments from the Global Fund. Stakeholders shared they believed that CIs have been catalytic as they allowed the acceleration of existing interventions. They also reported that being part of projects implemented in different countries allowed them to strengthen the implementation of interventions in Bolivia. Regarding what worked less well, stakeholders mentioned that MC proposals, developed across several countries, often had overlaps with local actions (e.g., the MC community-led monitoring by the ALEP project overlapping with another project led by ITPC in Bolivia). A lesson highlighted was the need to first scope and identify existing interventions, and accurately assess and prioritise gaps that could benefit from additional funding in order to avoid overlaps.

1.2.6. Partnerships

Stakeholders reported that the Global Fund was able to cultivate effective collaboration and partnerships across stakeholders including local partners and Civil Society Organizations as well as technical partners. Coordination is led by the National Aids Program who convenes a recurring technical table with PAHO, UNFPA and UNAIDS as well as key stakeholders including Global Fund PRs. Stakeholders shared these technical tables has been of great support to strengthen alignment and coordination for HIV, TB and malaria interventions, including for the design of Global Fund funding requests, as well as to coordinate technical assistance during implementation. For malaria, Bolivia received support from the PAHO regional malaria team for an extensive situational analysis to inform the malaria approach (including responding to more recent increase in P.vivax).

However, stakeholders expressed that there is scope to improve this coordination by, for example, better defining roles and areas of support across technical partners. They also recommended creating more spaces for coordination with civil society organizations outside the CCM including in other technical coordination spaces. Finally, they mentioned the need for better information sharing and use of insights generated by each other, highlighting for example a missed opportunity to disseminate recent studies on stigma and discrimination (by UNAIDS) which could have greatly benefit HIV interventions.

1.2.7. Gender, human rights, equity & communities (crosscutting)

Global Fund investments have helped to elevate the visibility of different groups and bring human rights and gender issues onto the national agenda. Global Fund investments are considered to have significantly contributed to improving KP-responsive interventions and reduce barriers to access for GB MSM and TG populations through its prevention services and by scaling up HIV testing.[46] Stakeholders also highlighted the increased participation of civil society groups not only in provision of HIV-AIDS interventions, but also in TB and malaria, including through their engagement in the CCM.

Although the Global Fund have encouraged better participation of CSOs, some stakeholders highlight there is still room for improvement. Some stakeholders mentioned that while Global Fund processes have encouraged the participation of CSOs in all processes and promoted inclusivity, they suggested more could be done to integrate civil society recommendations into intervention strategies and funding requests, especially on areas that concern them directly. They also expressed that some groups could be engaged more actively and suggest expanding the dialogue across all stakeholders (especially those involved in implementation) and underrepresented groups including non KP groups (such as heterosexual men). Most importantly, they flagged the need to strengthen civil society technical capacity to enhance their participation in Global Fund processes, including funding requests development, intervention design, implementation and evaluation. Furthermore, they highlighted the lack of specific indicators for monitoring and

[45] Global Fund. C19RM funding requests

[46] Global Fund (2023). DnA Country Factbook Bolivia (Plurinational State)

evaluating progress on human rights barriers, KP and gender equity, and the need to better document progress and remaining challenges on these issues to inform future interventions.

1.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Bolivia is considered a Global Fund focused country, with a relatively small amount of funding from the Global Fund (US$20.3 million for GC6), a decline of nearly US$11 million from GC5. Although this represents a smaller budget as compared to other Global Fund countries, investments from the Global Fund are considered highly relevant and beneficial, allowing the implementation of evidence-based, high impact activities that otherwise would be hard to implement.

Despite recent socio-economic and political challenges and the impact of the COVID-19 pandemic, Bolivia has overall achieved noticeable progress against HIV, TB and malaria over the last grant cycles period although there is room for improvement across each of the diseases. Global Fund investments have also enabled better participation of civil society organizations, scaling up of community-led interventions, prioritisation of prevention activities and actions aimed to addressing barriers for KPs and other vulnerable populations as well as raising the visibility of gender and human rights issues on the national agenda. This is in addition to progress made by the Government to invest more in heath including HTM funding and starting a transition process to gradually take-over HTM interventions. In regard to implementation arrangements, there is also an opportunity to monitor transition plans of the PR role from UNDP to the government.[47]

However, some challenges remain especially around (i) the inequitable progress across the population (for KPs as well as gender related differences), and across the country (concentrated prevalence in certain regions), (ii) fragmented information systems and gaps in M&E data, (iii) the lack of a clear transition plan to better coordinate ongoing sustainability efforts, and (iv) the need for greater coordination, communication and participation across stakeholders including CSOs.

Based on these findings, the review highlights the following suggested areas for strengthening that could be considered:

1. Prioritise the implementation of high-impact interventions (including PrEP) with special attention to high prevalence areas and adequate considerations for key populations and vulnerable groups across the three diseases.
2. Strengthen efforts to integrate information system across the three diseases into the national system (SNIS) and consolidate monitoring and evaluation across identified gap areas including female sexual workers data as well as gender, human rights, equity interventions.
3. Identify areas of potential inefficiencies and aspects of complementarity with government interventions to increase the strategic value add of Global Fund investments, avoid duplications and maximise value for money of available funding.
4. Design a clear transition plan with the Government to guide current hand-over efforts, with special attention to existing gaps and key priorities that need to be addressed, to enable effective transition and sustainability of interventions, with appropriate monitoring of this transition.
5. Increase efforts to improve sensitivity and flexibility of Global Fund processes to better adapt to the Bolivian context especially in light of the evolving environment and contextual challenges.
6. Enhance Civil Society and Community-led organizations participation by supporting capacity building, promoting their engagement with key stakeholders (including outside the CCM and in other technical coordination spaces) and encourage the inclusion of their recommendations in funding requests.
7. Ensure catalytic investments funding are informed by a thorough assessment of existing interventions to direct funding where its most needed, avoid overlaps and enhance their catalytic effect.

[47] It is understood that initial discussions regarding transition of the PR role from UNDP back to the government were held at the recent Global Fund Portfolio Performance Committee (PPC) meeting / Risk Review on UN entities.

A.1. References

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A.2. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 21 stakeholders from the following entities:

Stakeholder category	Entity
CCM	CCM
Ministry of Health	Malaria program
	Infectious disease program
	Prevention and disease control unit
	Epidemiology
Principal Recipient	PNUD
	HIVOS Bolivia (former)
Civil Society Organizations	Redbol
	Fundación Igualdad
	IPTC LACTA Bolivia
	ASUNCAMI
	Mujeres Positivas
	IDH Bolivia
	ITPC LACTA Bolivia
	REDLAC+
	Regional Network ALEP
Key Populations (HIV)	KP Representatives (HIV)
Technical Partners	UNAIDS
Global Fund Secretariat	Global Fund Country Team

2. CHAD CASE STUDY REPORT

2.1. INTRODUCTION

2.1.1. Country characteristics and HTM context

Chad is located in central Africa, with a population of 17.3 million in 2021.[48] The country has a young and mostly rural population[49,50] which is growing rapidly and projected to exceed 19 million by the end of 2025.[51] Chad has a complex political context and precarious security situation, with ongoing inter-communal conflicts. The democratic political system has been gradually developing since 1990, and marked by the arrival of a transitional military-civilian regime in 2021. Chad is bordered by countries that have also been experiencing high social unrest and insecurity (Libya, Niger, Nigeria, Cameroon, Central African Republic, Niger and Sudan) which has contributed to an influx of refugees, adding to the high number of internal displaced people in the country (IDPs). The situation is further exacerbated by recurrent incursions of armed groups such as Boko Haram and the recent Sudan crisis with 600,000 plus refugees in the Eastern part, resulting in a critical humanitarian and public health situation. Chad is part of the Global Fund Challenging Operating Environment (COE) portfolio of countries and has been managed under the additional safeguard policy since 2009, in recognition of the significant contextual challenges and the need for appropriate mitigation of related programmatic and fiduciary risks.

Chad's health system is fragile, with severe shortages in human resources for health (HRH), poor infrastructure, and persistent issues with the medical supply chain and access to medicines. The country has the second highest maternal mortality in the world (860 deaths per 100,000 people) and sixth highest infant and child mortality rate (122 deaths per 1,000 live births).[52] Although poverty has declined over the past fifteen years, it remains significantly high in the country, with 42% of the population estimated to live below the national poverty line and an estimated 1.9 million people in acute food insecurity. GDP per capita has decreased significantly in the last decade but has been showing some signs of stabilisation and timid growth since 2021, reaching $702.85 in 2023 (from $982.92 in 2013).[53]

The health system is organised in a pyramidal structure comprising a central level (7 national programs, 7 national hospitals with central administration), an intermediate level (provincial health delegations and 23 provincial hospitals) and a peripheral level (126 health districts, 114 district hospitals, 1672 health centres). Government Health Expenditure as % GDP was 0.7% in 2021, and out of pocket spending (OOPS) continues to account for a significant proportion of overall domestic health expenditure (62% from OOPS against 17% from Government). The country has adopted a national health policy (PSN 2016-2030) which is operationalised through the National Health Development Plans 2018-2021 (PNDS 3) and 2022-2030 (PNDS 4), financed by contributions from the State and Partners although they have remained consistently underfunded.

Epidemiologically, HIV, TB and malaria are among the priority diseases identified in the national health plan. Successive strategic plans to fight the three diseases have had mixed results, due in part to the limited funding available and high unmet funding needs for HTM programs (62% and 61% of funding needs for HIV were unmet for the 2017-2019 and 2020-2022 periods, 62% and 55% for TB, and 47% and 40% of malaria).[54]

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[48] Global Fund (2021). Funding request form_TB/HIV/RSSH

[49] 68% of the population are under 25 years of age, and 78.1% live in rural areas.

[50] US Department of State (2022). Chad Integrated Country Strategy

[51] World Population Review (2023). Chad Population

[52] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[53] International Monetary Fund (IMF) (2023). IMF Datamapper. Chad datasets

[54] Based on Global Fund internal documents (confidential)

- There are an estimated 120,000 people living with HIV in Chad and a disease prevalence of 1% (2022).[55] The epidemic is concentrated among key populations (KPs) (13.7% amongst sex workers, 5.2% in prisoners and other incarcerated people, 4.8% amongst populations at risk (personne à risque)[56]).
- There were an estimated 25,000 TB cases in 2022 and the disease incidence has been declining, though at a slow rate (decline from 144 to 140 cases per 100,000 inhabitants from 2016 to 2022).[57,58] Regardless of age group, the burden of TB weighs more heavily on men, with a male/female sex ratio of 2.75 in 2022. In addition, there are increasing concerns around the emergence and spread of drug-resistant tuberculosis.
- Chad is the 15th largest contributor of global malaria deaths.[59] WHO reported 3,635,701 estimated malaria cases and 13,587 malaria-related deaths in 2022 in Chad, respectively contributing to 1.5% and 2.2% of the global burden.[60]

2.1.2. Summary of Global Fund support

Since 2005, the Global Fund has provided more than US$ 551.5 million in grants and disbursed more than US$ 500 million to Chad.[61] Global Fund investments across GC4, GC5, and GC6 represented respectively US$ 122 million, US$ 106 million (-13% from CG4) and US$ 165 million (+56% from GC5).[62] Chad currently has three active grants: the HIV/TB grant implemented under the MoH[63] and two malaria grants (PRs are MoH and UNDP). Table 2.1. presents an overview of Global Fund active grants in Chad.

Table 2.1: Overview of Global Fund active grants in Chad.[64]

Grant name	Disease area	IP dates	Principal Recipient (PR)	IP signed amount
TCD-C-MOH	HIV/TB	01-Jan-22 to 31-Dec-24	Ministry of Public Health and Prevention (MOH)	US$ 60.5M
TCD-M-MOH	Malaria	01-Jul-21 to 30-Jun-24	Ministry of Public Health and Prevention (MOH)	US$ 43.94M
TCD-M-UNDP	Malaria		United Nations Development Programme (UNDP)	US$ 68.8M

Chad is highly dependent on donor funding for HTM and the Global Fund remains a major contributor for the three diseases. During the 2020-2022 allocation period (GC6), Global Fund contributions represented 69% of available funding for HIV, 79% of funding for TB, and 72% for malaria in the country (an increase for all three diseases from the 2017-2019 allocation period).[65] From GC5, Chad was able to receive additional funding through the C19RM to support COVID-19 responses and mitigate the pandemic impact on HTM programs. In GC6, funding for COVID-19 represented 37% of total grants as of June 2023.[66] In addition to COVID-19 grants, the amounts allocated to the three

[55] UNAIDS (2022). Chad Country Factsheet

[56] MSM are also referred to as “Personnes à risque” or “Populations at risk” in Chad

[57] Global Fund (203). Chad DNA Factbook

[58] WHO (2023). Tuberculosis profile: Chad

[59] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[60] WHO (2023). World malaria report

[61] Global Fund (2023). Data explorer: Chad

[62] Global Fund (2023). Chad DNA Factbook

[63] The MoH became the PR for the HIV/TB grant in GC5 after a transition from the Fonds de soutien aux activités en matière de population et de lutte contre le SIDA de la République du Tchad (FOSAP) at the beginning of GC5

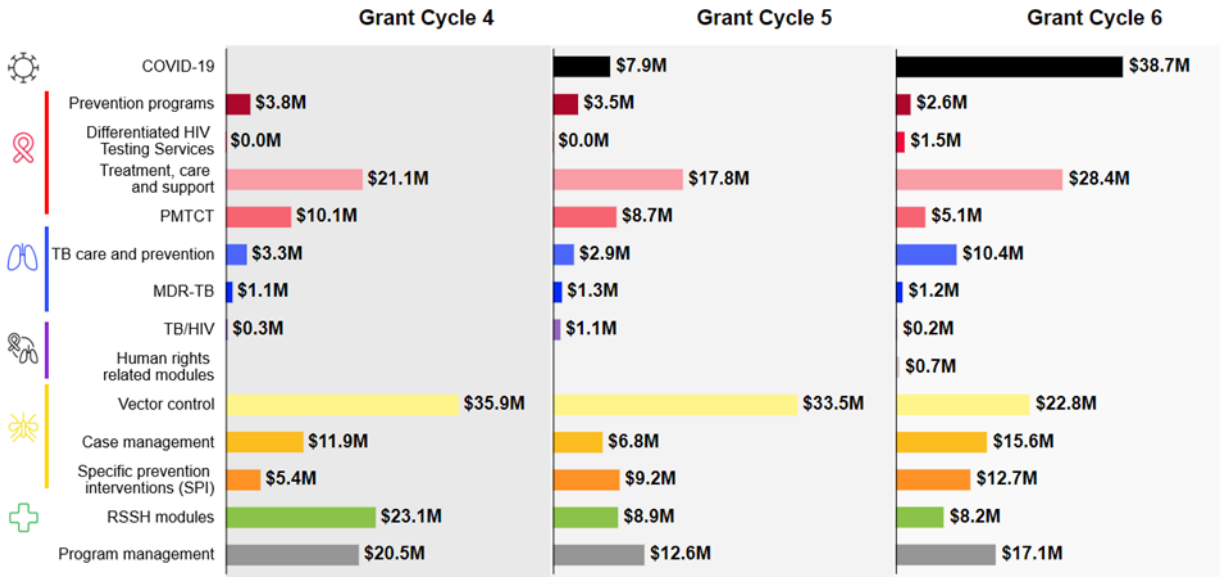
[64] Global Fund (2023). Data explorer: Chad

[65] Based on Global Fund internal documents (confidential)

[66] Global Fund (2023). Chad DNA Factbook

diseases, including allocation towards systems strengthening, have seen an overall increase over the last funding cycle. Figure 2.1 presents an overview of allocated funding across interventions in the last 3 funding cycles.

Figure 2.1: Global Fund budget breakdown by module by Grant Cycle from GC4 to GC6 in Chad[67]



2.2. KEY FINDINGS

2.2.1. Relevance of Global Fund investments

Global Fund investments are considered highly relevant, aligned with national priorities and responsive to the country's evolving needs. Stakeholder feedback and documentary evidence indicate that Global Fund investments have been consistently aligned with national strategic plans, which are based on a prioritization exercise considering the national and subnational epidemiological profile, progress made, gaps and shortcomings, international recommendations etc. Stakeholders shared that, starting in GC5, an additional prioritization of geographic areas is used across HIV, TB and malaria interventions to maximise the impact and value for money of Global Fund investments. The Global Fund also facilitated adaptation of interventions to be contextualised and responsive to the country's evolving situation. For example, nomadic and humanitarian population needs are considered when designing interventions (e.g., inability to access static health services) and HTM interventions are integrated into humanitarian responses.[68] Global Fund support for the prevention of TB and HIV drug resistance is also considered relevant as it helps fund resistance studies and implement appropriate actions supporting quality and adherence to treatment.

Global Fund investments include allocations for health and community system strengthening interventions, as well as considerations for KPs. However, stakeholders highlight key gaps remaining with regards to funding communities and KP interventions. In GC5 (NFM2) to GC6 (NFM3) cycles, system strengthening interventions have been prioritised based on crosscutting funding gaps analysis conducted in collaboration with partners (e.g., evaluation of the laboratory system in May 2018 by WHO, supply chain strengthening plan developed based on supply chain assessment conducted in 2018 (Project SWEED), analysis of community systems pillars[69] etc.). This approach is said to have facilitated scale up of key interventions (e.g., scaling up of government-supported community-based malaria management) or funding for neglected areas (e.g., funding of community-based interventions for KPs and human rights interventions). However, funding for systems strengthening remains significantly low overall, accounting for only 5% of Global Fund investments in the country in GC6. For KPs, the

[67] Global Fund (2023). Chad DNA Factbook

[68] Based on Global Fund internal documents (confidential)

[69] Global Fund (2022). Technical Brief. Community Systems Strengthening

national strategic plan for HIV[70] contains interventions catered for populations at risk, including considerations to promote human rights and the right to health for KPs. The NSP content had been informed by the national gender policy in force since 2011 and findings from a recent evaluation on gender considerations in TB and HIV interventions carried out by the CCM in 2018.[71] However, the institutional and social environment remains unfavourable for KPs, especially for populations at risk and transgender people who continue to be highly stigmatised and discriminated against.[72] Stakeholders shared that discussions on interventions and funding for KPs especially populations at risk remain challenging to have in the country, including during the country dialogue process, hindering effective program design and implementation of KPs interventions.

2.2.2. Progress and results achieved

HIV

Chad has made noticeable progress against HIV, but with slow progress across a number of areas due to gaps in implementation, limited financing and poor monitoring amongst other causes. There is an overall downward trend in HIV incidence which declined from 1.21 to 0.22 cases per 1000 population from 2000 to 2022, while HIV-related mortality decreased from 87 to 16 cases per 100,000 population in the same period.[73] According to UNAIDS 2022 estimates, progress against the 95-95-95 targets stands at 80%-77%-[…]%.[74] More recent data available through the 2023 national cohort audit[75] reports that 83% of PLHIV have viral suppression. The national cohort audit also revises down estimates for number of PLHIV on ART to 63,845 (29% less than the UNAIDS 2022 estimate). TB prevention for PLHIV has improved, including a rise in viral load testing among PLHIV on ART from 1% in 2019 to 18% in 2022, thanks to GeneXpert machines scale up across provinces. [76]

Challenges documented in HIV services include:

- Viral suppression remains below the country's 95% target (at 83%) and lower than regional and global estimates.[77] This is due to weak in-country mechanisms, including a lack of national viral load intervention strategy, lack of standardized procedures in laboratories and viral load centres, weak sample transportation mechanism as well as limited supply and demand.
- The low coverage of early infant diagnosis intervention is also reported as a key gap, with only 9% of newborns exposed to HIV tested for early detection of the virus in 2022.[78] This is due to weak integration of PMTCT and maternal health services, limited PMTCT interventions at the community level, a weak follow-up system and poor monitoring of the PMTCT cascade to ensure retention and adherence to treatment. In addition, the proportion of HIV-positive pregnant women on ARVs also remains suboptimal (65% in 2022).[79]
- Other areas of low performance for HIV interventions include (i) the low coverage of HIV prevention interventions among key populations (e.g., only 59% of populations at risk had an HIV test and received the result, only 5% of sex workers have received an HIV test and know the result)[80], and (ii) the low initiation of

[70] Plan Stratégique De Riposte Au Sida

[71] Global Fund (2018). Evaluation de la prise en compte du Genre dans les ripostes nationales au VIH et à la Tuberculose au Tchad

[72] Based on Global Fund internal documents (confidential)

[73] UNAIDS (2022). Chad Country Factsheet

[74] UNAIDS (2022). Chad Country Factsheet. No UNAIDS data available for % PLHIV with viral suppression.

[75] Ministère de la sante publique et de la prévention (2023). Audit de la file active des personnes vivant avec le VIH sous traitement antirétroviral au Tchad. The previous audit was conducted in 2016.

[76] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[77] Ministère de la sante publique et de la prévention (2023). Audit de la file active des personnes vivant avec le VIH sous traitement antirétroviral au Tchad.

[78] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[79] UNAIDS (2022). Chad Country Factsheet

[80] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

ARV treatment among children (11% in 2016 and 32% at the end of 2022) and adult men (74% at the end of 2022 compared to 86% among women).[81]

Stakeholders highlighted a number of crosscutting root causes for these issues including the underfunding of community-based screening, in particular differentiated screening for children, insufficient commodities due to delayed procurement supported by government co-financing, the small scale of combination prevention programs for KPs due to limited funding, the poor completeness and quality of the data, including estimates on the active queue of PLHIV on ARV[82], as well as financial barriers (OOP) limiting the use of certain services including antenatal care and the biological monitoring of PLHIV.[83] However, there are upcoming opportunities for improvement going forward through (i) the gradual transformation of some PMTCT sites into care sites to increase differentiated service delivery (DSD) and contribute to strengthening the continuum of ARV treatment, (ii) the inclusion of certain indicators such as viral load in the results-based financing supported by the World Bank, and (iii) efforts to strengthen sample collection and testing for early HIV detection in children born to HIV-positive mothers.

TB

There has been steady progress against TB overall although some gaps remain including regarding missing TB cases and slow notification rate especially for children. The incidence of TB and MDR-TB have been steadily decreasing, from 144 to 140 and 2.6 to 2.4 cases per 100,000 inhabitants respectively between the end of 2016 and the end of 2022. TB mortality (HIV negative) has remained relatively constant over the last decade (albeit with an increase in 2020, likely due to the COVID-19 pandemic) and was 24 per 100,000 population in 2022.[84] The increase in the GeneXpert fleet has led to improved diagnostic strategies and increased reporting rates for TB and MDR-TB cases through the use of molecular testing as a first-line test (29% in 2022).[85] This has also helped recovery in TB notifications since the COVID-19 pandemic, with an overall increase during the 2017-2022 period in TB notifications from 55% (2017) to 59% (2022).[86,87] For MDR-TB, the number of reported and treated cases has increased continuously from 45 cases in 2016 to 143 cases in 2021.[88] Testing and management of TB/HIV co-infection has also improved with the introduction of a "One stop shop" approach for HIV and TB coinfection management[89] and the provision of HIV testing and ARVs to TB services.

Despite this progress, overall reporting of TB cases remains insufficient and missing cases account for 41% in 2022.[90] Among children aged 0-14 years, the notification rate remains low, reported at 7.2% in 2022 and only 8.6% of children under 5 who are household contacts were put on preventive treatment. Despite an increase in the treatment success rate from 79% (2019) to 82% (2022), coverage remains low and below the objectives of the 2021-2025 NHP.[91,92] Regardless of age group, the burden of TB weighs more heavily on men with a male/female sex ratio of 2.75 in 2022 and high geographic disparities (14 of the 23 provinces have a male/female ratios greater than 2). In addition, there are increasing concerns around the emergence and spread of drug-resistant tuberculosis. These issues are the result of multiple compounding factors including the poor implementation of planned community activities, limited provision

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[81] UNAIDS (2022). Chad Country Factsheet.

[82] A review of the active queue of PLHIV on ARVs showed an overall overestimation of about 19.2% (i.e. 67,879 PLHIV on ARVs on March 31, 2023 instead of 83,983).

[83] Other than CD4 cells and viral load which are free.

[84] WHO (2022). Tuberculosis profile. Chad. The impact of COVID-19 resulted in a slowdown in the performance of the TB program, with a 6% decline in the number of TB cases reported in 2020 compared to 2019. The TB treatment success rate had reached 82% in 2021 (though remains below the global target of 90%). WHO (2022).

[85] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&iso2=%22TD%22&lan=%22EN%22

[86] WHO (2022). Tuberculosis profile. Chad.

[87] Global Fund (2023). Chad DNA Factbook.

[88] WHO (2022). Tuberculosis profile. Chad. 2022 MDR-TB data not available a time of this case study.

[89] Based on Global Fund internal documents (confidential)

[90] World Health Org (2022). Tuberculosis profile. Chad.

[91] 2021-2025 NHP planned to reach 80% in 2019; 82% in 2020 and 92%, eventually in 2025 of TB patients with INH treatment.

[92] World Health Org (2022). Tuberculosis profile. Chad.

of integrated package of services at the community level (including in PMTCT to assist in TB screening among pregnant women), limited available transport mechanisms for samples, etc. In addition, many gender and human rights-related barriers have been undermining the use of TB testing and treatment services in Chad, such as negative perceptions and high stigma of TB patients, and social rejection of patients and former patients.[93]

Malaria

Malaria remains a significant public health issue in Chad as earlier gains start receding and the country reports an increase in malaria burden and decline of coverage of some malaria interventions. In Chad, 99% of the population is at risk of contracting malaria, 67% at high risk, and malaria is the leading cause of consultations (42%), hospitalization (39%), and deaths (34%) in health care facilities.[94]The 2019 MICS reported 65.8% of households had a least one insecticide treated net (ITN), fewer than the 80% reported in the 2017 Malaria Indicator Survey (MIS). Use of ITNs was high among children and pregnant women in households owning an ITN (89.3% children and 93.3% among pregnant women, 2019 MICS), but low household ownership translates to only 54.3% of all children and 56% of pregnant women sleeping under an ITN (2019 MICS). These figures are very similar to those reported in the 2017 MIS.[95]

Global Fund investments have supported the implementation of key interventions including five mass distribution campaigns of insecticide-treated nets (2011, 2014, 2017, 2021 and 2023) with a gradual expansion of areas covered and the number of nets distributed, the continuous monitoring of insecticide resistance, the launch of community case management and extension from 2 to 3 provinces, seasonal Malaria Chemoprophylaxis (SMC) based on stratification in 41 out of 75 districts (with the remainder covered by UNICEF and Malaria Consortium) with digitalization piloted in 13 of those districts, and full digitization of the 2023 LLIN campaign in the 17 health districts covered by the Global Fund amongst others. However, although the country reported some improvement against malaria in GC4 (e.g., incidence reduced from 70 cases per 1,000 inhabitants in 2014 to 47 cases per 1,000 inhabitants in 2016), these initial gains have since receded and the country is recorded worse indicators that a decade ago. In 2020, there was a 52% increase in the estimated number of cases from 2010 and a 5% increase in malaria-related deaths.

A number of challenges have been reported as potential causes for the worsening malaria situation in the country. Long distances to health facilities (averaging 16km) have limited the use of ANC services, reported at 66% in 2019 for ANC1.[96] Coverage of intermittent preventive treatment for pregnant women (of those that attended ANC) is sub-optimal, with a high coverage for IPTp1 (82%), declining to 59% for IPTp2, 35% for IPTp3 and 16% for IPTp4. Stakeholders reported additional gaps including (i) the poor quality and completeness of the data due to the slow deployment and scale of DHIS2, (ii) limited vector control with Indoor Spraying (IRS) which is carried out only in the city of N'Djamena[97], (iii) limited coverage of community malaria management (only 3 provinces) and, (iv) the lack of awareness raising among the population to promote the use of mosquito nets. Due to multiple operational challenges, especially with timely availability of drugs, seasonal malaria chemoprevention (SMC) campaigns have been limited (in 2019, only three cycles were completed instead of the usual four) impeding effective targeting and access to critical services for many children. In addition the policy of free malaria prevention and treatment services faced recurrent challenges (e.g., frequent stock-outs of drugs) and is still not universally implemented, leaving many with high OOPS to access services.[98]

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[93] The 2023 assessment of gender and human rights data and barriers in access to TB services for key and vulnerable populations indicates that women with TB are more stigmatized than men, and TB patients are afraid to seek screening and treatment services for fear that their disease will be disclosed to members of their family who might reject them.

[94] Global Fund (2020). Malaria Funding Request and Global Fund internal documents (confidential)

[95] The 2017 MIS reported 53% of children under five years and 56% of pregnant women slept under an ITN among all households (with and without ITNs).

[96] Global Fund (2020). Malaria Funding Request and Global Fund internal documents (confidential)

[97] IRS in N'Djamena is not supported by the Global Fund.

[98] Global Fund (2020). Malaria Funding Request and Global Fund internal documents (confidential)

RSSH

Global Fund investments have highly contributed to strengthening health systems, in alignment with the NSP objectives. During GC5, RSSH was allocated 10.8% from each disease component, and in GC6, RSSH received 11% of the HIV/TB allocation and 3.1%[99] of the malaria allocation.[100] The Global Fund has supported a number of interventions to strengthen health systems in Chad over the last two grant cycles, including strengthening community systems through the establishment of a community health worker (CHW) network co-funded by the government, the Global Fund and other donors. Community-based interventions are reported to have contributed to better integration of HTM interventions in communities, through for example, awareness raising against diseases, community-based diagnosis and management of malaria by CHWs, support for MDR-TB patients, support groups and community follow-up for PLHIV by psychosocial counsellors etc. Global Fund investments have also supported improvement in the supply chain system including better storage capacities at the central level (Central Pharmaceutical Purchasing Pharmacy-CPA) and at the provincial level (Regional Pharmacy of Supply-PRA) which has led to fewer stock outs reported at central level for TB and HIV drugs (although challenges continue at subnational level). In addition, the Global Fund had commissioned a supply chain diagnostic review completed in 2018, which helped identify priority gaps, quantify the need and devised a Supply Chain Transformation Plan (SCTP) (created in 2019). The support of the Global Fund to strengthen the health information system through the implementation of DHIS2 (rolled out at national, provincial and district levels) and the laboratory system through the acquisition of devices (e.g., enable the set up a network of more than 50 GeneXpert devices) have also been reported as key areas of progress. Still, both face a number of challenges including delays in implementing the DHIS2 (see M&E section below) and challenges for the laboratory system, including a lack of operational sample transport system and capacity for equipment maintenance.

Key challenges include the implementation of the supply chain transformation plan and community systems strengthening, amongst other issues. Although Global Fund investments have supported the expansion of community health interventions from 2 to 3 provinces (GC5 to GC6), scale up efforts remains slow (only 3 provinces covered out of the 23 in the country), and the package of services offered does not yet fully integrate TB and HIV components. Stakeholders shared that the resources allocated to strengthening the community systems and community interventions remain insufficient including for interventions to reduce human rights related barriers and promoting gender equality in the country, limiting the effectiveness and impact these interventions can have. In addition, according to stakeholders, the late recruitment of the community SR in GC6 due to lengthy handover procedures led to delays in the implementation of community interventions. From a supply chain perspective, the implementation of the SCTP has been delayed due to a lack of funding to finance its implementation, poor governance, lack of monitoring, and disruptions from COVID-19.[101] As a result, key systemic challenges persist and have resulted in significant stock-outs at all levels, limited drug traceability and challenges to support last-mile distribution. In addition, HIV and community-based data are poorly integrated into DHIS2 and the quality and completeness of data remains insufficient due to a lack of tools and mechanism for data validation and quality assurance, as well as issues regarding access to electricity and connectivity at the peripheral level.

2.2.3. Funding Model and Business Processes

Funding model

The CCM and country dialogue process are considered inclusive and effective platforms to coordinate amongst partners and enhance intervention design and implementation. The country dialogue, coordinated by the CCM Secretariat, is said to be an effective process, inclusive of key stakeholders (e.g., MoH, national programs and CCM members etc.) and supporting appropriate funding distribution between different components (e.g., disease specific, RSSH etc.). To further strengthen the strategic monitoring and facilitator function of the CCM, the CCM Evolution initiative has been put in place which included a review of the CCM internal regulations, conflict of interest policy, manual of procedures and the terms of reference and composition of the Strategic and the Ethics

[99] The allocation of only 3% of the malaria funding to RSSH was taken to enable malaria interventions to cover the maximum number of provinces during the 2023 LLIN mass campaign.

[100] Based on Global Fund internal documents (confidential)

[101] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

Committees.[102] To consolidate funding requests, considerations beyond epidemiological factors, such as the level of overall available funding (Global Fund, government and other partners contributions) as well as programmatic gaps are included to inform decision making. A programmatic Gap Matrix is created by the CCM, partners and national programs to help identify gaps including on technical assistance needs, coordinate support across technical partners and direct Global Fund resources.

Stakeholders also shared that for HIV and TB, an additional joint prioritization exercise was conducted (based on epidemiology, needs, availability of services, progress and performance) during the funding request process which enabled further prioritisation by district, as well as defining areas of convergence between activities to better integrate interventions across districts. The Global Fund also conducts a national quantification exercise to estimate commodity needs for HTM, this is then used to coordinate procurement between the Global Fund, partners and the governments to optimise available funding. Furthermore, stakeholders highlighted that Global Fund investments facilitate program adaptations in response to changes in guidelines and new treatment recommendations, as was the case when switching to combination therapy with Dolutegravir, by supporting the transition plan and integrating it into its procurement plan, and enabling the transition of MDR-TB treatment from the long cycle to the short cycle.

The Global Fund funding model and processes are seen as appropriate and adapted to the Chad context especially the use of Challenging Operating Environment flexibilities, and the MoH as PR to promote better contextualisation and country ownership, although stakeholders highlight some issues in the operationalisation of these policies. Stakeholders shared that COE flexibilities are highly appreciated as they provide room for better adaptability for the disbursement, payment and justification of expenditure processes in the context of Chad (e.g., use of the mobile money system to pay CHWs and other activities) or to easily finance unplanned or unbudgeted activities.). The role of the MoH as PR for HIV and TB is also said to have promoted government ownership of interventions and alignment with national priorities whilst the co-financing commitments are said to enable better planning and prioritisation of State's contribution for HTM. However, stakeholders have highlighted some issues in the operationalisation of these policies especially regarding the inability of the government to meet its co-financing commitments due to funding constraints, competing national priorities (e.g., national security) over limited resources, a lack of effective disbursement of Government budget to national programs, and a lack of separate budget lines for co-financing allocation within the Ministry of Health budget. This has led to delays in the mobilization and disbursement of funds, gaps in procurement of health commodities (the Government is responsible for 35% of HIV procurement and 15% TB), and disruptions in the provision and quality of services (e.g., HIV testing).

The misalignment between Global Fund cycles periods with that of national strategic plans has also been highlighted as a challenge, leading to issues in coordination, additional workload for stakeholders and disruptions in grant implementation. The development of Global Fund grants is based on the National Disease Control (HTM) Strategic Plans, as well as the National Health Development Plan and the Community Health Strategic Plan. In general, strategic plans cover 5 years while the Global Fund's funding cycle is 3 years which means that Global Fund funding cycles periods are not entirely synchronised with strategic plans. Stakeholders reported that this has often led programs either to anticipate the development of a new strategic cycle or to extend the duration of the existing one (extension of the HIV NHP 2018-2022, extension of the Malaria NHP 2019-2023, early revision of the TB NHP 2018-2022 to develop a new one for the period 2021-2025). In addition, some stakeholders suggested that the 3-year cycle of Global Fund grants were quite short, because the first year is often devoted to the preparation of the grant and in the 3rd year the same actors are engaged for at least 6 months in the preparation of the next grant or sometimes in the renewal of the strategic plans, reducing capacity during these times and disrupting implementation. They also shared that this mismatch in Global Fund allocation cycle and national strategic plans hinders timely incorporation of results from the current cycle in either one of the plans and suggest that an alignment of timeline would be helpful.

Risk management

Whilst the risk management processes in place through the additional safeguarding policy (ASP) have proven to be effective, challenges in risk management at the government level persist, hindering the possibility of a short term exit out of the ASP. Chad has been subject to additional safeguard measures since 2009 with the establishment of a tax agency in addition to the local fund agent (LFA), implementation of regular audits, amongst

[102] Based on Global Fund internal documents (confidential)

other mechanisms. The use of UNDP as PR for one of the malaria grants also serves to mitigate fiduciary risk by leveraging the UN internal risk management mechanisms. A number of measures have also been put in place to mitigate the risks at the MoH level for the management of grants, including the establishment of a Project Management Unit (Unité de Gestion de Project (UGP)) by the Ministry of Public Health and Prevention with the support of donors and partners to oversee donor funded projects (i.e., currently from the Global Fund, GAVI, the Bill and Melinda Gates Foundation and ALIKO Dangoté), with technical support from Expertise France (for governance, procurement, monitoring and evaluation, finance and audit etc.) to strengthen its operationalisation.[103] In addition, there has also been a revision of UGP procedures and decentralization through provincial focal points, as well as other initiatives such as the introduction of contracts for CHW under the oversight of health centre managers and payment via mobile money[104] to further strengthen risk management.[105]

Despite these efforts, recent reports flag persisting issues in risk management especially for the UGP which faces a number of challenges including high staff turnover and delay in recruitment, poor internal technical capacity, a dependence on technical assistance, inadequacy of the internal control and processes which have led to ineffective absorption capacity and suboptimal grant implementation.[106] Reports have also highlighted suboptimal coordination of the UGP with SRs and difficulties in financial reporting by SRs which have contributed to delayed disbursements and impacted implementation.[107] Stakeholders reported similar issues, in particular the delays in recruiting an SR for community-based interventions which impacted the implementation of community based malaria and TB activities. As such, preparation for the country's exit from ASP has been slow, highlighting the importance identifying bottlenecks and strengthening national capacity for programmatic and fiduciary risk management.

Sustainability

The country is making timid progress towards sustainability although major challenges remain that could jeopardise current progress, especially the country dependency on donor support for HTM. The Ministry of Health is committed to universal health coverage and has been making some efforts to better prioritise health at the national level. A UHC Strategy was adopted in 2015 with the vision to deploy a national health insurance mechanism to strengthen access to health and social protection.[108] Whilst the national health budget allocation had declined between 2013 and 2016 (due to funding constraints at national level with lower oil prices, decline in government revenues and debt), it has recently increased from an average of 4.4% in 2016-2018 of Government Health Expenditure to 5.7% in 2019-2021.[109] In addition, a sustainable health financing strategy was developed to inform efforts on domestic resource mobilisation, although it has not yet been implemented. Over the longer term, the role of MoH as PR and establishment of the UGP have been positive in the sense of enabling gradual strengthening of national infrastructure and capacity ahead of a hand-over. Most recently, despite the country being under ASP, the CCM has been authorized to lead the recruitment process for all PRs for GC7 in recognition of recent progress.

However, the recent progress is fragile as domestic financing for health remained inconsistent over the last decade, easily affected by economic shocks, and the national security and contextual challenges also threaten to disrupt service provision. The government struggles to meet its co-financing requirements which have been irregular, further highlighting the persistent challenges to secure sustainable domestic financing for HTM.[110] As such, HTM

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[103] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[104] For the NGO BASE, the implementation of the payment of CSAs via mobile money made it possible to identify CHWs who were not in their area of assignment, which made it possible to clean up the file and to purge fraud. In addition, CHWs are satisfied with the terms of payment because they now receive their salaries directly, fully and on time.

[105] The African Constituency Bureau (ACB) (2023). Un aperçu des progrès réalisés par le Tchad dans le cadre de la mise en œuvre des subventions du Fonds mondial

[106] Global Fund (2023). OIG audit report. Global Fund Grants in the Republic of Chad

[107] Based on Global Fund internal documents (confidential)

[108] Ibid.

[109] Ibid.

[110] The review of the implementation of the HIV Strategic Plan showed that the State's contribution share for this cycle has increased from 6% to 15%, but since 2019 the coordinating entity which is the Executive Secretariat of the CNLS has not been able to mobilise resources from the State for its operation, which has reduced its coordination capacities, supervision and technical support to the actors of the national response.

interventions remain highly dependent on donor funding such as Global Fund as well as technical support from partners to continue as elaborated earlier in this report. At the operational level, the sustainability of achievements and investments are also weakened by the limited national capacity as illustrated by challenges in the UGP, the fragility of the health information system which rely on competent human resources and adequate infrastructures, and persisting fragmentation and poor integration of services, amongst other challenges.

M&E

The Global Fund performance framework is seen as adequate to track performance progress against the three diseases, and stakeholders report good progress to consolidate M&E processes at national level including through the deployment of the DHIS2. Performance framework indicators are aligned with disease indicators and contained in national strategic plans. To strengthen M&E processes and promote better integration across data sources, the DHIS2 is being rolled out under the oversight of the MoH with the support of the Global Fund and GAVI. In addition, the Global Fund supports staff training and the coordination of data collection though one-off missions of complementary data, data control and quality assurance missions (DQA missions, assessment of the active queue of PLHIV on ARVs, data validation). The digitalization of the LLIN campaign and SMC are innovations in data collection. The recent involvement of SRs in the preparation of progress reports has been highlighted as a good initiative which has helped improve the quality of reports.

However, stakeholders flag remaining challenges in particular with delays in the DHIS2 roll out and poor capacity to support subnational monitoring and data disaggregation to enhance decision making. Recent reports highlight significant delays in deploying the DHIS2 including training, procurement of equipment, and the availability of data collection and reporting tools.[111] In addition, the lack of adequate infrastructure in the country including issues with poor energy and connectivity further hinders the implementation and operationalisation of the system. Stakeholders noted that the maturity of DHIS2 is still low and that the system does not currently integrate all available data including HIV and community-based data. As a result, stakeholders shared that a parallel data collection mechanism is in place to capture data from CBOs on community intervention without being integrated in the main system through DHIS2. In addition, stakeholders have highlighted the lack of disaggregated data (e.g., by province, district, health center, sex, age, etc) and a lack of adequate guidelines and tools (e.g., scorecards) to support monitoring of performance at the sub-national level and to guide supervision and technical support efforts. With respect to these issues, one actor remarked *"without a view of subnational level performance, our supervisions sometimes feel like courtesy calls".* Furthermore, stakeholders shared that reporting activities by the national programs have sometimes been irregular in their frequency or lacking in detail. The Global Fund grant performance framework is therefore often the document of reference through which HTM program performance is monitored.

2.2.4. C19RM

Stakeholders consider that C19RM investments greatly contributed to Chad's response to the pandemic emergency whilst also providing an opportunity to strengthen the health and community systems. Like other countries, Chad has been affected by the COVID-19 pandemic, particularly regarding barriers to accessing healthcare services due to public health measures such as lockdowns. COVID-19 has caused excess mortality among the population estimated at 19,200 deaths between January 2020 and the end of December 2021.[112] To help national emergency responses and mitigate the impact of the pandemic, Chad received a total of approximately $48.6 million from the Global Fund C19RM, including $38.8 million under the 2021 C19RM grant.[113] The grant, implemented by UNDP and the UGP, enabled the implementation of COVID-19 response interventions (e.g., case management, oxygen provision), as well as interventions to mitigate COVID-19 impact on HTM programs such as adaption of services (e.g., linkage of LLINs and distribution at householders, nutritional support for TB and HIV patients).

C19RM funding was also used to support health system strengthening efforts, with the acquisition of additional GeneXpert devices and solar equipment for healthcare facilities and laboratories to enhance HIV and TB diagnostic capacity at the country level, and the digitalization of the mass mosquito net distribution campaign to support malaria programming. The Supply Chain Transformation Plan (PTCA) also benefited from the contribution of C19RM with the

[111] Based on Global Fund internal documents (confidential)

[112] Global Fund (2023). Chad DNA Factbook

[113] Data as of June 2023. May not include more recent awards (e.g., as part of C19RM Portfolio Optimization).

refurbishment of purchasing and storage centres, the acquisition of logistics for last-mile distribution, and the strengthening of the logistics management system. In addition, C19RM investments also enabled scaling of community interventions including by increasing capacities of community actors, hiring and training of additional psychosocial counsellors and community health workers, provision of medicines to patients' homes, and strengthening capacities of the listening centres with consideration of human rights and KP support. Stakeholders shared that, *"if the C19RM funding did not exist, it had to be created. It has contributed a lot to the financing of the strengthening of the health system and the flexibility in reprogramming has been very useful in meeting or responding quickly to some needs for which the country would not have been able to mobilise resources."* For malaria and HIV, mitigation measures have reduced the COVID-19 impact on performance, whilst for tuberculosis, a lack of a contingency plan affected the performance of TB interventions in 2020. Difficulties in involving the National Network of TB Patients (RENALTUB) in community interventions and patient support were cited as one reason for this.[114]

Challenges in implementing C19RM funded interventions however have led to poor in-country absorption. The implementation of the C19RM grant has faced difficulties related mainly to the long delay in the awarding of contracts, the thresholds of which require the approval of several ministries, thus delaying interventions. This had an impact on the absorption of funds. With the reduction in direct COVID-19 prevention and care needs, the C19RM grant has seen more reprogramming and repurposing in GC6 in order to redirect funds to other or new needs. Stakeholders reported that the Global Fund was very flexible and the involvement of the team and the rapid review of notices were highly appreciated as it made it possible for interventions to be somewhat agile and adapt funding to the evolving needs. This includes redirecting funding to finance health system strengthening interventions or to support the Government's efforts to respond to the challenges related to the Sudanese crisis in the east of the country. However, some stakeholders expressed a desire to be more informed and involved in initiatives to reschedule and cancel certain activities, in order to maintain the coherence of activities.

2.2.5. Catalytic investments

Catalytic funds have proven to be relevant to further support the performance of the TB program, particularly the notification of cases, but the effects are slow to be visible because of the delay in the implementation of interventions and the late recruitment of the TB grant community SR. Under NFM3, Chad was eligible for additional catalytic matching funds in the amount of approximately $2 million. This allowed activities to be funded by the matching fund and TB grant for the priority area "Finding Missing TB Cases: Strategic Engagement in West and Central Africa". In addition, strategies were included in the grant to strengthen the search for missing TB cases based on especially through community-led interventions. CHWs have been recruited and deployed to major urban centres to strengthen the search for those lost to follow-up, those absent from treatment, additional GeneXpert devices have been acquired, consultants have been hired, training has been conducted for staff, and guides and guidance have been produced. Stakeholders however report some delays implementing these interventions due to delays in the recruitment of a community SR, as well as delays in the procurement of equipment amongst other challenges. Other interventions are supported in prisons and in mobile health to improve case reporting. Stakeholders from the TB program believe that catalytic funds contributed to increase TB case detection in prisons (increased from 44 cases in 2021 to 104 cases in 2022). Stakeholders also shared positive feedback on the use and effectiveness of CIs, and are of the view these investments have enabled tangible progress in community health systems strengthening and supported overall improvement in quality of services in Chad.

Strategic initiatives have been reported as very relevant areas to help strengthen the health system and improve performance across the three diseases. In GC6, Chad was eligible for 10 SIs: Differentiated HIV Service Delivery, TB Finding Missing People Cases, Data, HR, Sustainability, Transitions and Efficiency (STE), PSM Transformation, CCM Evolution, Service Delivery Innovation Strategic Initiative (SDI SI) South-South strategic support and learning, SDI HRH Strengthening / Quality of Care, SDI National Laboratory System Improvement. Several SIs have been underway since 2021 including the Service Delivery Innovation Strategic Initiative (SDI SI).

The SDI SI seeks to support better service delivery for HIV, tuberculosis and malaria through more strategic and innovative resilient and sustainable systems for health (RSSH) approaches, leading to improved health outcomes.[115]

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[114] TB NHP Review Report 2018-2022

[115] ITAD (2023). Evaluating the Global Fund's Service Delivery Innovation Strategic Initiative

Interventions began in March 2022 with 31 trainings in two health districts and consisted of (i) recruitment of staff, (ii) selection of field actors, (iii) training and provision of quality assurance tools, (iv) site visits, (v) peer-to-peer exchange and sharing sessions, and (iv) initial and mid-term evaluation by ITAD. The results, although encouraging, were affected by shortages of HIV reagents and malaria RDTs (associated with gaps in government co-financing of commodities and some challenges with communication and information flow). Discussions are underway with the Country Team to better focus their interventions on coherent action plans, in line with national priorities for 2024.

2.2.6. Partnerships

Chad has a diverse development partners landscape which has been making efforts to be better coordinated, including through the Global Fund CCM. However coordination remains overall suboptimal with fragmented efforts and missed opportunities for synergy in the absence of a formal framework for consultation across all partners. There is a dense and diverse partnership operating to support HTM and health interventions in Chad, including UN agencies as well as bilateral and multilateral partners.[116] The bilateral and multilateral partners have helped mobilise resources for certain programs and support the strengthening of the health system (GAVI, Expertise France, AFD, World Bank). This include the partnership with AFD, through Expertise France, which helped mobilise technical assistance to support Global Fund funding requests during the various cycles and the partnership with WHO and UNAIDS which supports mobilization of technical assistance when applying for funding and supports health system strengthening interventions.[117] Partners collaboration have contributed to complement funds to develop interventions (e.g., GAVI and the Global Fund on DHIS2, AMF and the Global Fund for the Purchase and Distribution of MOSTIC PBO nets, UNICEF/JHPIEGO and the Malaria Consortium with the Seasonal Chemoprophylaxis Campaign (SPC) in other districts in addition to the Global Fund). The Global Fund country dialogue is said to provide a good platform to strengthen partner coordination during the development of grants as well as throughout program implementation.

Despite these efforts, stakeholders report there is room for improvement as coordination remains somewhat weak and suboptimal especially between in-country partners and program entities. They shared that, apart from the High National Coordinating Council for Access to the Global Fund (Haut conseil national de coordination pour l'accès au Fonds Mondial (HCHC)) and the Joint Team for UN System Agencies, there is no formal framework for the overall coordination of partnership. Before the political transition that happened in Chad earlier this year, monthly meetings were held with the Head of State on key indicators and health issues, which supported greater coherence in development partners' contributions. This framework is no longer regularly functional, with the exception of the last meeting held to address the implications of the Sudanese crisis and it is unclear if these will resume regularly post-transition or be replaced by another coordination mechanism. In terms of the AIDS response, the National Council for the Fight against AIDS (CNLS), which is a coordinating body for the AIDS response, has not met since 2014. The Ministry of Public Health and Prevention is trying to coordinate regular meetings with partners to strengthen coordination and alignment however, stakeholders have flagged these have been inconsistent. Similar findings are reported in documented evidence, including a lack of coordination between country stakeholders and program entities (e.g., between the Sector Program to fight HIV/AIDS (Programme sectorial de lutte contre le VIH/SIDA et les IST), the National program and the National AIDS control commission (CNLS) responsible for implementing HIV interventions) leading to fragmentation of service delivery with a negative impact on the continuum of care.[118]

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[116] Contributions from bilateral and multilateral partners include: World Bank with the REDISSE project and Results-Based Financing (RBF), USAID which supports the HIV component in the defence sector, the Egyptian Cooperation which supports hepatitis management activities, particularly hepatitis C diagnostic devices, the French Development Agency (AFD) which supports the country with technical assistance, the strengthening of the Project Management Unit which manages GAVI and Global Fund grants as well as other areas (https://www.afd.fr/en/page-region-pays/chad).

[117] The Chadian Health Sector Support Project – Phase 2 (PASST2) is part of France's support to the Chadian Government to strengthen its health system, via a financing agreement between the French Development Agency (AFD) and the Ministry of Public Health (MSP). The aim of the project is to reduce maternal, infant and neonatal mortality in Chad. The objectives are: (i) To strengthen the capacity of the Ministry of Public Health, (ii) To strengthen health structures (supply and quality), (iii) To strengthen the training of health personnel and (iv) To strengthen the financing of care and payment exemption mechanisms. The PASST2 financing agreement was signed in March 2015 for an initial period of four years and an amount of €10 million. This project is supported by France through two sources of funding, the I3S funds and the French Muskoka Fund (FFM).

[118] Based on internal Global Fund documents (confidential)

2.2.7. Gender, Human Rights, Equity and Communities (cross-cutting)

The gender and human rights situation in Chad is complex, with high stigma and discrimination related to social, legal and cultural barriers as well as significant gender inequalities hindering access to health services especially for HIV and TB. Despite ongoing efforts, access to health services remain highly constrained for key and vulnerable populations as well as underserved populations. Barriers to accessing services include not only distance and accessibility of facilities and security challenges but also high stigma and discrimination related to religious beliefs, cultural, social and gender norms. Socio-cultural norms and legal barriers have fuelled discrimination and stigma against people living with HIV and TB, especially KPs and other vulnerable populations. This has significantly hindered efforts to reach KPs with prevention, testing and treatment services, translating into low coverage of HIV services and high prevalence of the disease among these groups. As per the latest IBBS survey, HIV prevalence among sex workers and men who have sex with men is high: 13% on average among sex workers, but as high as 47% in some provinces and 4.8% among populations at risk.[119] In addition, some key populations are still not prioritized, as for example drug users for which there is no intervention under the current funding.

Women and girls' rights to access health and other basic services such as education is also highly limited despite efforts to strengthen legal and statutory regulations in Chad. Only 22% of women are literate. Harmful social practices and gender-based violence (GBV) continue to be the norm, where 34% of women and girls were estimated to have undergone female genital mutilation (FGM) in 2019 and 44.2% women are estimated to have experienced physical and/or sexual violence from an intimate partner in their lifetime.[120] Furthermore, for the majority of women, decision-making is taken by their partners or a male head of family, including for matters related to access to healthcare, especially in low socio-economic groups and rural settings. This imbalance between men and women's agency has contributed to significant gender inequity in disease prevalence where HIV prevalence among women is higher than among men (1.8% in women and 1.3% in men). Women represent 67% of the 63,845 PLHIV on ART reported in 2023.[121] The strong stigma around HIV and socio-cultural norms are reported as important factors negatively impacting men's health-seeking behaviours, resulting in low numbers of men knowing their HIV status, late diagnosis, and low ART coverage among men.[122] Consistent with global trends, men are more affected by tuberculosis than women (66% of the 14,725 reported TB cases in 2022 were men).

Stakeholders have welcomed Global Fund investments in gender sensitive programming and interventions to reduce gender and human rights barriers to health, although these remain insufficient. Under the current strategic plans, an analysis of vulnerable populations and priority areas for intervention have been carried out and have informed interventions under the NFM3 grant. The Global Fund has been supporting several initiatives to reduce gender and human rights-related barriers and increase access to health services for KP as well as other vulnerable and underserved populations including:

- Establishing an observatory and four listening centres to provide information on the services available, collect complaints from key populations and service users.
- Supporting vulnerable and underserved populations through nomadic health interventions (integrating malaria, TB and HIV services) and community health programs currently extended to three provinces.
- Reprogramming interventions, including C19RM, to integrate HIV, TB and malaria interventions into the humanitarian triple nexus in eastern Chad following the Sudan refugee crisis.
- Targeting underserved populations including refugees, internally displaced persons, nomads and returnees during distribution of LLINs campaigns and routine malaria interventions.
- Funding health promotion activities targeting KPs.

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[119] CNLS (2021). Enquête biologique, comportementale et d'estimation de la taille chez les populations clés et vulnérables au VIH au Tchad : Professionnelles de Sexe (PS) et chez les Personnes à risque

[120] Based on internal Global Fund documents (confidential)

[121] Ministère de la sante publique et de la prévention (2023). Audit de la file active des personnes vivant avec le VIH sous traitement antirétroviral au Tchad

[122] Based on internal Global Fund documents (confidential)

- Increasing advocacy for Gender, Human Rights, and Equity to support KPs including through the establishment of a network of pro-bono lawyers, advocacy to revise Law 19 on the protection of PLHIV, integration of gender and human rights aspects in training for health personnel.

However, recent reports[123] continue to highlight the persistence of stigma and discrimination towards PLHIV and TB patients as well as high gender related barriers to health such as:

- The lack of structure and coordination of gender and rights interventions
- Hostile legal environment that criminalizes KPs[124] and the limited scope of Bill 19 vis-à-vis other diseases
- Persistent stigma and discrimination in both community and care settings
- The small scale of community-based interventions and the slow progress in expanding the country's community health coverage and overall weakness of the community systems.

2.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Since 2005, the Global Fund has remained a major contributor to health financing in Chad with other partners such as the United Nations system, GAVI, the World Bank, the French Cooperation (AFD). Global Fund investments have contributed to noticeable progress in the fight against HIV, TB and malaria in Chad including through its C19RM investments which have helped respond to the COVID-19 emergency, mitigate the of the pandemic on HTM and support system strengthening interventions. The implementation of the Challenging Operating Environment policy is said to have facilitated financial and programmatic adjustments to strengthen the implementation and execution of programs. The Global Fund has also been a catalyst for partnership in the country, promoting collaboration and coordination across stakeholders to better align strategies and optimise available resources. However, many gaps remain in the implementation of interventions, and current challenges are compounded by a complex security context in the country, as well as legal, socio-cultural and legal barriers hindering access to health, and poor capacity and systems for health.

In light of the overall findings in this case study, the following suggested areas for strengthening are highlighted:

1. Sustain investment in HTM in Chad and identify potential areas of inefficiencies and cost-saving opportunities to increase value for money and optimise the use of limited available funding
2. Increase investment and prioritise high impact malaria interventions to reverse recent downward trends, including scaling up interventions across provinces, increasing community-based interventions to reach underserved populations especially women and children and ensuring free access to malaria services
3. Prioritise the implementation of the SCTP to strengthen supply chain systems with particular attention on capacity building, systems strengthen and timely procurement and distribution at subnational level
4. Increase advocacy and awareness raising on gender and human right barriers for health as well as increasing technical and funding support to develop and scale up culturally sensitive interventions to support KPs, as well as other vulnerable and underserved populations, with a focus on community-led interventions
5. Increase efforts to strengthen community and civil society organisations capacity (technical and financial) to enable better engagement of CSOs and CBOs and increase investments in community systems strengthening including integrated M&E systems and CHWs networks
6. Increase support from Global Fund and partners to strengthen Government technical capacity and internal systems including domestic resource mobilisation for health and risk management processes, to reduce donor dependency and enable a gradual transition of HTM programs in the long-term
7. Consolidate coordination across health stakeholders and partners at national level by mapping opportunities for joint planning and establishing formal coordination mechanisms (outside of the Global Fund country dialogue) with adequate representation and participation of CSOs.

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[123] These are (i) MAF/Global Fund, October 2023: Assessment of Gender and Human Rights Data and Barriers in Key and Vulnerable Populations' Access to TB Services and ii) MAF-IF/Global Fund: Literature Review on Integrating Community, Human Rights and Gender Aspects into National HIV Responses, tuberculosis and malaria (July 2023).

[124] Since 2014, article 361 specifies that the penalties are a fine of 50,000 to 500,000 CFA francs, or even 15 to 20 years in prison.

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MAF-IF/Global Fund (2023). Literature Review on Integrating Community, Human Rights and Gender Aspects into National HIV Responses, tuberculosis and malaria

National documents

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Plan Stratégique De Riposte Au Sida

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A.4. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 25 stakeholders from the following entities:

Stakeholder Category	Entity
CCM	CCM
Global Fund Secretariat	Global Fund Country Team
Government stakeholders (Ministry of Health, UGP, national disease programs, etc.)	National Program to Combat AIDS and STIs (PSLS/STI)
	National Tuberculosis Control Program (NTP)
	National Malaria Control Program (NMCP)
	Health Information System and Statistics
	Ministry of Gender
	Health Provinces
	CNLS
PR Public	Ministry of Health/ Project Management Unit-UGP
Technical and financial partners	WHO
	UNAIDS
	UNICEF
	World Bank
	JHPIEGO
Civil society	Office for Health and Environmental Support (NGO BASE)
	Chadian National Network of Associations of People Living with HIV/AIDS (RNTAP+)
COVID-19 stakeholders	UGP
	National Coordination of Actions to combat COVID-19
	Case Management, Surveillance and Laboratory
LFA	Local Fund Agent (LFA)

3. CÔTE D'IVOIRE CASE STUDY REPORT[125]

3.1. INTRODUCTION

3.1.1. Key country characteristics and HTM context

Côte d'Ivoire is a lower-middle income country located in West Africa. It has a population of 28 million, and around 50% live in urban areas. Although Côte d'Ivoire is experiencing one of the fastest sustained economic growth rates in Sub-Saharan Africa in over a decade, largely withstanding economic shocks due to COVID-19 and enjoying notable political and social stability since 2011[126], performance of the Ivorian economy has not been accompanied by expected results in terms of social inclusion. Côte d'Ivoire ranked 165 out of 189 on the Human Development Index, and 165 out of 189 on the Gender Inequality Index.[127] While GDP growth has averaged 8% per year since 2011, around 46% of the population live below the poverty line.[128]

Côte d'Ivoire's health system has three layers: i) 133 health districts which are the operational unit of the system and oversee private and public health structures, ii) 33 Directions Régionales de la Santé (DRSLS) which are responsible for implementing health policy in the regions, iii) and the central government which is organised around centralised services, the Minister's Cabinet, and Direction Général de la Santé (DGS) which in turn oversees the national disease programs for HIV/AIDS, malaria, and TB (PNLS, PNLP, and PNLT).[129] Each of the disease programs has developed an NSP for the 2021-2025 period. Despite recent progress towards devolution, the health system remains highly centralised and districts exercise limited autonomy. Access remains a key issue with around 33% of the population living more than 5 kilometres from a health care facility.[130]

HIV Context: Côte d'Ivoire has one of the highest HIV prevalences in West and Central Africa at 2.6% among populations 15-49 years, with a higher burden among women (3.5% vs 1.7% for men). The HIV epidemic in Côte d'Ivoire is concentrated among KPs, with prevalence rates of 12.6% among sex workers, 11.57% among MSM, 3.4% amongst PWUDs and 6% among PWIDs, and 22.6% among the transgender population. There are also large geographic disparities- 37% of PLHIV live in Abidjan. HIV incidence overall is less than 1%.[131]

TB Context: In 2018, WHO estimated incidence of TB in Côte d'Ivoire to be 142 cases per 100,000, and TB-related mortality to be 32 deaths per 100,000. It is estimated that only around 59% of TB cases are notified. The country also has a high burden of drug resistant TB, and in 2019 the DR-TB case detection gap was 55%. The treatment success rate for all forms of TB is just below the target at 83%.[132][133]

Malaria: Malaria is a major public health problem, and is endemic in Côte d'Ivoire throughout the year. Suspected malaria cases represent the greatest volume of consultations at health facilities. Incidence is increasing, from 155 per 1,000 in 2016 in the general population to 191 per 1,000 in 2019. The national annual incidence rate among children

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[125] The Côte d'Ivoire case study has been conducted by Suzanne Fournier and Anisa Hasan-Granier.

[126] World Bank, Côte d'Ivoire Country Profile, 2023

[127] UN Women, Côte d'Ivoire in Brief, undated, available at: https://africa.unwomen.org/en/where-we-are/west-and-central-africa/cote-d-ivoire)

[128] Global Fund, Audit Report: Global Fund Grants in Republic of Côte d'Ivoire, 2020

[129] Program National de Lutte Contre la SIDA (PNLS), Program National de Lutte Contre le Paludisme (PNLP), and Program National de Lutte contre la Tuberculose (PNLT).

[130] GC6 Funding Request and internal Global Fund documents (confidential)

[131] GC6 Funding Request and internal Global Fund documents (confidential)

[132] GC6 Funding Request and internal Global Fund documents (confidential)

[133] Audit Report: Global Fund Grants in Republic of Côte d'Ivoire, 2020

under five years is higher than in the general population, at 441 cases per 1,000.[134] Malaria related mortality is decreasing however, from 3,340 deaths in 2016 to 1,641 deaths at the end of 2019.[135]

3.1.2. Summary of Global Fund support

Côte d'Ivoire is classified as a High Impact country by the Global Fund. The Global Fund is the largest external donor for TB and malaria (approximately 40% for each disease) and the second largest donor for HIV after PEPFAR (approximately 13% of total funding). Approximately 25% of the funding to fight HIV, TB and malaria is provided by the government.[136]

During GC6 there were six active grants across 3 PRs: four grants were managed by the national disease programs (PNLS, PNLT, PNLP), and the Unité Coordination des Programs (UCP, Program Management Unit) under the Ministry of Health. There are also two non-State PRs: Save the Children serves as community PR for the malaria grant, and Alliance Côte d'Ivoire as community PR for TB and HIV grants. Although most implementation arrangements in GC6 were a continuation from GC5, a major shift was that cross-cutting RSSH activities which had once been split across HIV and malaria public grants, were moved to a standalone RSSH grant managed by UCP. This was done to streamline management of funding flows for RSSH activities and ensure that the UCP was fully accountable for programmatic oversight (see Section 1.2.2).

Details on levels of funding and trends over 2017-2022 by disease area and module are provided below (Table 3.1 and Figure 3.1). Overall, the allocation split by disease area has remained relatively stable, with the largest increase over GC5 to GC6 within the HIV allocation.

Table 3.1: Overview of Global Fund allocation by disease area[137]

Disease	Allocation GC5 and GC6	Main investment areas GC6
HIV	US$57.91M GC5 US$70.95M GC6	Differentiated ART service delivery and HIV care (45% of HIV budget).
TB	US$11.3M GC5 US$14.4M GC6	Case detection and diagnosis (64% of TB budget).
Malaria	US$79.6M GC5 US$76.9M GC6	Vector control (71% of the malaria budget).

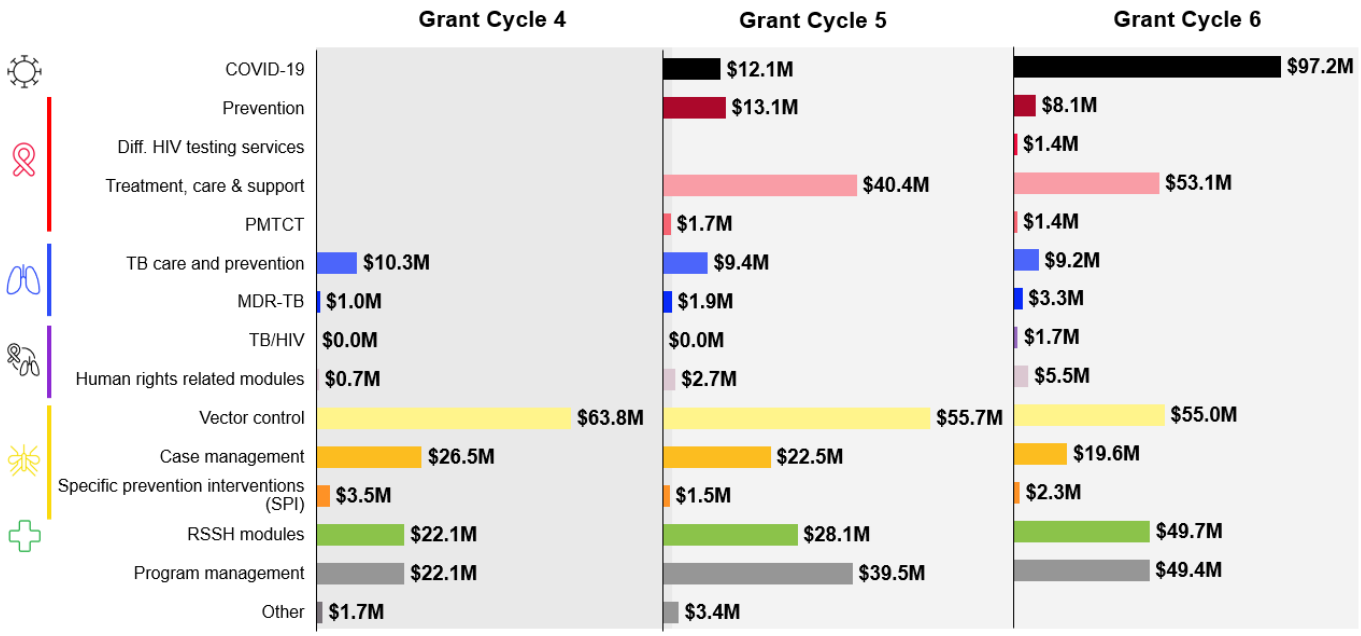
[134] MOP, 2022

[135] RASS 2016 and 2019, GC6 Funding Request and internal Global Fund documents (confidential)

[136] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

[137] Excludes C19RM, program management costs, RSSH (slide 25 of the DnA Factbook Côte d'Ivoire Aug 2023).

Figure 3.1: Côte d'Ivoire Global Fund budget breakdown by module by allocation



Other key features of the country portfolio include[138]:

- RSSH funding increased from US$28.1M in GC5 to US$49.7M in GC6.
- C19RM funding awarded in 2020 totalled US$12.1M, with an additional US$55.1M awarded in 2021.[139]
- Program management costs have increased from US$22.1M in GC4 to US$49.4M in GC6, nearly doubling.
- Funding for HIV modules was introduced in GC5

Catalytic Investments (CI): The following Matching Funds (MFs) were awarded in GC5: Human rights and Key Population in HIV (€2.1M and €3.5M respectively) and Data Strengthening and Use (€$2.6M). In GC6, a single Matching Fund was awarded for continuation of the Human rights CI (€1.9M). The total budget for the Human rights priority area in GC6 was €5.1M (allocation plus MF requested amount), an increase from the GC5 total investment of €2.6M.[140] Côte d'Ivoire was also eligible for eleven Strategic Initiatives, including CCM Evolution, Human Rights, Differentiated HIV Service Delivery, and PSM Transformation. Côte d'Ivoire was also one of the countries involved in the West Africa multi-country TB grant.

3.2. KEY FINDINGS

3.2.1. Relevance of Global Fund investments

Funding requests for GC6 were assessed as being technically sound and strategically focused by the TRP, with clear consideration of evidence to inform prioritisation. All three funding requests (the RSSH and malaria FRs were combined during GC6) were aligned with NSPs, and included programmatic gap analyses, challenges identified during the previous funding cycle, and analysis of results. Stakeholders made use of a set of ranking criteria to prioritise modules and interventions during development of the malaria and RSSH funding request. The funding requests also placed a strong emphasis on VfM: for example, the HIV funding request used the Spectrum GOALS modelling study to identify cost effective interventions, and all three funding requests proposed interventions to build the financial management capacity of PRs and SRs. The country also benefitted from Global Fund negotiations to reduce the cost of nets and medicines, viewed as critical given the increased cost of next generation bednets. The

[138] Global Fund (2023). DnA Factbook Côte d'Ivoire Aug 2023, slide 24

[139] Global Fund (2023). DnA Factbook Côte d'Ivoire Aug 2023, slide 40

[140] Based on internal Global Fund documents (confidential)

TRP and Secretariat did note however, an increase in program management and travel costs which they recommended the country address to ensure economic efficiencies.

In addition, although funding requests remain largely the same between cycles to ensure continuity, stakeholders pointed to multiple examples of studies and operational research being used to adapt programs. For example, PNLT (TB program) conducted studies on the epidemiology of TB in Côte d'Ivoire, and reasons behind delayed care seeking and loss-to-follow up (with support through Expertise France). In response to this study, GC6 interventions were subsequently targeted to Abidjan and the PNLT expanded strategies to promote active case-finding and patient follow-up at the community level (including through private sector and traditional healers). Likewise, a study of HIV prevalence among KPs led to development of activities catering to the transgender population (which has the highest HIV prevalence amongst KPs, but previously had received services only through MSM programs), and delivery of opioid substitution therapy to PWIDs. However, stakeholders also pointed to continuing poor data quality and usage, and some inefficiencies around funding request development limiting review and effective tailoring of funding requests (see Section 1.2.3 on Funding Model).

Although there are examples of integration of innovations in funding requests (HIV self-testing piloted in response to low testing rates, see above for other examples), there was a perception amongst stakeholders that the funding request development process provided limited space for new ideas and innovations. This was attributed to:

- ***Overall improved engagement of stakeholders during funding request development, with room to further improve civil society engagement and effectiveness in the request process.*** Generally, stakeholders consider that engagement of the CCM with civil society stakeholders during the development of funding requests was strengthened substantially over 2017-22 (noting difficulties to ensure civil society engagement during development of GC6, given COVID-19 movement restrictions). More recently in the GC7 funding request in 2023, a specific community dialogue with civil society was organised by Alliance CI. However, some stakeholders felt that the dialogue, while fruitful, was not optimised to generate innovations and new ideas, as it was organised by a PR and mainly engaged current SRs. Stakeholders also felt that further capacity-strengthening and sensitisation are needed to support civil society in engaging fully with the funding request development process (recognising that this process was started during GC6 and GC7, as community PRs did set aside initial funding to strengthen capacity of CSOs). There was also a majority view among interviewees the consultative process of the funding request is functioning sub-optimally, with a mix of too short a time period as well as too many stakeholders involved which affect meaningful strategic review of the GC5 and GC6 grants and the effectiveness of the funding request process.
- ***Re-engagement of the same PRs and SRs to implement the Global Fund grants.*** Although there is a competitive process for the engagement of PRs and SRs (community), capacity of previous PRs and SRs is stronger than other organisations in country limiting competition. Continued implementation of programs by the PR and SR has a clear benefit by minimising implementation disruptions and ensuring continued strong performance, but may somewhat discourage innovation. The CCM will be overseeing SR selection for GC7, to mitigate this and strengthen transparency and competition.
- ***Desire among country stakeholders for more information sharing regarding emerging innovations and other country experiences.*** Some stakeholders requested greater access to sensitisation and trainings when important innovations emerge. There was a perception that the Global Fund previously provided more support in this regard (E.g.AccessMod for geolocalisation of health institutions) and that this would benefit country stakeholders, especially in the disease programs and UCP.

Despite marked strengthening and expansion of community-based programs within funding requests, there is a need for further balance between community-based and facility-based interventions, as well as amongst biomedical, behavioural and structural approaches. In response to challenges such as difficulties in diagnosing HIV and TB cases and an increase in malaria incidence, community-based interventions were allocated a greater

proportion of the GC6 budget (especially malaria, which increased by 135% from €12.7M to €29.9M).[141] Community-based interventions are regarded as particularly important, given that a high proportion of the population live more than 5 kilometres from a health facility along with need to reach key populations in urban areas. However, multiple stakeholders reported that the emphasis on community-based interventions as well as structural and behavioural interventions was insufficient in relation to HTM objectives. For example, the greatest portion of the malaria grant is spent on LLIN mass campaigns[142], with limited interventions aimed at increasing demand for and utilisation of nets (utilisation remains low at 63%). This tension also reflects overall insufficiency in available funding, alongside reported rising costs (e.g. Côte d'Ivoire has areas with insecticide resistance requiring PBO an dual AI nets). Nevertheless, stakeholders were clear that community health systems would be far weaker without Global Fund support. Relevant structural interventions such as nutritional support were also considered underfunded, despite the link to treatment drop-off for TB and HIV patients. Stakeholders also supported further strengthening of integrated and multisectoral approaches, including through collaboration between disease programs and the Ministère de la Femme, de la Famille et de l'Enfant (Ministry of Women, Family, and Children). Recently, the PNLS has shifted towards providing services to people who have experienced violence based on gender or sexuality, but this remains a small investment.

Côte d'Ivoire is highly reliant on the Global Fund for TB financing and interventions are appropriate and relevant to the disease burden - however constrained funding levels limit full financing of key interventions. It was reported that certain important interventions have gone unfunded and remain so for GC7, such as sample transportation is underfunded which is a significant threat to the TB program. Additionally, although identified as an important avenue to reach people who are not accessing health centres, work with private sector service providers and traditional healers has not been funded.

3.2.2. Progress and results achieved

Malaria

Although the malaria grants are performing strongly against coverage targets, the program faces considerable challenges and stagnating results. The estimated number of malaria cases dropped by 26% from 2010 to 2014, from 9.6 million to 7.1 million. However since then, the situation has stagnated. From 2015 to 2018, there was an increase in 3% in estimated malaria incidence. The national health management information system reported a 26% increase in the reported incidence rate during the same period. Data inaccuracies, as well as an increase in active community case-finding, cannot fully account for the upward trend reported through the HMIS. [143]

On the other hand both public and community malaria grants were the highest performing according to the latest PUDRs, and either met or overperformed against targets (with the exception of IPTp, see below). There has also been a slight decrease in mortality since 2018, attributed to improvements in case management. However, stakeholders pointed to the following challenges accounting for limited impact on malaria burden:

- ***Weak performance on coverage of IPT*.** This target is challenging to meet, given low rates of ANC attendance among pregnant women in the first trimester (and underscoring importance of integrated approaches with the Ministry in charge of maternal and child health). However, active search for lost to follow-up pregnant women has contributed to an increase in IPTp coverage from 23% in 2016 to 35% in 2021.[144]
- ***Poor data quality*, *including high use of presumptive malaria diagnosis***: the expansion of DHIS2 over the last strategy period is a significant improvement, however for malaria the platform does not integrate epidemiological, entomological and logistical data accurately.[145] A crucial issue in the quality of malaria data which has affected decision-making is the high use of presumptive diagnosis of malaria (without confirmatory test). This is widely known to country stakeholders as a key issue for the malaria program.

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[141] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

[142] Around 67% of MOH grants during GC6 are directed to health commodities and related procurement and supply chain costs.

[143] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

[144] Institut National de la Statistique, Enquete Démographique et de Santé, 2021

[145] PMI, Malaria Operational Plan, 2023

- ***Low utilisation of nets*** (52%[146]) particularly in urban areas, where transmission is likely to increase given changing climate patterns in the Côte d'Ivoire.
- ***Recurring stockouts of malaria commodities at the last mile of service delivery***. According to the Plan stratégique de la santé communautaire, in October 2019 the proportion of CHWs who experienced stock-outs of malaria RDTs at least 15 days per month was 41% and the proportion which experienced stock-outs of anti-malaria drugs was 52%.[147]
- ***Resistance to insecticide***, lowering LLINs' effectiveness. Although second generation LLINs have been included in the upcoming mass distribution campaign (planned for 2024), the increase in associated costs has led to a funding gap for GC7. Abidjan will not be included in the first wave of distribution, until resources can be mobilised.

Given stagnating results despite a growing malaria burden, some stakeholders called for a closer review of what is being funded through Global Fund grants in order to identify interventions which may be effective in decreasing incidence, while encouraging the government to increase funding for antimalarials and LLINs (see Section 1.2.3 on sustainability). A retrospective analysis of malaria data over the last 10 years is near completion to support decision-making within the malaria response.

HIV

Côte d'Ivoire's strong HIV response has led to a decrease in HIV prevalence, incidence and mortality. According to Spectrum analysis (2020), incidence has declined 34% since 2015 and mortality has decreased by 37%. The ratio of incidence to prevalence is 2.8% which is below the target for epidemic control at 3% and largely below the average of 5.5% in West Africa.

In addition, Côte d'Ivoire has made substantial progress in reaching KPs with prevention programs and HIV testing, particularly SWs and PWIDs. The coverage of combination prevention amongst sex workers, the incarcerated, and PWID is 77%, 81%, and 83% respectively. Coverage of MSM lags behind significantly however, at 38%. This is mirrored by programmatic performance, with PRs reporting that they met or exceeded targets for coverage of SWs, PWIDs, and the prison population but underperformed against targets related to MSM.[148] Loss-to-follow up among KPs has also decreased. The allocation of a budget to link newly diagnosed HIV-positive individuals to treatment increased new enrolment on ARVs from 69% in 2017 to 95% in 2018.[149] Finally, aided through a Matching Fund allocation, a number of interventions have been implemented by Alliance CI to address human rights-related barriers to HIV services. The 2022 Stigma Report detailed a substantial improvement in stigma and discrimination against PLHIV across multiple indicators, showing that the scale-up in human rights related-interventions is contributing to promising results (see Section 1.2.7 on HRG).[150] Nevertheless, the HIV program faces challenges:

- ***The primary challenge that stakeholders identified was in achieving 95-95-95 targets.*** Although Côte d'Ivoire has made progress, achieving 82%-72%-62% on the HIV testing and treatment cascade in the general population in 2022[151], stakeholders reported challenges in reaching men with HIV testing due to stigma, discrimination, and poor health-seeking behaviours. Additionally, progress to the last 95 is significantly impeded by lengthy turnaround times for viral load testing because of limited availability of laboratory services at the last mile and difficulties in sample transportation (PEPFAR supported areas reportedly have better performance on this third 95-) .

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[146] Enquete Démographique et de Santé, 2021

[147] Plan stratégique de la santé Communautaire, quoted in OIG Audit Report: Global Fund Grants in Republic of Cote d'Ivoire, 2020

[148] GC6 Funding Request and internal Global Fund documents (confidential)

[149] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

[150] Index de la stigmatisation et la discrimination envers les PVVIH en Cote d'Ivoire 2.0 (Index Stigma 2.0), 2022

[151] UNAIDS, Côte d'Ivoire Data, 2022

- ***Difficulties in addressing paediatric AIDS.*** Despite PMTCT services being offered in 94% of facilities, the MTCT rate is estimated at 10.3%. Rates of ANC attendance in the first trimester are low (34%), and many women do not receive ART during pregnancy (causing 51% of MTCT cases). Once exposed, children are also not receiving ARV prophylaxis or EID (coverage is 63% and 53% respectively). In 2019, around 50% of children 0-14 years knew their status, 36% were on ARTs, and 18% were virally suppressed.[152]
- ***There is scope to strengthen TB/HIV integration.*** Mortality rate amongst co-infected TB/HIV patients has been stagnant at 21% from 2015-2020.[153] Although coverage of HIV testing among TB patients is at 99% with 95% of co-infected cases on ARVs, TB screening among HIV patients is only at 75% and TPT coverage is very low.[154] The OIG Audit Report pointed to insufficient joint planning of activities and supervision between PNLT and PNLS as a factor, although stakeholders reported that this has improved.
- ***The HIV program has also been impacted by commodity stockouts, particularly STI kits at community level.*** This is a particularly problematic for KP programs, which use STI testing as an entry point into the larger program.

TB

Although TB remains a substantial public health problem in Côte d'Ivoire, incidence and mortality are decreasing. A major success of the program has been the expansion of community-based interventions and active-case finding strategies, including in prisons. The number of notified TB cases had previously been falling by around 5% annually, but since 2016 community-based interventions have contributed to stabilising the number of notified TB cases. The proportion of cases identified by CHWs was 30% in June 2019. Loss to follow-up has also decreased from 7% in 2012 to 2% in 2018, and treatment success rate increased from 79% in 2012 to 87% in 2018.

Despite these improvements, challenges persist. The proportion of missing cases remains high (around 41%) with an even higher proportion of missing MDR-TB cases (55%). This was attributed to underutilisation of molecular testing such as GeneXpert, in part due to sample transportation and procurement challenges. Additionally, coverage of TPT which was initiated in Côte d'Ivoire in 2017 remains very low, with the program underperforming against targets by around 50%. Finally, the country scaled up the number of TB centres from 184 facilities in 2015 to 307 facilities in 2018, however, the number of notified cases has remained stagnant: 46% of the new TB facilities notified fewer than 10 cases per year, mainly due to a lack of awareness raising on the existence of the TB centres. The PNLT has therefore implemented a differentiated approach to TB case detection and treatment, targeting hotspots and hard-to-reach areas as well as expanding TB services at non-specialised health facilities. Given the tight funding environment for TB (smallest of the disease allocations), scale up of active case detection and use of the more costly GeneXpert are placing a considerable strain on the TB program.

RSSH

The creation of a standalone RSSH grant centralised under UCP management in GC6 was successful in addressing accountability challenges posed by the GC5 arrangements. Stakeholders were very supportive of this shift and view that centralising accountability and programmatic oversight for RSSH interventions under the UCP has improved performance as well as absorption. The UCP has proved effective in ensuring implementation of interventions, including through efforts to coordinate and sensitise the necessary MoH stakeholders (Diréction de Information Sanitaire (DIS), Diréction de Santé Communautaire (DSC), Nouvelle Pharmacie de la Santé Publique (NPSP), etc.) Details on key achievements across RSSH investments are as follows:

- Significant investments were made in rollout of DHIS2 and support integration of data from HTM programs including data collected from communities. This has improved timeliness of reporting, although the quality, completeness and coherence of reports requires improvement. Global Fund investments have thus

[152] GC6 Funding Request and internal Global Fund documents (confidential)

[153] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

[154] GC6 Funding Request and internal Global Fund documents (confidential)

supported frequent data workshops with stakeholders and partners to review data discrepancies, and the strengthening of the governance and leadership of the DIS.

- Global Fund investments have supported the development and operationalisation of the National Santé Communautaire Strategy (Community Health), including mapping and quantifying CHWs, and developing a CHW electronic data collection tool to expand CLM. Plans to integrate CHWs formally into the health sector, rationalise payments, and implement a minimum kit to provide integrated disease services stalled during GC6 and is included in the GC7 funding request. Other priorities to strengthen the CHW platform include stockouts, persisting low ratio of CHWs to populations in catchment areas, and limited government oversight. With Global Fund-support, CHW supervisors were placed by the community PR to conduct review activities in tandem with a facility-based nurse (bolstering the capacity of the primary health centres), though there are some concerns around the sustainability of this approach.
- Global Fund investments have been used to strengthen the capacity of supply chain actors including the Nouvelle Pharmacie de la Santé Publique, and to implement m-Supply (an electronic stock management software) to improve tracking of commodities. However, despite relatively good accountability for commodities at the central level (also recognised by the OIG audit), poor accountability and tracking at the peripheral level continues to lead to stock-outs, discrepancies in quantification versus actual stock, and leakage. Strengthening last mile availability and stock management is within the GC7 funding request.

Despite progress made, Côte d'Ivoire's weaker health system is one of the key threats to the performance of the HTM grants suggesting the RSSH investment should potentially receive greater attention (recognising limited resource context). Key difficulties related to supply chain, transportation and laboratory systems have led to stockouts of key commodities such as STI kits, condoms, anti-malaria drugs, and RDTs, and delayed transportation of sputum and blood samples affecting quality of care . Data quality problems and active use of existing data impede programmatic oversight and decision-making. Finally, the availability of health services at the last mile and difficulties in decentralising the health system remains a key challenge affecting intervention coverage.

3.2.3. Funding model and business processes

Funding model

The CCM has undergone a significant strengthening process during the 2017-2022 strategy period, with room for continued growth. Through the CCM Evolution Strategic Initiative (initiated in 2021) a consultant was hired to support training and capacity-strengthening to improve CSO engagement in the CCM, and support the CCM in reviewing national programs holistically. In order to improve the strategic oversight function of the CCM and address technical challenges, staff were seconded from the MOH to the CCM to serve as the focal point for each disease program, RSSH, and health product management. An Ethics Committee was also established within the CCM in 2022. Stakeholders reported that the coordination role of the CCM is being fulfilled, with relevant actors strongly engaged in processes. However, despite progress, several challenges were identified. The development of the funding request for GC7 was characterised as somewhat disorganised, with limited time for in-depth strategic review, over-dependence on technical assistance (although stakeholders reported TA to be useful), and too many people engaged (around 140). In addition, stakeholders felt that the role of the CCM regarding strategic oversight needed to be strengthened, as the CCM is not sufficiently empowered to act as the intermediary between PRs and the Global Fund on the basis of its review function. From a resource perspective, the CCM has limited funding with which to conduct oversight visits at the district level.

The UCP as a complimentary structure to the CCM has matured significantly from GC5 to GC6 but continues to struggle in fulfilling procurement responsibilities, in particular. The creation of the UCP in early 2018 was a major change in implementation arrangements, in response to a 2016 OIG Audit which found a lack of authority and flexibility to implement cross-cutting grant activities, gaps in fiduciary control, and difficulties related to procurement within programs. The UCP centralised certain functions, and has proved particularly effective in fulfilling its risk assessment role (see section on Risk below). The 2020 OIG Audit suggested that the UCP has also been able to effectively fulfil its financial management role, with some risks due to a lack of accountability for MoH grant budgets (as UCP technically reports to the MoH). Similarly, although the UCP is meant to support program monitoring and evaluation including the validation of programmatic sections of the PUDR, the audit suggests that in practice the UCP

consolidates reporting but has little visibility on programmatic activities and results, limiting its ability to provide oversight to MoH programs. Finally, the procurement function of the UCP requires strengthening. Stakeholders reported long delays in activities reliant on UCP procurement (non-medical equipment like x-rays, cold chain storage, consultants, and surveys such as the IBBS), in part due to long contracting process. Given the persisting challenges of stock-outs at the district and health facility level, the OIG report suggested that the UCP provide greater support to disease programs to ensure timely and accurate submission of procurement requisitions and minimise inefficiencies and administrative delays.[155]

Overall, stakeholders are satisfied the Global Fund model has offered flexibility and a country-led approach. Stakeholders were generally satisfied with the Global Fund model and policies supporting funding request development, noting strong alignment with NSPs, engagement with civil society as well as government actors, strong TA support provided by partners and financed by grants, and helpful guidance documents. Additionally, country stakeholders appreciated the availability of the LFA and Country Team, and reported strengthened dialogue with both .37 During the development of GC7,country stakeholders were particularly positive regarding the negotiations which took place in Geneva to finalise the funding requests which strengthened interventions and were based on mutual dialogue and understanding. Examples cited of issues addressed through the open dialogue process include with the Secretariat the extent to which AGYW and youth would be included as focus populations in the HIV funding request, and the balance between community and facility-based malaria interventions. Stakeholders also appreciated the Global Fund's relative flexibility in allowing frequent reprogramming during grant implementation. Stakeholders did, however, identify a few difficulties regarding the Global Fund model, policies and processes:

- There were mixed views regarding the appropriateness of the balance between a country-led or Global Fund-directed approach, despite the overall positive perspective highlighted above. Some stakeholders felt that guidance from the Global Fund was useful, and supported more effective country programs and achievement of results. Others expressed concern that the Global Fund was become overly directive, evident during recent GC7 negotiations. The integration of gender into the already overstretched TB program was cited as a decision imposed by the Global Fund, suggesting further attention is needed to sensitise stakeholders to the significance of gender-responsive approaches.

- Multiple stakeholders also critiqued Global Fund processes as being heavy and burdensome. This includes the multiple forms required to develop funding requests (with some version control issues further complicating the process), reporting requirements, and frequent missions and requests related to the Global Fund (e.g. SI evaluations). Additionally, stakeholders were frustrated by the lack of harmonisation in processes and requirements between donors.

- Stakeholders also reported historic issues in delayed implementation of grant activities, citing contributing factors such as protracted grant negotiations, need to address TRP requests and PR challenges when new activities were introduced in a grant. Some of these challenges may in future be mitigated through efforts by the Global Fund to contract grants earlier.

It is recognised that the significant Global Fund financing has influenced the civil society landscape and national disease programs.

- **National disease programs.** Stakeholders pointed to a situation whereby government PRs who are expected to coordinate and assume responsibility for the NSPs as a whole, have difficulty maintain progress in areas not financed by the Global Fund because of staff capacity constraints. Additionally, in trying to manage misalignment between government planning cycles and Global Fund funding cycles, the NSPs were extended by one year to match the Global Fund funding cycle. Not all country stakeholders supported this decision, particularly as they felt that a strong strategic review process was circumvented. Because of the close relationship and interdependency between NSPs and the Global Fund funding requests, stakeholders suggested that there was a need for the Global Fund to support NSP strengthening in addition to funding

[155] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

request development (for example, support the country in addressing gaps related to gender and community-based interventions in the NSPs, and ensure there is a strong review process).

- **Civil society.** Amongst community PRs, it was observed that Alliance's work in areas not financed by the Global Fund have disappeared or dissipated, and its role has moved from that of a grassroots organisation to the equivalent of a funder of Global Fund financed activities. Additionally, other organisations struggle to compete with PRs and SRs which have reached much stronger capacity levels through Global Fund financing and support. Although this presents efficiencies (see Section 1.2.1 on Relevance), this also suggests a need for the Global Fund to consider its impact on the health and civil society ecosystem in the Côte d'Ivoire, particularly when planning for sustainability and transition.

Sustainability

The programmatic and financial sustainability of programs in Côte d'Ivoire was identified as a major potential risk to HTM and RSSH programs. The country is highly dependent on external funding to support health systems, with the government contributing approximately 5% to health spending as a proportion of GDP - a proportion that has not evolved in the past decade. There is a perception amongst stakeholders that the government is not adequately assuming responsibility for the provision of health services particularly commodities, and despite standing commitments there are often significant delay and gaps in procurement and delivery of ARVs, anti-malarials, and tuberculosis treatment which the Global Fund and USG partners are forced to fill to ensure continuity of essential services. A previous commitment in 2019 to raise health spending by 15% annually has reportedly not been met. Additionally, stakeholders pointed to an overreliance on technical assistance, which while overall of high quality, is insufficiently contributing to the long-term capacity of national programs and organisations. Some stakeholders also view the Global Fund does not have adequate levers in place in order to encourage use of domestic resources, and the need for a step up in engagement with other key Ministries, beyond Health. For GC7, the co-financing commitment will be signed by the Minister in charge of the newly created Direction General du Budget et des Finances (which merges these two portfolios), considered a positive development in supporting release of financing to the health sector.

Efforts are currently being made to improve sustainability of programs with partner support. The government has consistently met the 15% co-financing requirement in GC5 and GC6, and currently finances more than 50% of the ARV need (PEPFAR is planning to transition out of financing ARVs completely). Sustainability plans are being developed for core programs as well as community health. Alliance CI, the national NGO and PR, has been substantially strengthened by Global Fund financing and is contributing to capacity-strengthening of local CSOs (this also reportedly lowers operational costs of the program). Additionally, stakeholders reported that the Global Fund is engaging in advocacy efforts with the Ministry of Health, as well as the Ministry of Budget and Finance to increase domestic financing for health. During GC7 in particular, the CT has made significant efforts to engage with Côte d'Ivoire government in order to improve the co-financing outlook and ensure there is a shared understanding. This includes ensuring that commitments are in line with requirements and country capacity but not overly ambitious, that the overall government health budget is increasing such that HTM spending does not crowd out other essential health spending, that budget execution data is shared, and that steps are taken to minimise stock-outs linked to co-financing.

Moving forwards, there are opportunities for further strengthening. The Global Fund and Gavi UCP will be merged in t2024, in order to promote donor harmonisation. Additionally, Gavi is launching an accelerated transition plan, which envisages a full transition out of Côte d'Ivoire by 2030. This has launched interest in developing a comprehensive sustainability plan for health. Although development is currently stalled, this is a key opportunity for partners to align on a sustainability and transition agenda, and jointly sensitise government and non-governmental country partners to prepare for transition.

Risk

Risk management processes within Côte d'Ivoire are functioning smoothly. In particular, the UCP has been fulfilling its risk assessment and internal auditing function well.[156] Stakeholders spoke to a smooth and collaborative

[156] Global Fund (2020). OIG Audit Report Global Fund Grants in the Republic of Côte d'Ivoire

process for identifying risks with the Country Team, with frequent follow-up discussions. The relationship between the LFA, CT, CCM and PRs is also strong, and stakeholders expressed that the LFA identification and follow-up of new risk areas is smooth. That being said, stakeholders felt that there was a missed opportunity to strengthen the CCM in its strategic monitoring of programs, and ensure that risks and challenges are taken into account during the development of new funding requests. The capacity of program implementers to manage and mitigate identified risks was also viewed as a weak point which requires further improvement (perhaps, requiring further intervention from the UCP).

M&E

Indicators reported through the Global Fund performance framework were regarded by country stakeholders as relevant and aligned with NSPs. Multiple stakeholders pointed to issues related to target-setting however. In particular, the following indicator targets were viewed as overly ambitious. These may reflect a natural tension between the Secretariat encouraging ambition in grant performance with views by implementing partners of what is achievable. Additionally, there was also a perspective that targets were 'imposed' by the Global Fund with limited flexibility given to country stakeholders to adjust targets based on early implementation experience

- HIV testing amongst KPs, which was based on HIV prevalence rather than incidence in districts that were already saturated with other partner support, as well as inherent challenges of working with accurate KP population size estimates.
- Proportion of pregnant women provided IPTp at three ANC visits, given that it failed to take into account the low proportion of pregnant women attending ANCs in the first trimester.
- TPT amongst adults and children, which failed to take into account difficulties in testing for TB among index cases due to a lack of tuberculin availability on the global market during GC6, partially due to the context around the COVID-19 pandemic.

3.2.4. C19RM

Processes for applying to C19RM funding were perceived as heavy, and unsuited to the rapidly evolving emergency situation of the pandemic. The C19RM award in 2021 was $US55.1M though absorption was very low owing to the country not being able to use the funds as per the approved budget in the absence of an updated pandemic plan or national framework for testing. These conditions were considered by stakeholders as not feasible to put in place at the peak of the pandemic.[157] There is a view that many of the COVID-19 response interventions were no longer relevant by the time the C19RM grant implementation began in earnest, as the peak of the pandemic had passed and by which time the country also pivoted aggressively to rolling out the COVID vaccine. While the impact of COVID-19 was relatively minimal in the Côte d'Ivoire, several stakeholders perceived C19RM would not have been appropriate to meet needs given the above cited challenges to implementing approved funds. Interventions did however mitigate the impact of the pandemic on access to HTM programs and services, through interventions such as multi-month distribution of ARVs, and PPE for health workers and CHWs **The flexibility to reprogram C19RM funding to support RSSH objectives was perceived very positively,** which is highly relevant as in-country absorption of C19RM funds was only 33% at the time of this case study.[158] Reprogramming has allowed the funding to support reinforcement of health systems through i) strengthening surveillance (epidemiological, laboratory and community-based); ii) instalment of oxygen systems in hospitals; iii) strengthening of waste management systems; and iv) quality assessment of laboratory, surveillance and oxygen systems.

[157] Cote d'Ivoire did not apply for C19RM fast track funding. C19RM funding awarded in 2020 totalled US$12.1M, with an additional US$55.1M awarded in 2021. The TA financed to support development of the C19RM funding application in 2021 was positively perceived by stakeholders.

[158] Absorption data extracted August 22, 2023. At this time, 67% of grant implementation period was elapsed. C19RM funds were reprogrammed in 2023 to support pandemic preparedness and health systems strengthening as detailed. These funds are planned to be used during 2024-2025.

3.2.5. Catalytic investments

Stakeholders pointed to positive impacts derived from catalytic investments, particular the Matching Funds (MF) on Data Use and Human Rights, as well as the CCM Evolution Strategic Initiative.[159] The Data Use MF contributed to strengthening the routine health information systems , contributing to a near 100% completeness and timeliness of reporting (with remaining gaps on data quality). The budget was integrated into the main RSSH grant following discontinuation of the MF in GC6. The Human Rights MF has been implemented by Alliance CI, and supports a range of human-rights related interventions which have contributed to a decrease in stigma and discrimination (see Section 1.2.2 and Section 1.2.7 on HRG). The CCM Evolution SI has also played a significant role in improving CSO engagement with the CCM, amongst other aspects (see Section 1.2.3 on Funding Model).

Stakeholders felt that Strategic Initiatives required refining in order to have the desired impact. Because SIs were proposed following the finalisation of grant design under GC6 (and were outside the funding request development), stakeholders suggested these opportunities were not appropriately capitalised upon (this issue is being addressed in GC7 through communication of MFs and SIs within the country allocation letter). Many stakeholders when questioned, were unaware of the existence of the SIs (and to a lesser extent, Matching Funds). There was a perception that there were too many SIs to implement effectively, and that the choice of SIs was driven neither by the country nor the CT. Communication of MFs and SIs as part of the country allocation letter is intended to lead to a greater common understanding including among country stakeholders regarding the objectives of MFs and SIs and available funding.

3.2.6. Partnerships

Stakeholders praised strong coordination of partners and donors at the country level, which improved over the 2017-2022 period. There are multiple mechanisms through which partners are able to coordinate the HTM response, including the CCM, Donor Group, and technical working groups. Close coordination and collaboration has led to a decrease in duplication and overlap between partners. For example, PEPFAR , PMI, and the Global Fund have worked to delineate geographic zones and areas for intervention since the beginning of GC6. Since 2017, they also jointly contribute to a 'virtual' commodity basket, which reflects quantification of the needs of the country as a whole. This minimises any gaps or surplus in provision of commodities. The Global Fund also has close working relationships with UNAIDS, WHO, and UNICEF at the country level. UNICEF acts as a procurement partner for logistics management of malaria nets during campaigns, while UNAIDS and WHO provide technical assistance and guidance at the country level. At the WHO for example, there is a full time position financed through grant funds to support the MOH in its efforts to strengthen data quality.

There is a strong system for provision of technical assistance through partners such as UNAIDS, Expertise France, Stop TB, and Frontline AIDS. These partners have contributed to diverse interventions, including expansion of CLM, studies on TB patient follow-up, and implementation of human rights-related interventions such as the Looking in, Looking Out initiative aimed at reducing stigma and discrimination in healthcare settings. Generally, technical assistance is aligned with country needs and was characterised as helpful by country stakeholders. However, stakeholders did raise concerns regarding the quantity of technical assistance requested and the extent to which this threatened the sustainability and long-term capacity of country programs. Stakeholders suggested that there was a need to review the technical assistance approach, to ensure that support is strategic and focused.

Multisectoral approaches and partnerships needs strengthening with some promising work in GBV. For example, despite clear links for the malaria program, partnership with the Ministry of Women, Children and Family and Ministry of Education (implicated in school-based services) is lacking. Embedding human rights approaches in particular within country institutions (such as the Ministry of Justice) is crucial to sustainability, but has been a weak point in past grant cycles. However, multisectoral approaches are being strengthened, with funds being made available to work more closely with the Ministry of Justice on addressing GBV, and with noncommunicable disease programs to address HIV comorbidities such as cervical cancer.

3.2.7. Gender, human rights, equity & communities (crosscutting)

Stakeholders were clear that progress related to human rights-related barriers and gender, equity and communities are attributable to the Global Fund, which played a catalytic role in drawing attention to these areas. At the CCM level, engagement of CSOs has been considerably strengthened in development of the funding requests. Additionally, funding has been set aside to capacitate local CSOs, strengthen technical capacity to provide services to KPs, programmatic and financial management, and ability to engage with the CCM. Through Alliance CI and sub-recipients (with support from the Human Rights and KP Matching Funds), a number of interventions have been implemented to remove human-rights related barriers to HIV and TB services. These include implementation of the Looking In, Looking Out project to address stigma In healthcare settings, legal literacy programs, provision of mental health services in Drop-In Centres, establishment of GBV platforms within each district which promote coordination between the police, medical professionals, and disease focal points, mobilisation of patient groups (particularly women) to strengthen access to services, and provision of services to the prison population. This has been accompanied by a scale-up in funding for community-based interventions, and strong focus on KPs. While not a direct beneficiary of the matching funds, the malaria program has also sought to integrate a human rights and gender-responsive approach, to ensure that underserved populations are prioritised for service delivery. Community-based approaches have significantly contributed to improvements in attaining HTM objectives, although weaknesses in community systems were noted (discussed in Section 1.2.2).

As a result of these efforts, several advancements have been reported. Stigma 2.0[160] found improvements across multiple indicators since 2016: in 2021, 11.8% of respondents chose to not participate in social encounters as opposed to 18.8% in 2016; 6.3% avoided going to health facilities as opposed to 7.5% in 2016; 3.1% were excluded from activities and social engagements as opposed to 74% in 2016; and 2.8% were excluded from family life as opposed to 90% in 2016. The BDB mid-term assessment also reported a significant scale-up of HIV and TB programs to reach operations at sub-national level.

Despite significant efforts from the Global Fund to advance human-rights based approaches in the Côte d'Ivoire, a hostile social context remains a barrier. Stigma 2.0 found experiences of discrimination to be far more likely amongst MSM, TG, PWIDs, and SWs than among PLHIV as a whole. There is also variation in services amongst KP groups (e.g. coverage of prevention services amongst MSM is far lower than other KP groups), and the BDB mid-term assessment (December 2020) highlights that the needs of TG individuals are invisible and they remain excluded from outreach efforts (although SRs reported this is no longer the case, indicating an important change since the BDB mid-term). Additionally, fostering political will and momentum and ensuring the sustainability of HRG programs remains challenging. There is also a need to continue sensitising disease programs to the importance of HRG-responsive programming, and to ensure that community-based and HRG-based approaches are integrated into NSPs.

3.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

From 2017 to 2022, there has been a significant maturation of the programs and implementing structures of the Global Fund's investments in Côte d'Ivoire. The leadership and governance of the Diréction de Santé Communautaire has been strengthened, and there has been a significant scale-up of community-based interventions which have yielded improvements in integrated community case finding and management for HIV, TB, and malaria. The DHIS2 has been established as the national HMIS and integrates HIV, TB, and malaria data and is beginning to systematically include community level case management, although challenges regarding the quality and coherence of results persist. Finally, the UCP is maturing as a structure, and absorption and performance of RSS investments have improved since management of the cross cutting activities were centralised under the UCP.

Despite considerable advancement in HIV, TB and malaria and RSSH, challenges persist including high rates of missing TB and DR-TB cases, slow progress towards 95-95-95 targets on the HIV testing and treatment cascade, and

[160] Report financed by PEPFAR and the Global Fund with TA from UNAIDS, which surveyed just under 2,500 PLHIV across Côte d'Ivoire on experiences of stigma and discrimination (conducted in 2016 and 2021).

an increase in malaria incidence and burden. In order to maximise the impact of investments during GC7, the review proposed the following suggested areas for strengthening:

1. Address risks to HTM objectives posed by weaknesses in the health system. Key areas for intervention include i) improving quality and coherence of data, particularly at the district level; ii) strengthening the supply chain, procurement and sample transportation; and iii) strengthening community systems, including by supporting development and operationalisation of plans to increase saturation of CHWs, rationalise salaries, establish minimum kits which integrate multiple disease areas, and expand CLM. These interventions are especially important for addressing health inequities, and ensuring access to services at the last mile. This may involve engaging more closely with heath system actors outside of traditional HTM PRs, including the DSC, nPSP, and DIS. It is recognised that many of these are already within the planned GC7 grants, with needed oversight during GC7 implementation.
2. Continue to support gender-responsive and human rights-related programming, as well as community-based interventions. The scale up in human rights-related interventions has reportedly led to decreases in stigma and discrimination and likewise, the scale-up of community-based interventions have addressed issues related to service access, but these remain important barriers to achieving HTM elimination. There is a need to ensure that these are addressed appropriately in NSPs, and enhance integration with other sectors in order to maximise impact. This includes ensuring disease programs and key stakeholders are sensitised to HR and GE-related barriers, with adequately responsive programs.
3. Focus on improving programmatic and financial sustainability of investments, as well as harmonisation and alignment with other donors and partners. In particular, strengthen alignment with other donors and technical partners around a sustainability and transition agenda, and implement appropriate levers to increase domestic resources for health. Some stakeholders also recommended that the Global Fund should play a greater role in ensuring that co-financing committed by the country government is invested in a strategic and optimised way, and that new policies being developed (Human Resources for Health, UHC) are well-supported.
4. Continue to strengthen the UCP and CCM. In particular, strengthen the UCP's cross-cutting and oversight functions including programmatic supervision, financial management and procurement. By around 2024/2025, it is planned that the Global Fund and Gavi UCP will be merged which is likely to both strengthen the UCP, while also presenting an opportunity to strengthen alignment and harmonisation of donor funds in support of national ownership and sustainability. Efforts to strengthen the UCP should be pursued and supported by the Global Fund. Likewise, the ability of the CCM to provide strategic oversight, work closely as an intermediary between the PRs and Global Fund Secretariat, and coordinate effective development of funding requests with strong KP inclusion needs to be further improved (with efforts already underway through the CCM Evolution SI).
5. In preparation for GC8, a review of progress and lessons from implementing the current NSP (which is being extended to cover the full GC7 period) should be undertaken so that the GC8 funding request is prepared on the basis of evidence of what worked well and less well in the preceding years, alongside changes in the context and operating environment. Additionally, understanding that a retrospective analysis of malaria data over the last 10 years is near completion, insights should inform GC7 implementation and GC8 design in order to specifically address malaria-related challenges.

A.5. REFERENCES

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A.6. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 33 stakeholders from the following entities:

Stakeholder category	Entity
Global Fund Secretariat	Global Fund Country Team
CCM	CCM
Ministry of Health	Direction Général de la Santé
State Principal Recipients	Program Management Unit (UCP)
	PNLT
	PNLS
	PNLP
SRs	Collecte d'Organisations pour le Lutte Contre la Tuberculose et maladie respiratoire (Alliance SR)
	Heartland Alliance (Alliance SR)
Community PR	Save the Children
	Alliance Côte d'Ivoire
Technical Partners	UNAIDS
	WHO
	UNICEF
Donors	French Embassy, MoFA
	PEPFAR
LFA	PWC

4. INDIA case study report

The India country case study was conducted along with thirteen other country case studies as part of the Global Fund Strategic Review 2023 (SR2023). A reduced scope for the India case study was agreed with the ELO and Global Fund Secretariat (i.e., high level document review, small number of consultations, focus on a few aspects of the Global Fund funding to the country only) in recognition of the special situation of India where Global Fund funding to the country represents a small part of overall HTM and health budget which are mainly government driven. The brief case study report below aims to summarise the main points of feedback primarily from the interviews, to ensure the useful feedback received is documented and made available for the use of the Global Fund Secretariat and other stakeholders for India. Key points have also been considered in the overall findings for SR2023.

4.1. Summary of Global Fund contribution

The Global Fund disbursed a total allocation of US$1 billion ($500 million for each grant cycle) in GC5/NFM2 and GC6/NFM3. There were 11 Principal Recipients in GC5 and 10 in GC6, including both government and nongovernment PRs. Grant agreements with the government are signed with the Department of Economic Affairs in the Ministry of Finance (MoF) and implemented through the Ministry of Health. Non-government PRs include NGOs and private entities that implement activities across the three diseases.

4.2. Relevance

Although Global Fund investments in India represent a small proportion of HTM funding in the country, they are seen as highly relevant and complementary to Government funding, providing a source of catalytic resources to implement innovative initiatives, and support scale-up of key interventions. Stakeholders indicated that Global Fund investments are viewed as very relevant for India especially as the country remains a top contributor to the overall HTM disease burden worldwide (especially for HIV and TB). India has the highest TB burden in the world with one of the highest burdens of HIV-associated TB and MDR/RRTB.[161] An estimated 2.3 million people are living with HIV in the country, making it the second highest HIV burden country in the world. Whilst malaria burden is relatively low in India and in the region overall (as malaria cases in South-East Asia represented ~2% of global burden in 2021), India is remains a top contributor of regional malaria burden, accounting for 83% of all malaria deaths in South-East Asia and 79% of cases in the region in 2021.[162] As such, stakeholders highlight that progress in India are critical to reach the global goals of ending the three epidemics which will require both multisectoral actions, innovative interventions and strategic multilateral partnerships.

In general, stakeholders indicated that the role of the Global Fund is not to support the mainstay of the disease programs that are well funded through the government. Instead, they have highlighted the strategic value add of Global Fund investment as a source of catalytic investment to provide proof of concept for innovative interventions and support government scale-up efforts. Over the last few years, the Global Fund has used its funding to take measured programmatic risks in areas where the Government was less able to do so, and demonstrate results on innovative interventions that can be taken to scale. An example of effective and successful partnership supported by the Global Fund is the Joint Effort to Eliminate TB (JEET). The JEET initiative, led by the Global Fund in collaboration with NGOs, supported scale-up of a new private sector engagement model to enhance TB diagnosis and treatment accessibility through private physicians and hospitals. The program has proven to be highly effective, resulting in an increase in private sector notification from 398,542 in 2017 to 678,895 in 2019.[163] The program has since been scaled up in other districts and transitioned to the government. This initiative was particularly relevant to the India context as over 70% of healthcare services in the country are provided by the private sector which plays a crucial role in

[161] Global Fund (2023). OIG Audit Report. Republic of India

[162] WHO (2022). World malaria report 2022

[163] Based on Global Fund internal documents (confidential)

achieving universal health coverage.[164] The success of the JEET program represented a significant strategic success for the Global Fund as it demonstrated its role as a catalytic funder to promote innovations and tangibly contribute to progress on HTM in the country.[165]

, In addition, Stakeholders pointed the key role of the Global Fund in strengthening the engagement of CSO/CBO sectors in the country. The CCM was viewed as a good forum for this although there are mixed views on the extent to which CSOs/ CBOs are effectively engaged and have a voice at the CCM (also relates to the assessment of the funding model discussed below). Another aspect that highlighted the relevance of the Global Fund for India was its guidance, which serves as a "soft push" for the country in terms of ensuring it follows the latest WHO/ international standards for disease control.

Global Fund engagement has also enabled the mobilisation of additional resources through innovative financing mechanisms such as the recent Buy Down Loan implemented to leverage funding. Through this initiative, the Global Fund contributed US$41.6 million to a US$400 million buy down loan from the World Bank to the Government of India to narrow down the funding gap for TB.[166] Stakeholders shared that the buy down loan was particularly helpful for India as it increased the palatability of borrowing to provide a source of additional fund at minimal to no interest (interests which would otherwise be high especially for IBRD loans).[167] In the absence of such interventions, countries that need additional cash to meet development needs may be less inclined to contract additional loans due to existing large debt ratio.

In sum, the tailoring of Global Fund support to India is viewed as an excellent example of effective differentiation of Global Fund funding, where the overall investment approach is highly attuned to the country specific context and requirements.

4.3. RESULTS

India has made significant improvements in the fight against HIV, TB and Malaria over the last two decades, thanks in large part to a strong government commitment and political will to invest in HTM interventions and in the national health sector overall. The country has demonstrated significant progress in the fight against HIV, TB and malaria, reporting positive results across key indicators over the last few years. HIV new infections have fallen by 42% since 2010 and AIDS-related deaths have decreased by 76%[168]. Incidence for the disease was reported at 0.05 per 1000 in 2021, mortality was reported at 3 per 100,000 and the country reach 78:83:85 progress against the 95:95:95 targets that same year.[169,170] TB incidence was reported at 210 per 100,000 in 2021 and a mortality at 35 per 100,000, with a fast recovery from the impact of COVID-19 on TB programs due to pandemic related disruptions[171]. TB notifications have increased from 1.32 million in 2011 to 1.93 million in 2021 (67% of 95% target) and the disease had a prevalence of 312 per 100,000 people in 2022. India represented 3% of the global malaria burden in 2017[172] and has since made remarkable progress in the disease including for malaria deaths which have fallen by 92% since 2000 (53.61% between 2017 to 2021).[173,174] Stakeholders have unanimously commended efforts and leadership from the Government of India (GoI) in the fight against the three disease and emphasized the

[164] WHO (2018). Overcoming India's TB challenge: Success of the private sector engagement models

[165] Based on Global Fund internal documents (confidential)

[166] Ibid.

[167] UHC2030 (2030). Taskforce Factsheet/Buy-Downs

[168] Based on Global Fund internal documents (confidential)

[169] Global Fund (2023). DNA factbook/India

[170] UNAIDS (2022). AIDSinfo. Country Factsheet/India

[171] Global Fund (2023). DNA factbook/India

[172] WHO (2023). South-East Asia/India. Health topics/Malaria

[173] Global Fund (2023). OIG Audit Report. Republic of India

[174] Based on Global Fund internal documents (confidential)

instrumental role it has played to enable the recent progress. Thanks to India's strong economic position and political drive, the GoI has been able to provide the main bulk of funding for HIV, TB and malaria programs through domestic financing over the last few years. Global Fund investments (~US$500 million for HIV, TB and malaria for each grant cycle) have been strategically used to complement national funding and support the delivery of India's ambitious national strategies and comprehensive national programs. At the same time, government expenditure on health remains lower than 5% of national GDP (2.96% in 2020)[175], an aspect that has been flagged for attention by several international partners, including the Global Fund, as the WHO indicated it would be difficult for countries to achieve UHC at less than 5% of national GDP[176]

With regards to Global Fund investments in country, they have largely been viewed as effective by country stakeholders, although they have also flagged some issues around the timely transition of interventions to domestic financing. Stakeholders have flagged gaps and delays over the transition of interventions and take over by the Indian government as was the case for some HIV and TB interventions. This includes for example the hand-over of a number of care and support centres (CSC) for HIV supported by the Global Fund and the JEET intervention for TB. Of the 310 CSCs sites supported by the Global Fund, 110 were planned for take-over by the government by end of GC5, however, only 38 had been fully transitioned in 2022.[177] Delays in the handover of the JEET interventions were also reported to have had a noticeable impact, as private sector contribution to TB case notifications declined from 36% in Q1 2021 to 29% by end of Q4 2021 amongst the sample of nine JEET sites visited a part of the recent OIG audit.[178] These delays were reported to be due in a large part to the COVID-19 pandemic which diverted the GoI efforts away from transition planning and execution, as well as the absence of costed detailed transition plans (for the CSC handover).

Stakeholders highlighted the importance of ensuring effective transition and timely take-over of interventions by the GoI, with the support of the Global Fund where possible to inform an effective handover of activities. Whilst the Global Fund may be in a position to advise transition planning and activities, the decision to take over programs and the implementation of transition activities are mainly within the remit of the GoI. As such, the Global Fund may have limited scope to influence transition processes.

4.4. FUNDING MODEL AND PROCESSES

The Global Funding model and processes are seen as appropriate and responsive to the contextual needs in India, notably the current Payment for Result (P4R) model which was described as particularly helpful and effective to support country ownership, program agility and efficiency. Under GC6, 60% of the total Global Fund country allocation to India (US$300 million) was implemented under a Payments for Results (P4R) model for government led grants. The P4R modality was also aligned to the World Bank's Buy Down Loan intervention. This model directly links the disbursement of Global Fund investment to the achievement of specific programmatic results through defined Disbursement Linked Indicators (DLIs). To enable effective verification of results, the government reports yearly on the achievement of DLIs based on data collected through the national health information system. These results are also independently verified based on an agreed verification protocol.[179] Stakeholders highlighted the strong value of such model as it provides both strategic and operational benefits to support increased flexibility and efficiency, including reducing reporting and other transactional costs for both the Government and the Global Fund, and incentivizing greater impact against the outcome indicators for the diseases. Furthermore, this approach provides an additional independent verification mechanism for reported results to support the GoI in consolidating progress oversight and accountability. India is only the second Global Fund country to receive the majority of its funding through a P4R modality, and the first at this scale, offering a good opportunity for learning to support future implementation of a similar approach in more countries, where feasible. This approach was possible thanks to the

[175] The World Bank (2023). Databank. Current health expenditure (% of GDP) - India

[176] WHO (2010). The World Health Report.

[177] Global Fund (2023). OIG Audit Report. Republic of India

[178] Global Fund (2023). OIG Audit Report. Republic of India

[179] Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

strong programmatic and financial capacities of the GoI who had adequate systems and controls in place to mitigate risks and provide sufficient assurance for Global Fund investments. Stakeholders have also highlighted that such model is particularly fit to the Indian context where it enhances trust and mutual accountability, and further supports the Global Fund's strategic goal of elevating its relationship with the GoI.

In sum, the adaptation of the Global Fund funding model in India through the use of P4R is viewed as highly relevant and appropriate by the Global Fund, with a good consideration of the relevant balancing of programmatic and fiduciary risks, a balance which has not been well struck in the case of many other Global Fund supported countries, as highlighted in the main report.

Another aspect highlighted in our consultations was the discord between the three year grant cycle of the Global Fund and the need for a long term view on the engagement with India given Global Fund strategic interests in the country (as outlined in different parts of this case study report). This is not to suggest the Global Fund funding is discontinuous across grant cycles, but to highlight that the special case of India requires tools beyond the funding through the 3-year grant cycle to develop and enhance the relationship between the Global Fund and the country. In-country stakeholders indicated that the Global Fund would benefit from being more visible in country to have a sustained relationship with the government and country stakeholders as a whole. They also indicated the need to engage with politicians as well as invite India to regional meetings to help demonstrate and support its leadership and progress in the region.

4.5. C19RM

Limited stakeholder feedback was provided on Global Fund C19RM funding to the country – being mostly critical.

It was indicated that the fast track funding from the Global Fund C19RM did not go as planned, and rather domestic resources were leveraged for oxygen through the GoI PM Cares initiative. Emergency support for PPE was well received but beyond this the feedback was that not much impact was achieved in terms of mitigating the effects of the pandemic on HTM. An example cited was that handheld X-ray machines for TB were funded but these are still in the process of being introduced. Another example cited was of direct Global Fund support to the non-governmental sector, programmed to provide food and ration for KPs but this went through considerable challenges in processing due to the inability of operating a cash transfer program. Ultimately this resulted in lots of unspent monies and then cancellation of the program which caused much discord amongst different stakeholders. However it was also indicated that the challenges experienced through this program have led to a greater consideration of social protection schemes for KPs, a positive unintended consequence.

Country stakeholders indicated that reprogramming across the board did not work very effectively (also due to the emergency situation of the pandemic).

4.6. PARTNERSHIPS

Stakeholders reported a collaborative partnership model between the Global Fund and partners in country, although with room to coordinate further with in-country partners to enhance the strategic relationship with India (especially noting the lack of Global Fund in-country presence). Despite a small partners landscape in India, stakeholders highlighted the strategic value of bringing partners and donors together to drive innovation and scale up key interventions. This also includes partnerships with national stakeholders such as Indian philanthropies like the Tata Trusts which has been collaborating with the Global Fund (e.g., through the India Health Fund initiative in GC4) as well as other stakeholders across the healthcare industry. India plays an essential role to scale up equitable innovations for global health worldwide through its local manufacturing capacity, by enabling access and availability of quality and affordable health products for programs around the world. It is also a leader in advancing new technologies such as new vaccines and treatments as well as developing generic medicines and essential health products such as mosquito nets and diagnostic tests. Partners suggested that the Global Fund could enhance its strategic relationship with the GoI by further coordinating and working through in-country partners, whilst recognising that the Global Fund does not have country presence. In particular, they recommended greater information sharing and coordination in terms of the direction of investments following grant making and implementation, where development partners fall off following their role in the initial design through the CCM. In addition, in 2022, the GoI

announced an increased commitment as a donor of US$25 million as part of the Global Fund Seventh Replenishment. As such, it is important for the Global Fund to look beyond grant implementation and find new ways to elevate its relationship with the government of India. Partners shared that the CT has been very active in engaging stakeholders both during country visits and remotely, though they highlighted that sustained and continuous in-country engagement would enhance the Global Fund efforts to elevate its strategic relationship with the GoI especially in light of India's special position as donor and recipient, as well as its growing role to support global health interventions worldwide.

4.7. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

In light of the special position of India in the Global Fund portfolio and the strategic role of Global Fund investments and relationship in the country, this review proposed the following areas for strengthening in India:

1. Enhance Global Fund engagement with in-country partners to help further elevate Global Fund relationship with the GoI, noting this is a common agenda for all international partners
2. Invest in more innovative financing interventions in light of the success of the buy down loan initiative to support effective resource mobilisation efforts
3. Support GoI during transition processes, including where possible, by contributing to the development of clear transition plans that reflect the required resources for a full transition (HR, systems and costs) and a transition risk management plan highlighting potential challenges and mitigation measures.

A.7. REFERENCES

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A.8. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 10 stakeholders from the following entities:

Stakeholder Group	Entity
Global Fund Secretariat	Global Fund Country Team
CCM	CCM
Government	National Aids Control Organization (NACO) - Ministry of Health and Family Welfare (MHFW)
PRs	International Union Against Tuberculosis and Lung Disease (The Union)
	Plan International (India Chapter)
Technical Partners	UNAIDS
Donors	BMGF
	World Bank

5. KENYA CASE STUDY REPORT[180]

5.1. INTRODUCTION

5.1.1. Key country characteristics and HTM context

Kenya is a lower-middle income country with a population of 54,986,000, nearly 48% of whom are under 18 years.[181] Kenya has a devolved two-level governance system: 47 county governments are responsible for managing health facilities, pharmacies, and service delivery, while the central Government responsible for providing policy and strategic direction, technical assistance, quality control, and management of national referral facilities.

Kenya's guiding health policies and strategies include: the Kenya Health Policy 2014-2030 which provides the long-term policy directions for health, the Kenya Health Sector Strategic Plan (2018 - 2023) which defines medium-term priorities, the AIDS Strategic Framework (KASF 2020-2025), the National Strategic Plan for Tuberculosis, Leprosy Nand Lung Health (2019 -2023), and the Kenya Malaria Strategy (KMS 2019-2023).

Kenya has been classified as an LMIC since 2015 and continues to face substantial, although declining, donor dependency in the health sector. Donor spending is around 50% greater than domestic government expenditure for health, with higher proportion for tuberculosis and malaria. Within this context, Kenya is in the midst of undergoing important healthcare and health financing reforms. At the time of this case study, the recently elected new government is advancing four healthcare financing bills through Parliament with the purpose of accelerating progress towards UHC. The Government of Kenya has also recently committed to a formal Community Health Promoter (CHP) cadre of 100,000 CHPs. A domestic donor transition plan is also under development with the aim of reducing donor dependency in the health sector to 10% by 2030. Kenya has experienced recent setbacks due to COVID-19-related economic shocks, elevated cost of living, global price impacts of the war in Ukraine, exchange rate pressures, and debt[182,183], along with some continuing pockets of political unrest following the 2022 election.

HIV context. Kenya has made significant progress towards HIV epidemic control: from 2013 to 2019, the country achieved a 61% reduction in new infection among adults, reduced HIV related deaths by 64% and increased people on ART by 45%.[184] In 2022, Kenya achieved 94%-94%-89 on the treatment cascade[185]. However, it ranks fifth worldwide in terms of the number of PLHIV at 1.5 million and continues to experience a generalised epidemic (HIV prevalence estimated at 4.4%) and a concentrated epidemic among KPs.[186] [187] AYP account for 41% of all new adult infections in country.[188] County prevalence also varies substantially, from 0.2% in Mandera and Wajir counties to 17.9% in Homa Bay County.

TB context. Tuberculosis is the leading infectious disease killer in Kenya: the national TB prevalence survey of 2016 revealed that the true burden of TB in Kenya was 426 cases per 100,000 population. It is estimated that 146,445

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[180] The Kenya case study has been conducted by Suzanne Fournier and Anisa Hasan-Granier

[181] UN Data, 2021

[182] IMF Country Report, 2023

[183] World Bank, Kenya Context, accessed 17th October 2023, available at: https://www.worldbank.org/en/country/kenya/overview#:~:text=In%202021%2C%20the%20economy%20staged,rising%20earlier%20in%20the%20pandemic.

[184] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[185] UNAIDS National HIV Estimates, 2022

[186] HIV prevalence is estimated at 4.4%, and the number of PLHIV is estimated at 1.5 million. HIV prevalence among FSW is 29%, 18.2% among MSM, and 18.3% among PWID.

[187] Kenya GC6 Funding Request

[188] National HIV estimates, 2022

persons became ill with TB in 2019, and that 41% of estimated cases were not diagnosed, treated and notified.[189] Kenya is classified as a Tuberculosis, drug resistance (DR) TB, and TB/ HIV high burden country.[190]

Malaria context. Malaria prevalence in Kenya is 6%, but higher in endemic areas (19% in lake endemic areas and 5% in coast endemic areas). Approximately 70% of the population is at risk of malaria.[191] Given significant variation in malaria prevalence due to differences in altitude, rainfall and ecological characteristics, Kenya has stratified malaria interventions over the last decade.[192]

5.1.2. Summary of Global Fund support

Kenya is classified as High Impact portfolio. Since 2003, the Global Fund has signed over US $1.8B in support and disbursed US $1.4B to Kenya.

For the period of 2017-2022, the National Treasury (TNT), Kenya Red Cross Society (HIV/TB), and Amref Health Africa (malaria) were grant Principal Recipients (both GC5 and GC6). The Ministry of Health implemented grants on behalf of the National Treasury, with the exception of procurement which was done through TNT funding to KEMSA, Kenya's official procurement entity.[193] Each disease program was therefore implemented by a government implementer and non-governmental organisation.

Details on levels of funding and trends over 2017-2022[194] by disease area are provided below (Table 5.1 and Figure 5.1). Of note:

- Funding levels by disease module have overall declined for HIV and malaria from GC4 to GC6 (11% decline for HIV and 23% decline for malaria), whereas TB increased.
- RSSH is embedded in the HIV/ TB grant (no standalone RSSH grant). Each disease allocation contributes 7% to RSSH. RSSH funding declined from US$50.2M in GC4 to US$43.7M in GC6.
- There was $119.5M in C19RM funding during the 2020-2022 period (GC6).

Table 5.1: Overview of Global Fund allocation by disease area and Grant Cycle ($US)

Disease	GC4	GC5	GC6
HIV	US$271.6M	US$221.1M	US$240.6M
TB	US$40M	US$39M	US$53.2M
Malaria	US$89.7M	US$66.6M	US$68.7M

[189] Kenya GC6 Funding Request

[190] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

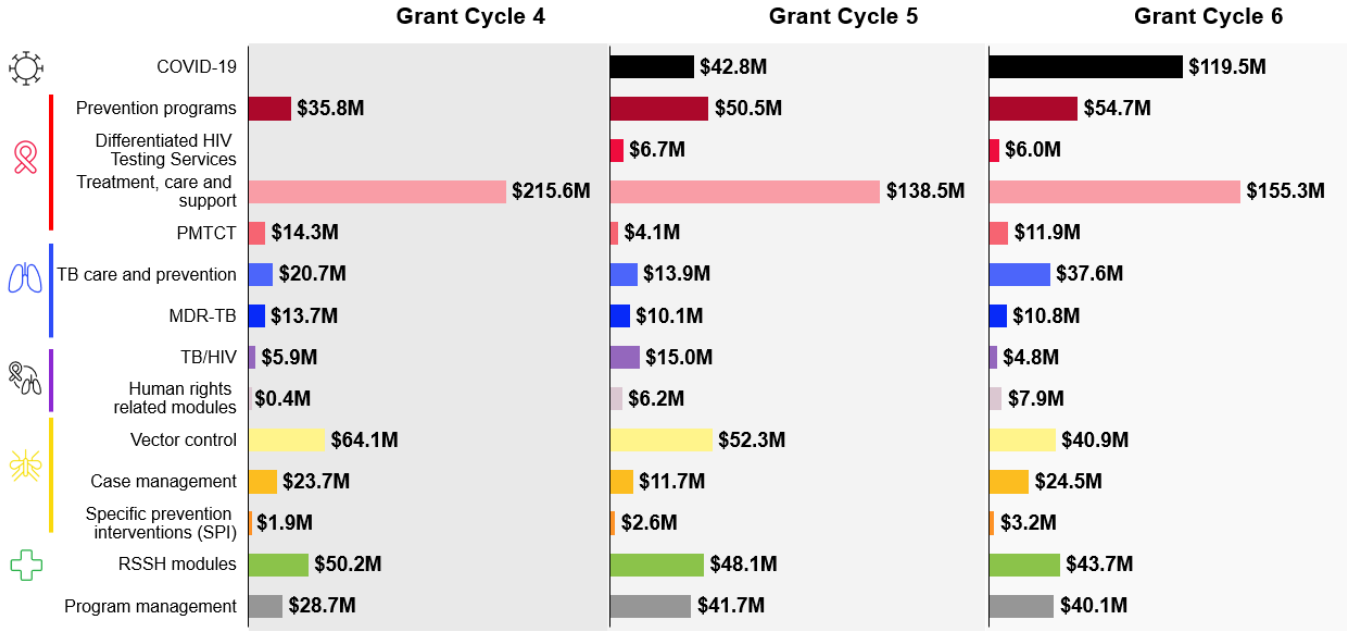
[191] KMIS, 2020

[192] Kenya Malaria Strategy, 2019-2023

[193] KEMSA is Kenya's official procurement entity, capacitated to guarantee supply of essential medicines and other medical supplies and devices to all public health facilities.

[194] DnA Factbook Kenya June 2023. Table 5.1 excludes COVID-19, Payment for results, RSSH and Program management modules.

Figure 1: Kenya Global Fund budget breakdown by module by Grant Cycle[195]



Other key features of the Kenya portfolio include:

- Program management costs across all grants have increased from US$28.7M in GC4 to US$40.1M in GC6. This increase also reflects C19RM program management.
- Approximately 60% of Global Fund grant funding supports procurement of medicines and health products.

Catalytic Investments. Kenya received the most catalytic funding of any Global Fund-supported country for the 2017-22 period. Four matching funds were implemented in GC5 (US$25 million total) and GC6 (US$26 million total). Three of the four were continued across the two grant cycles: Human Rights, AGYW, and Finding Missing TB Cases. HIV Key Populations was a focus in GC5 only and RSSH Human Resources was new for GC6. Kenya was also eligible for 10 Strategic Investments in GC6: AGYW; TB Finding Missing People Cases; Malaria RTS,S Vaccine; Data; CRG; Human Rights; STE; PSM transformation; CCM evolution; and, South-South Strategic Support and Learning. During the GC6 period, two multi-country grants in the African region were applicable to Kenya.

5.2. KEY FINDINGS

5.2.1. Relevance of Global Fund investments

Interventions for HTM are largely aligned with NSPs and thus evidence-based and responsive to country needs, with space 'at the margins' to improve responsiveness. The TRP considered both the malaria and HIV/TB funding request to be technically sound and strategically focused. The GC6 TB/ HIV funding request is aligned with KASF II and the TB National Strategic Plan, builds upon work done during the GC5 allocation cycle, and is in alignment with the Kenya Health Sector Strategic Plan. The malaria funding request is based on the KMS, and appropriately stratifies and adapts interventions in line with Kenya's heterogenous epidemiological situation based on a number of ecological factors.[196] Additionally, funding requests take into account investments from other donors and partners to avoid duplication (e.g. certain activities were dropped from RSSH HRH due to duplication with WHO activities). By and large therefore, investments are relevant with some space 'at the margins' to improve the design of funding requests to maximise impact (described below).

[195] Global Fund (2023). DnA Factbook Kenya June 2023

[196] Based on Global Fund internal documents (confidential)

However, stakeholders raised concerns that some emerging issues and epidemiological trends were not being appropriately addressed in grant design. For example, AGYW are facing a triple threat: high rates of pregnancy during adolescence[197], high rates of GBV[198] , and high rates of HIV incidence.[199] In parallel to this challenge, Kenya has a high MTCT infection rate at 10.8%[200] and lower rates of achievement across the HIV treatment cascade for children than adults (63%-63%-51%).[201] In light of these issues are poised to be important drivers of the HIV epidemic in Kenya in future years, some stakeholders felt that the GC6 grant response to this complex situation as inadequate. Both the CT and TRP acknowledged robust and innovative strategies (biomedical, behavioural and structural) proposed in the GC6 funding request to address challenges posed by the MTCT rate and prioritise AGYW vulnerable to HIV. However, there were strong views from some country stakeholders who still perceived the AGYW and PMTCT programs as inadequate and noted concerns on their relevance and design given the scale and urgency of the situation. Key critiques included:

- PMTCT interventions did not address the barriers to Early Infant Diagnosis and long turn-around time on tests, as well as barriers to ART retention such as inadequate nutrition among pregnant women. Additionally, stakeholders were concerned that interventions were largely facility-based and not engaging with community-led organisations to adequately involve and respond to the needs of women living with HIV to address PMTCT barriers. During GC6, the PMTCT approach was amended post-grant signing to engage more community-led organisations working with WLHIV in delivery of PMTCT activities which was a "game changer".
- Multiple stakeholders also commented on an overemphasis within the AGYW program on advocacy with national and sub-national government stakeholders, community and religious leaders – that while a best practice for increasing support, was less well balanced against the need for direct beneficiary support and peer-to-peer programs.
- Post-violence care for survivors was also perceived as neglected within the funding request, although there was an intention to leverage funding from GoK, PEPFAR and elsewhere to provide facility-based post violence care.

Given the fiscal environment where NSPs are part-funded, there are views prioritisation of modules/interventions is not consistently informed by evidence when the limited funding envelope is considered. GC6 was particularly difficult for malaria following significant reduction in the allocation, and thus 43% of the NSP is unfunded. Key interventions such as the LLIN campaign and vector control were under-resourced and cut in certain counties (Refer to Relevance Section 1.2.3 for details regarding how the grant-making process and budgeting by module may impact prioritisation particularly when resources are limited).

Progress has been made in GC6 to balance biomedical, behavioural and structural interventions and focus on KPs and other vulnerable populations (particularly for TB and HIV, less so for underserved populations within malaria response). Under the TB grant, there has been a scale-up of active case finding and treatment at the community level in all 47 counties. The HIV grant has maintained and continued to strengthen structural and behavioural interventions, including the delivery of prevention packages to KPs and other vulnerable populations (such as AGYW). The malaria program under GC6 included the largest CCM expansion for malaria with an additional 1,800 CHVs supported.

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[197] According to K-DHS 2022, rates of adolescent pregnancy are 15% nationally and up to 50% in one county- with a slight increase in median age at first birth from 20.3 in 2014 and to 20.7 in 2022.

[198] According to KDHS, 20% of women reported experiencing violence in the preceding 12 months in 2014 and 16% of women in 2020.

[199] 41% of new adult HIV cases are among AYP, of which 78% are among AGYW according to National HIV estimates from 2022.

[200] Sources of new infection including women who did not receive ART (10%); women infected during pregnancy and breastfeeding (23%), and women discontinuing ART during pregnancy and breastfeeding (47%) demonstrating the need to address issues of retention on ART for pregnant and breastfeeding HIV positive women and the need for timely diagnosis of HIV exposed infants through POC EID.

[201] GC6 Kenya Funding Request.

Malaria stakeholders reported there are less focused interventions on underserved populations within malaria programming. The GC6 funding request did not detail interventions for migrants or the prison population, partly attributed to limited expertise and resources, as well as a lack of clarity on who constitutes underserved populations in malaria (as opposed to more developed definitions for HIV). Similar challenges were reported by stakeholders in design of GC7, despite use of the recently published Malaria Matchbox Tool in 2021 which was meant to guide integration of HR and GE considerations in malaria programming. Stakeholders acknowledge need to further strengthen the understanding of what constitutes underserved populations for malaria (including how this may differ geographically) and develop evidence-based strategies to reach these populations.[202]

RSSH interventions are supportive of HTM objectives, with adequate focus on community system strengthening and integration, particularly in GC6. RSSH support in GC6 covers all eight RSSH modules. Interviews were consistent with the TRP's assessment of appropriate emphasis on community systems strengthening (empowerment, community-led programming) across Kenya's Global Fund grants and within RSSH. However, the low country absorption of RSSH modules (29% as of the most recent progress update available at the time of this review) is indicative of broader design and governance challenges in Kenya's RSSH support.[203] Despite these challenges, UHC, government stakeholders noted desire for future RSSH investments to respond more holistically to Kenya's UHC strategy (supporting implementation for the Social Health Insurance Fund, for example) beyond the eight RSSH modules.

There is good balance within grants between established approaches and innovation. Stakeholders noted that GC6 interventions largely built upon and scaled GC5 approaches ensuring continuity, but with space for innovation in the grants. Innovations include: i) in **medicines and technologies** (for GC5 and GC6, there was a notable scale-up in diagnostic tools and technologies such as GeneXpert and mobile x-rays, and long-lasting PrEP has been included as a module in the GC7 funding request); and ii) **service delivery** (e.g. innovations regarding the private sector, such as engaging with pharmacies to strengthen malaria services and engaging formal and informal private sector healthcare to offer screenings and referrals for TB with performance-based financing incentives).

Procurement of commodities has provided good VfM, with some risks to VfM posed by frequent meetings, training and travel. Procurement via KEMSA was reported by the OIG to have achieved comparable or better pricing than Global Fund pooled procurement.[204] A tripartite agreement between KEMSA, AMREF, and Cepheid has also allowed for GeneXpert to be procured in Kenya via AMREF, instead of KEMSA, and stakeholders reported this did not affect value for money.[205] V4M concerns in Kenya's grants arise in two main areas: i) significant travel-related costs for meetings as well as training within the grants[206], with some stakeholders advising need to strike a more appropriate balance to achieve overall VfM; and ii) stock outs affecting grant activities (e.g., CHWs not having RDTs).

5.2.2. Progress and results achieved

This section describes the results achieved over 2017-22. A cross-cutting issue relevant to HTM results and C19RM concerns **procurement and supply related challenges through KEMSA,** which stakeholders and documentary evidence indicate has affected the performance of Kenya's Global Fund grants. Additionally, concerns were raised in May 2019 by the Kenya Medical Laboratory Technicians & Technologists Board (KMLTTB) to Kenya's court concerning quality assurance in task-shifting of diagnostic tests. Despite efforts to resolve this issue, this has

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[202] It was reported separately that KeNAAM (Kenya NGO Alliance Against Malaria) has done a mapping of populations/geographies most affected by malaria with support through the Community Engagement SI, though this was not referenced by country stakeholders interviewed for the case study.

[203] At the time of the most recent progress update available for this case study, 50% of the grant implementation period had elapsed.

[204] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[205] Cepheid is the GeneXpert manufacturer. The AMREF, KEMSA and Cephid agreement takes advantage of AMREF's flexibility to meet the Cepheid requirement of payment when order is placed, as KEMSA only makes payment following delivery.

[206] Travel related costs were the second largest cost category in GC6 after commodities, at US$135.4M or 24% of the total budget. This feedback was reviewed with the KCM who communicated the importance of travel and training budget categories for program delivery and oversight.

infringed on use of RDTs for HIV and malaria during the second half of the strategy period, which are a mainstay of HIV and malaria programs. Findings on results in HTM and RSSH are elaborated below.

HIV Progress

Kenya has made significant progress towards epidemic control, achieving 94%-94%-89% on the HIV treatment cascade. HIV prevalence declined from 4.9% in 2018 to 4.5% in 2020, and the HIV incidence rate reduced from 0.27% in 2016 to 0.14% in 2020.[207] ART delivery has been an area of consistently strong performance, aided by the strengthening of drop-in centres and recent improved quantification and validation of the number of PLHIV. As of December 2022, the percentage of people on ART of PLHIV was 90% according to the grant PF, exceeding the target. Coverage of Global Fund-supported prevention programs for MSM, transgender people, sex workers, PWID, and AGYW has increased from 2018 until 2022 although still somewhat below target.[208]

Despite significant progress made towards epidemic control however, there is significant variation of HIV prevalence and incidence rates by population and geography and pockets of continued difficulty including:

- Frequent issues related to procurement and supply of commodities has negatively impacted implementation and results. Results for the percentage of MSM, transgender, and sex workers receiving HIV tests and knowing their status were repeatedly below 30% of the target between July 2021 and December 2022. In 2020, for FSW, MSM and PWID who were reached with prevention packages, only 49%, 54% and 72% respectively were tested.[209] This was attributed to clients being ineligible for testing at that point, as well as a shortage of HIV tests. SRs also anecdotally reported being able to meet half of the demand for condoms amongst FSWs.
- High rates of pregnancy, HIV, and SGBV experienced by AGYW and difficulty in addressing MTCT transmission rates (see Section 1.2.1 for details on challenges in grant design for AGYW and PMTCT programs). Stakeholders noted important flexibility within GC6 for FSW-responsive interventions to be differentiate to AGYW-FSW.
- Scope to improve outreach to certain KPs and vulnerable populations such as PLHIV and the transgender community. Of note, transgender (TG) is a new concept for Kenya and the package for TG-responsive services isn't yet defined.
- Challenging policy environment in Kenya, affecting implementation of the HIV programs. KPs continue to face criminalisation, with a recent upsurge in human rights related issues in Kenya (and the East African region.) SRs reported increased difficulty in reaching KPs, although have continued to perform well in terms of maintenance of preventive and treatment services. A new Family Protection bill is being discussed in Kenya, which would create a more punitive environment for LGBTQ individuals.
- A court challenge against attempts to task shift HIV testing and EID away from health facility workers presents a potential risk to program implementation.

TB Progress

The WHO National TB prevalence survey in 2016 revealed that true burden of TB was 426 cases per 100,000 population. This was nearly double previous estimates, and estimated the proportion of undiagnosed individuals at 41%. Since then, **renewed efforts have made to address TB morbidity and mortality through Global Fund investments**, and shift from passive to active case finding including:

- Increasing the scope of community-based TB activities across all 47 counties;

[207] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[208] Global Fund (2023). DnA Factbook Kenya June 2023

[209] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

- Scaling up successful innovative approaches to find missing cases- including public-private mix for TB care and control, working with new populations such as truck drivers and PWID, and school-based programs;
- Significant expansion in diagnostics and adoption of WHO-recommended technologies- including mobile screening through digital x-rays and molecular testing through GeneXpert;
- Improvements in facility and community-led monitoring;
- Continued strengthening of HIV/ TB integration.

These efforts have contributed to positive trends: between 2018 and 2020 the TB incidence rate fell by 11% per the WHO TB report, from 292 to 259 cases per 100,000 population. In 2021, Kenya transitioned out of the 30 high MDR/ RR-TB burden countries.[210] Additionally, there has been a consistent decline in HIV co-infection rate among TB patients over the years, largely due to strengthened ART and IPT uptake among PLHIV. In 2019, 98% of registered TB patients had a documented HIV status and 98% of TB-HIV co-infected patients were on ART during TB treatment.[211]

However from 2018-2022 there was a decline in performance across grant indicators (except HIV/ TB integration). TB case notifications decreased by 14% from 81,518 in 2015 to 77,943 in 2022 (out of a target of 106,193.)[212] Additionally the number of people in contact with TB patients receiving preventive therapy was just over 10,000 in 2022, despite a target of slightly below 30,000 people.[213] This decline is attributed to COVID-19 as well as:

- **Continued difficulty in reaching missing cases** due to low awareness of TB, inadequate TB screening in health facilities, low TB diagnostic and treatment services coverage, limited community engagement and linkage to facility-based services.
- **Procurement and commodity issues:** Although procurement of a select number of TB commodities has been transferred to AMREF, delays persist (related to long response and approval times, and delays in communication and clarification of specifications).
- **Underutilisation of GeneXpert:** Kenya has 206 GeneXpert machines. Machines ran at 46% and 47% of capacity in 2019 and 2020[214], and some machines were not functional due to a lack of maintenance, stockout of cartridges, and difficulties regarding sputum transportation. Plans for a national GeneXpert expansion plan has therefore been delayed, given the need to optimise existing machines.
- **COVID-19 disruptions:** Performance of KPIs dropped in 2021 across indicators attributed to the pandemic. In 2020/2021 stakeholders reported that national treatment coverage decreased from 63% to 51%, due to restricted movement, closure of facilities, and reduced patient demand (in absolute numbers this is a decline from 10M patients/ month at facilities, to 4M during the first four months of COVID-19).

Malaria Progress

Kenya has made some progress in the fight against malaria- for example malaria prevalence among children under 5 declined from 8% in 2016 to 6% in 2020.[215] Recent PUDR results from July 2021 to December 2022 show that the malaria program achieved 90-100% of targets across indicators (related to case management and treatment, HMIS, and laboratory systems.)

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[210] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[211] GC6, Full Funding Request

[212] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[213] Global Fund (2023). DnA Factbook Kenya June 2023

[214] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[215] Message from ED, Global Fund Grants in Kenya, 2022. Accessed 19 January 2024: https://www.theglobalfund.org/en/oig/updates/2022-03-11-message-from-the-executive-director-global-fund-grants-in-kenya/

Notably, only one indicator captures results relevant to prevention interventions (proportion of pregnant women attending antenatal clinics receiving IPTp.) This is at odds with the budget breakdown of the malaria program, as 47% of the budget goes towards vector control (including LLIN campaigns), and 28% is allocated for specific prevention interventions, suggesting that the **performance framework could be strengthened to better reflect interventions**.

Performance has overall declined in the last couple years, mainly as a result of supply chain-relate issues affecting key commodities (SP, RDTs, AL) create inconsistency in programs (CCM, IPTp, facility management), along with the court challenge to task-shifting testing. From 2020 to 2022, there was a decline in IPTp including in endemic areas[216], LLIN coverage stalled[217] and the number of suspected malaria cases that received a parasitological test and cases of malaria treated has also decreased.[218] The COVID-19 pandemic also had considerable impact. There was an average weekly reduction of 100,000 suspected malaria patients in the first few months from March 2020, suggesting a decline in use of health services. In 2020, 15.9 million LLINs were meant to be procured and distributed, however the campaign was delayed due to procurement challenges and delays in adapting to COVID-19. Only 1.4% LLINs of the original target were distributed in 2020.[219,220]

Underfunding is a major challenge facing the malaria program in Kenya. From GC4 to GC6 there was a 23% decline in the malaria budget, with a further 10% reduction expected for GC7 and 43% of the malaria NSP is unfunded. This is a concern of country stakeholders in the context of emerging threats such as widespread pyrethroid and AL resistance, the novel *An. Stephensi* vector, and climate-related risks. As described above, underfunding has reportedly also impacted the ability of the malaria program to tackle human rights-related barriers to malaria services (Refer to Relevance Section 1.2.1).

Despite these challenges, strengthening in community systems, as well as coordination at the sub-regional level are amongst some of the positive developments that occurred in GC6. GC6 saw the largest increase in community-case management for malaria. Community Health Units are being strengthened and 1,800 CHVs are being managed by AMREF, reaching saturation in some high burden counties. In some parts of Kenya, the malaria burden has decreased indicating opportunity for greater focus in investments. Additionally, stakeholders reported that COVID-19 heightened awareness of the need to plan and act sub-regionally, with efforts to strengthen engagement with East African countries (e.g. through synchronized campaigns, commodity visibility, surveillance methods), which is highly relevant in the context of the emerging threat from *An. Stephensi.*

RSSH Progress

Absorption of RSSH funds to date during GC6 is the lowest amongst the top 10 modules (29% as of June 2023[221]). This is partly because during GC5 and GC6, stakeholders reported a **lack of clarity regarding which activities** should be included in RSSH modules leading to confusion during implementation (refer to next section on Funding Model)**.**

- Key programmatic results include: training new leadership in 30 counties on program-based budgeting, post market surveillance and development of a commodity gap warning system with real-time data to support KEMSA, rationalising staff distribution in facilities, and development of a Donor Transition Framework.
- Key areas of underperformance include health products and technology (80% of activities not implemented, largely because new bills are being passed that will accomplish the same), and HMIS (activities were concentrated in Year 1 causing difficulty in implementation). CSS work is being implemented by AMREF, and includes the roll-out of CLM and strengthening of CHUs.

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[216] KMIS 2020, KDHS 2022

[217] KDHS 2020

[218] Global Fund (2023). DnA Factbook Kenya June 2023

[219] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

[220] Based on internal Global Fund documents (confidential)

[221] Global Fund (2023). DnA Factbook Kenya June 2023 (page 33). The GC6 grant runs June 2021 - 2024.

- For GC7, Kenya plans to invest more significantly in CSS and community health workers to strengthen primary health care as part of Kenya's UHC goals.

Despite limited results and progress thus far, stakeholders felt there was opportunity for improvement due to strengthened planning during GC7. This was attributed to updates made by the Global Fund to the modular framework and guidance on what to include in RSSH investments for GC7. Sensitisation of stakeholders was considered to have reached an adequate level, and currently with support from PEPFAR, an HSS Investment Plan is underway which is likely to strengthen planning around RSSH investments. Importantly, a Donor Transition Framework (currently a draft version exists) which outlines the steps and processes to shift away from donor dependence in health, is under development with the intent it be endorsed and implemented during GC7.

Procurement challenges over 2017-2022

A majority of interviews conducted referenced supply issues as a recurrent challenge over the last strategy period. Over the 2017-2022 period, there was significant strengthening of KEMSA, including support to establish a large storage warehouse, digitization, and strengthening coordination between KEMSA and counties to minimize stock outs. However KEMSA performance issues during this period included non-adherence to procedures/ guidance, insufficient coordination and planning creating inefficiencies and delaying availability of commodities, and traceability and availability risks.[222] This is significant as 70-80% of Global Fund resources support commodities which are predominantly procured through KEMSA, where timely release, under absorption, and accrual of debt in the GoK-financed Counterpart Funding (CPF) has contributed to complexities and delays in Global Fund-financed procurements. Risk level ratings for procurement and in-country supply chain have subsequently increased from 'moderate/ low' in 2019, to 'high' and 'very high' in 2021. Certain mitigating measures have since been put in place, including a change in KEMSA leadership (2023), a commodity-tracking system, and shifting of procurement for C19 to wambo.org as well as task-shifting some procurement activities to AMREF.

5.2.3. Funding model and business processes

Inclusivity in development of Global Fund-support and country ownership through the KCM increased successively over GC5 and GC6, with the recent GC7 Funding Request process regarded as highly participatory – however the extent of civil society and community engagement was considered to decline at the grant making stage.

- The KCM comprises an equal balance of State and non-State members. There was high consensus amongst stakeholders of a notable increase in inclusiveness of non-State actors within the KCM and country ownership from GC5 to GC6, and was particularly strong during the recent GC7 funding request development in 2023. Financial support by the Global Fund for the GC7 country dialogue was considered to have a significant role in this inclusivity, as GC5 and GC6 country dialogues were reportedly under-funded. An important change to the KCM membership during the 2017-2022 period was expansion in 2017/18 of the government constituency to include three sub-national members from county governments, reflecting Kenya's devolved health governance and thus involving counties in Global Fund processes and oversight.

- While the overall trend is one of inclusivity, the grant-making stage was regarded by a variety of stakeholders as less transparent than funding request development, with fewer stakeholders "at the table" during grant design. This was also a finding of the recent TERG Prospective Country Evaluations (PCEs) extension period (noting Kenya was not among the PCE countries) and external survey report on the 2020-2022 funding cycle.[223][224] Specifically in Kenya, stakeholder interviews suggested a number of factors are at play, ranging from the desire of stakeholders who have shaped the funding request, but are not KCM members or PRs/SRs, to continue to have a voice given the importance of grant design; KCM members and SR stakeholders not

[222] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya. One government stakeholder interviewed for this case study indicated it takes on average 345 days from initiation of procurement to delivery of commodities for HTM and COVID-19 (this figure not independently verified).

[223] Global Fund (2022). TERG PCE Extension Synthesis Report

[224] Global Fund (2020). Results of the 2020-2022 Funding Cycle Lessons Learned External Survey

being included in grant-making; and financial/logistics/connectivity barriers to participation which are not prioritised as part of the grant-making process. This may also reflect a need to make trade-offs within the development process, noting that increased transparency in grant making would extend the length of grant making (see finding below).

The funding model and its implementation works better for HTM and less well for RSSH which is operationalised by State and non-State PRs, with involvement of multiple GoK departments – affecting implementation and coordination. RSSH financing is managed under the TB grant and operationalised by both government and non-state PRs (AMREF and KRCS). At the start of GC5, the RSSH implementation arrangement had not yet been defined. A newly created RSSH Division within the Department of Medical Services was charged with overseeing operationalisation of the 8 RSSH modules in the Kenya grant (with implementation done by respective MoH units e.g. lab systems, M&E). This division struggled in its early years to establish itself and coordinate implicated stakeholders implementing the RSSH modules (coordination of ten to fifteen focal points was reportedly required under GC6). Several departments responsible for implementing RSSH activities also had limited prior contact with the Global Fund and thus minimal understanding of its processes, contributing to challenges to operationalise RSSH described earlier. Of the CCM TWGs (HTM, RSSH) which meet monthly to discuss grant details, the RSSH TWG is reportedly the weakest given the number of stakeholders to coordinate.

There are views the high burden associated with executing Global Fund processes across the funding cycle leaves the KCM with less time to adequately reflect on implementation experiences and lessons learnt in developing funding requests and grant design.

- Stakeholders praised the inclusive composition and processes of the KCM and acknowledged that processes such as FR development become lengthy (especially certain modules, notably KP module for GC6[225]). While this is viewed positively in terms of the KCM reflecting the Global Fund's inclusive governance, a consequence is less bandwidth for the KCM to focus on oversight of grant implementation[226] and encouraging sufficient reflection on lessons learned to make the next Grant Cycle more effective. It was noted also the KCM are thinly stretched given increasing portfolio size (considering C19RM).

- Some stakeholders requested there be greater Country Team (CT) involvement in grant design on key challenges, specifically i) ensuring grant design adequately learns from past cycles; ii) when there are areas of significant KCM discord during grant design. An example of the former is that GC5 and GC6 included new activities planned to be delivered in the first year of the grant which had not yet been designed, with the result of delayed implementation (e.g. HMIS strengthening activities (under RSSH) were not yet implemented as of September 2023, despite being planned for GC6 Year 1 (2021)).

Global Fund modules, technical guidance, and TA were regarded as helpful for developing funding requests for HTM – less so for RSSH. More guidance on changes to funding request materials is requested.

- Technical assistance for funding request development was provided significantly through UNAIDS, with WHO, CHAI and other partners also supporting specific modules. The TA provided by UNAIDS in particular was regarded as highly valuable by multiple stakeholders. The experience of developing the funding request for RSSH, and subsequent implementation, was reportedly slowed by a lack of familiarity of MoH units with Global Fund processes (e.g. the unit leading RSSH in the Ministry of Health coordinates 10-15 focal points)

- Given the recency of the GC7 Funding Request process during this case study, several points of feedback on Global Fund materials were made by stakeholders. Key issues raised were: i) updates to GC7 templates were not well communicated with request for country teams to have reviewed changes with the KCM and stakeholders responsible; ii) the time to develop newly introduced protection from sexual exploitation, abuse, and harassment practises (PSEAH) after the FR was finalised was considered by stakeholders as too short.

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[225] GC6 funding request development was reported to be 7 months from receipt of the allocation letter to request submission.

[226] Grant performance is reported to the KCM quarterly by disease specific sub-committees.

There is a dynamic of a strong community and civil society competing for Global Fund financing, with steps to engage non SRs within programs (e.g. as SSRs). There are also a variety of views whether the composition of SRs is adequate, particularly in the HIV space. An improvement in SR selection over 2017-2022 was the introduction in GC6 of an SR assessment framework developed with the support of UNAIDS. However in the context of Kenya's strong civil society and funding gaps in the fight against HTM, there is a mix of views on whether the "right composition" of SRs are in place. Acknowledging potential respondent bias given the competitive environment for scarce funds, issues identified by some stakeholders pertaining to GC6 SR selection were as follows: i) Some SRs lack county/sub-county presence, reducing V4M and performance, as these organisations do not necessarily have the local networks to identify and support PLHIV and require resources to travel to these geographies; ii) newer HRG priorities (e.g. TG) added to existing SR mandate rather than contracting partners already working with TG populations; iii) under-representation of AGYW- or KP-led SRs delivering AGYW and KP programs. It is recognised that the Global Fund's reporting and auditing requirements do "shut out" many organisations. Each of these issues would require more in-depth examination and assessment of trade-offs concerning selection, contracting, and management of SRs within Global Fund-supported grants. A minority of interviewees provided examples where smaller community-led organisations have been financed to implement activities on behalf of SRs (e.g. as SSRs). While this is helping to support more effective service provision to communities, it may also contribute to perceptions that SR selection is not functionally optimally. Finally, in the context of the 'hierarchical' dynamic of the PR-SR-SSR relationship, a minority of stakeholders also raised concerns on the effectiveness of Organization Development & Systems Strengthening (ODSS) for civil society.

It has been advantageous to program delivery to continue with the same non-State PRs, however lengthy SR selection delayed some activities. AMREF and KRCS have been the civil society PRs for several cycles which has helped to keep the pace of implementation between funding cycles. It was noted though that SR selection is a lengthy process which can delay SR-led activities. The TB finding cases matching fund was given as an example where it reportedly took 1.5 years for SRs to be confirmed to implement the private sector model.

Domestic financing and sustainability

Amid the difficult economic context[227], particularly since COVID-19, the Kenyan government is advancing its UHC priority and vision for programmatic and financial sustainability of Global Fund-supported programs. Global Fund systems strengthening support through HTM grants and C19RM have provided critical investments supporting transition preparedness.

- This review finds evidence of demonstrable progress over the last strategy period in **programmatic sustainability**[228,229] in key areas including human resources for health, strengthened laboratory and surveillance systems and electronic health information systems, including DHIS2 and a unified national electronic Community Health Information System (eCHIS). Despite significant supply chain challenges described earlier, channelling Global Fund-financed procurement through KEMSA is regarded as important to support systems strengthening, though this remains a weak area requiring considerably more strengthening. A threat to programmatic sustainably of note is the proposed anti-LBGTQ Family Protection Bill, which partners including the Global Fund are actively working to mitigate (refer to Partnerships section).
- Health has continued to be a domestic priority under both the previous and current Kenyan government with evidence as follows:
    - The government has most recently committed to a formal Community Health Promoter (CHP) cadre of 100,000 CHPs, with stipends jointly supported by the central government and counties, bringing

[227] The Joint World Bank-IMF Debt Sustainability Analysis for Kenya for 2022 notes that while Kenya has a high overall risk of debt distress, the situation has improved since the 2021 DSA assessment.

[228] The share of government expenditure on health in 2020 was 8.2%, similar to 2015 level (8.1%) (WHO, Global Health Expenditure Database. https://apps.who.int/nha/database/country_profile/Index/en Accessed 04.10.2023)

[229] Challenges to the health sector identified in Kenya's third medium term plan 2018 – 2022 were predominantly low absorptive capacity of the development budget, skewed distribution of health workers and inadequate infrastructure, inadequacy of health financing, industrial relations challenges and natural disasters.

community health workers formally into the health system.[230] The launch in September 2023 was regarded by stakeholders as the culmination of significant investment in community health platforms, including through the Global Fund, and increased recognition during the COVID-19 pandemic of their integral role in service provision.

- This commitment should be considered in the wider context of Kenya's health financing reforms, with four bills before Parliament at the time of this case study to accelerate Kenya's attainment of UHC: the Social Health Insurance Bill, the Primary Health Care bill, the Facility Improvement Bill, and the Digital Health Bill.[231]
- Additional opportunities for sustainability and demonstration of Kenya's progress in this regard noted by stakeholders were domestic manufacturing of ARVs through a partnership between local pharmaceutical industry, the government and the Global Fund established in 2019, and domestic manufacturing of HIV tests and malaria RDTs by the Kenya Medical Research Institute (KEMRI).

The Global Fund reports that Kenya has historically met co-financing commitments, with more difficulty in 2021 due to COVID-19. Co-financing commitment for commodities held by TNT is challenged by slow procurement processes. A donor transition framework outlining the process for reducing donor dependency in the health sector to 2030 is in draft form and expected to be implemented during GC7.

- Kenya's co-financing incentive (counterpart funds) over 2017-2022 was 20% as a LMIC. Government stakeholders view the co-financing policy is clear and appropriate. For GC7 Kenya's co-financing commitment was dropped to 15%, given the difficult context of COVID-19, the cost of living crisis and the decrease in fuel subsidies.
- The Global Fund reported that US$686M was co-financed by Kenya over the 2017-2019 allocation period, representing a 14% increase in total government spending compared to the previous allocation cycle. For the 2020-22 cycle, meeting co-financing commitment was more challenging due to the Covid-19 pandemic, but this was reportedly achieved through accounting for RSSH GoK financing.
- Significant counterpart funds (CPF) are held by TNT and are utilised to procure health products, pharmaceuticals and non-pharmaceuticals and health equipment. As noted above, issues including timely release and under absorption have contributed to procurement challenges during the last strategy period. Analysis of absorption of TNT commodity co-financing commitments over 2017-2022 shows high variability across HTM year on year, with an overall realised absorption of 88%[232] over FY 2017/18 to 2022/23 inclusive, if both expenditures and pending bills are taken into account (Appendix C).
- TNT attribute the low absorption to slow procurement processes, which were said to take on average nine months from quantification to delivery, with a longer period if any interventions are made (e.g. challenge to tender award).[233] As KEMSA is unable to work on an accrual basis (i.e. funds are only disbursed on delivery), there has been significant under realisation of financial commitments if invoices cannot be paid before FY end. To illustrate the challenge for TNT, if only expenditure by FY is considered (and not orders placed but not received), absorption of GoK counterpart funds drops to 54% over 2017/18 to 2022/23 inclusive. The slow procurement time was also reported in the Kenya case study as part of the TERG STC Review 2020.[234] For 2022, TNT reports fully meeting the 2022/23 FY commodities commitment.

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[230] Some counties are reportedly topping up the minimum stipend value, per stakeholders.

[231] These bills would repeal the current National Health Insurance Fund and establish in its place the following funds: Primary Healthcare Fund; Social Health Insurance Fund; and Emergency, Chronic and Critical Illness Fund.

[232] For 2020-21, only expenditure data were available. The lowest overall absorption years correspond to the COVID-19 pandemic (2020-21 and 2021-22). CPF for commodities are within the GoK budget, thus financial commitments correspond to Kenya's fiscal year (FY) running from July 1 – June 30.

[233] The OIG in its 2022 audit reported an average of 345 days from initiation of procurement to delivery of commodities.

[234] Global Fund (2020) TERG Thematic Review on Sustainability, Transition and Co-financing (STC) Policy

- During 2017-2022 the government has actualised all Global Fund supported HRH, with a final 167 Global-Fund financed positions, mainly in laboratories, set to be taken over by the government at the end of 2023. This is of concern to the government who view it is creating a "crunch point", noting however the original transition date was June 2021 and previously extended twice.
- Looking ahead, a donor transition framework is in draft form and a national consultation was held in April 2023 with UNAIDS support, signalling Kenya's direction towards reducing donor dependency.[235] This framework will include HTM financing and more broadly including HRH and health products and technologies.

There have been efforts to increase visibility at county level of Global Fund financing and supported programs, to support country involvement, accountability and co-financing. For GC7 the county health planning process is to be strengthened to integrate planning of Global Fund-supported grants. This is part of the overall drive of strengthening county ownership of Global Fund supported-programs.

Risk

The balance between fiduciary and programmatic risk is a complex issue in Kenya. For the most part, stakeholders view risk management as acceptable given the Global Fund's obligation to ensure fiduciary responsibility. There were some calls for the Global Fund to consider options for allowing access to funds for smaller community-led organisations despite the potential increased fiduciary risk, in the interest of improving programmatic impact and mitigating programmatic risks (described in Funding Model Section 1.2.3).

Additionally, some expressed the need for the Global Fund Secretariat to take on a more proactive response to managing programmatic risks when these arise, particularly related to procurement and supply. This was corroborated by the 2022 OIG Report, which found that Secretariat risk management and assurance arrangements are not adequately mitigating emerging and known risks related to procurement and supply chain. During the 2017-2022 period, PEPFAR discontinued procurement through KEMSA due to risk concerns. Some measures such as pre-award reviews of procurement, as well as procurement and supply chain reviews were assessed as having been effectively implemented, but the majority of mitigation measures were not. Reasons cited included pandemic-related disruptions, ineffective follow-up on LFA recommendations (which in 2019, highlighted many of the same issues noted by the OIG report in 2022), and structural changes needed at the country level to address risks.[236] In the response to the 2022 OIG report by the Global Fund Executive Director, the ongoing progress of KEMSA's reform program was noted, including establishment of the KEMSA Reforms Implementation Committee (KRIC) and KEMSA reforms action plan to strengthen visibility of health products and accountability and reporting at all levels of the supply chain, with support from the Global Fund and partners. A KEMSA strategic team had also recently been appointed to "steer the reform agenda to concrete implementation".

M&E

There has been increasing support for strengthening HMIS in Kenya including through digitisation of data, and addressing gaps in data quality at the community and facility level through Global Fund investment. This includes expanding electronic platforms for data collection, integrating existing platforms to improve accountability and transparency, and supporting data quality assessments. There are still substantial investments in surveys during GC6, such as malaria MIS and the Modes of Transmission survey, despite preferences expressed by the TRP to shift away from funding these.[237] Community-led monitoring (CLM) has also been substantially scaled up, with 15 counties implementing CLM in GC6. There is room for further strengthening of CLM however - stakeholders reported that tools needed to be simplified and that CLM was still not being regarded as sufficiently robust to drive decision-making regarding program design and implementation.

A challenge related to M&E is that while the performance frameworks are generally aligned with national programs and reporting priorities, indicators that are not in the Performance Framework (PF) but are

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[235] Prior to COVID-19, Kenya was set to achieve MIC status by 2030, underscoring the importance of this sustainability planning.

[236] Kenya Grants, OIG Report, 2022

[237] Based on internal Global Fund documents (confidential)

important to program delivery are not consistently reviewed and acted upon to improve performance. For example, during GC6 there were only three indicators tracking performance for RSSH which were monitored by the RSSH department, despite all eight RSSH modules being implemented in Kenya. RSSH components not covered by the PF was not implemented independently by the RSSH department. Another example is that although the KP and AGYW 'defined package of services' indicators are generally regarded as useful, these do not capture i) low continuity on PrEP or ii) granular information on which elements of the package have been delivered. For the AGYW package indicator (which is a composite indicator), given procurement challenges outlined above, program implementers indicated they struggled to meet targets when there is a shortage of HIV tests (which are part of the composite indicator). A 'workaround' in use seems to be that implementers report delivering the AGYW package, and note qualitatively in reporting notes where stockouts affected provision of the full package.

Although many targets are set nationally based on NSPs stakeholders are of the view that some targets were not set rigorously based on data from previous funding cycles, funding gaps, or population estimates, particularly compared to PEPFAR's M&E processes. A new population size estimate is needed for KPs, with implementers reporting that government numbers are far lower than the reality. Additionally, commodity gaps and stockouts are not taken into account when setting targets which makes it difficult for SRs/ PRs to meet targets. Anecdotally, implementers did report flexibility in expanding programs to other geographies to serve high-need areas following a more rigorous assessment of KP population sizes.

5.2.4. C19RM

C19RM was highly regarded by stakeholders in providing valuable country support for mitigating COVID-19 impacts and later to strengthen systems - however the C19RM structure was not fit for purpose or conducive to an emergency response situation. This was mainly due to the perception that C19RM application and approval processes were lengthy and burdensome given the context. The lack of support for additional human resources for program management in C19RM was also viewed by stakeholders as a challenge, given that resources were already overstretched with implementation of the HTM and RSSH grants. There were major delays related to supply and procurement as well- with some laboratory reagents arriving in country 1.5 years after they were requested despite attempts to mitigate procurement challenges by procuring some goods centrally through wambo.org.

Kenya adapted to COVID-19 by putting multiple mitigating measures in place. This included: ensuring service providers had PPE, use of virtual platforms, implementing measures to allow patients already on treatment to continue collecting their drugs, arranging for health care workers to deliver medicines to people's homes, capacitating COVID-19 champions at the community level to encourage health seeking behaviour, and cash transfers to patients. NASCOP worked to ensure continuity of KP service delivery, and created technical guidance to support service providers in the context of COVID-19. Mobile dispensing services for people who use drugs were established as well as psychosocial support groups and hotlines to respond to incidents of violence. However, given a decline in performance across the portfolio during 2020/2021, measures that were funded were not able to completely mitigate disruptions due to COVID-19 (partly perhaps, due to underspending). Additionally, not all of these interventions were viewed as sustainable past the C19RM funding (e.g. C19 champions were an example of vertical programming with limited use following the worst of the C19 peak).

Significant underspend greatly impacted the effectiveness of C19RM funding. Eight months after the first COVID-19 funds were awarded (31 December 2020), only 15% had been utilised and by the end of the grant date in June 2021, 51% of C19RM funds and grant flexibilities were used.[238] At a recent KCM reprogramming meeting, some programs reported an absorption rate of 7% (September 2023). This underspend was attributed to efficiencies in terms of commodity prices, as well as approval and procurement delays, and changing dynamics of the pandemic which made certain budgeted activities irrelevant.

PPE and oxygen provided through C19RM were viewed by stakeholders as critical to the success of Kenya's management of COVID-19 and certain longer-term systems investments such as labs and event-based disease surveillance have been built up. Building up the oxygen ecosystem and PPE infrastructure has had a long term

[238] Global Fund (2022). OIG Audit report of Global Fund Grants in the Republic of Kenya

impact for other diseases. For example, greater availability of PPE has supported TB control, and improved infrastructure and ICUs has helped with the management of other epidemic outbreaks such as Marburg, Ebola, etc.

Reprogramming of C19RM funds is underway for the 55% that was yet to be absorbed[239]. Areas include community systems strengthening and mental health (non-State PRs), and surveillance and lab system strengthening (government PR). Given underspend, the flexibility of the Global Fund in allowing for reprogramming of C19RM funding for general pandemic preparedness and systems strengthening was greatly appreciated. An observation from 2023 reprogramming planning for C19RM was that State and non-State proposed reprogramming did not articulate how activities proposed 'built up' towards a national plan/ strategy for pandemic preparedness and response.

5.2.5. Catalytic investments

Kenya received the most MF funding of any country during the 2017 to 2022 period, and was also eligible for ten SIs during the GC6 period.[240] Progress of a subset of catalytic investments is considered below.

Strategic Initiatives[241]:

- There were mixed views on progress in the **CCM Evolution SI**, with perceptions that it did not take into account high baseline maturity levels of KCM at the start of catalytic funding. However, certain tools such as a real-time issue tracker allowing oversight of challenges across the KCM (including commodity stock-outs and shortages) was greatly appreciated by stakeholders. It is too early in the implementation of the CCM Evolution in Kenya to determine the extent to which this TA has been catalytic and effective however.
- The **AGYW SI** was considered significant in strengthening the alignment of interventions to specific populations as well as global policy. However implementation was slow initially, kicking off with only a few months until the end of GC6 implementation due to a heavy stakeholder engagement process. A few stakeholders expressed concerns the decline in SI funding for GC7 and thus end of the SI for AGYW could affect momentum in the AGYW program.

Matching funds were considered useful in bringing attention and focused support to AGYW HIV interventions, HRG, KP HIV interventions and Finding Missing TB cases, with some evidence of sustainability and scale-up of interventions. Innovations piloted under the TB MF had mixed results, with the successful interventions (e.g. school-based interventions, engaging with private sector service delivery, and new populations) integrated within the main allocation program for GC7.

For AGYW, although there were concerns expressed by some stakeholders that interventions for AGYW have not been scaled up sufficiently given need, it was noted that the investments paired with the most recent K-DHS results had catalysed action by the Government of Kenya and supported a conducive environment for greater donor investment in AGYW. This includes a new Development Impact Bond in 10 counties to address teenage pregnancy and HIV among AGYW, an SDG platform formed by UN partners to focus on sexual and reproductive health for adolescents, and a President's office campaign on teenage pregnancy and child protection. Within this initiative, the 10 County governments involved will be responsible for provision of SRH and HIV services to vulnerable adolescent girls. In relation to sustainability of MF's, one stakeholder opined that matching funds could be more ambitious in trying to influence DRM by requiring domestic matching rather than matching from the allocation. Overall, a clearer view of sustainability of these MF will come from the recent GC7 funding request and grant-making.

5.2.6. Partnerships

Kenya's partnership landscape across HTM is highly coordinated, with stakeholders commenting that collaboration was smooth and effective. Coordination between UNAIDS, PEPFAR, and the Global Fund is particularly strong. All three sit on the HIV TWG coordinated through the Government of Kenya. Additionally, they

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[239] Progress as of September 2023.

[240] For GC7 the value of matching funds has reportedly declined to US$15 million (from US$26 million in GC6)

[241] Per the Kenya CT, an evaluation of SIs in Kenya is planned.

participate in frequent meetings to troubleshoot challenges (including mitigating risks presented by anti-LGBTQ legislation). Notably, stakeholders highlighted greater co-planning and involvement of the Global Fund in PEPFAR COP 2022 writing processes (attributed also to PEPFAR's novel 2-year funding cycle which allows for greater alignment between Global Fund and PEPFAR processes and programming). UNAIDS also plays a key role in Global Fund processes as a significant provider of TA for funding request development, which is highly regarded by stakeholders. A malaria coordination platform also allows for frequent communication and troubleshooting between the Global Fund, PMI, and the Government of Kenya alongside other key stakeholders, and development of PMI's malaria operational plan takes into account Global Fund malaria priorities. Stakeholders described coordination between PMI and the Global Fund as strong.

Coordination between PEPFAR and the Global Fund in Kenya is working well, though some stakeholders suggested certain areas for further coordination. This includes improving PEPFAR and Global Fund's collaborative response to commodity shortages, as well as ensuring a clear take-over by the Global Fund or GoK in counties where PEPFAR is no longer providing services (occurs when a county has become lower-burden). For HIV there has been effective coordination around supplies and commodities between PEPFAR and the Global Fund, such as Global Fund covering ARV supply during a period when PEPFAR switched away from procurement through KEMSA resulting in supply disruptions. Additionally, given PEPFAR and Global Fund do not support the exact same mix of interventions, greater collaboration would ensure that the correct balance of biomedical, behavioural and structural interventions are provided even in counties where both are supporting programming. Another area suggested was for program reporting to be synced between PEPFAR and the Global Fund.

There have been strong recent efforts to enhance collaboration between Global Fund, GoK, as well as other technical partners regarding the sustainability agenda, which presents an important opportunity for partnership moving forward. This includes development of a Health Financing Plan and Donor Transition Framework (up until 2030). As Kenya shifts towards systems strengthening and fulfilling its UHC agenda, there is scope for the Global Fund to strengthen its relationship with key technical partners not traditionally engaged in the HTM response (i.e. National Laboratory). Currently, a lack of familiarity of partners with the Global Fund processes and support has slowed implementation and absorption of the RSSH grant significantly (see Section 1.2.2).

5.2.7. Gender, human rights, equity & communities (crosscutting)

In part due to the centring of civil society and communities during grant writing as well as Global Fund guidance, there has been a substantial scale-up of interventions aimed at removing human rights-related barriers to HTM services and addressing challenges related to equity and gender. Funding for the removal of human rights related barriers to HTM has increased to US$7.4M in GC6, and Kenya receives a matching fund dedicated to human rights and gender through the *Breaking Down Barriers* initiative. However, as noted earlier in this case study, the policy environment supporting human rights-based approaches in particular is becoming increasingly challenging in Kenya.

Stakeholder consultations as well as the midterm assessment of the Breaking Down Barriers were positive regarding Kenya's progress on removing human-rights related barriers to HTM services, although progress is advancing more rapidly for HIV than TB and malaria programs.

- According to the Breaking Down Barriers midterm assessment, Kenya saw progress in removing rights-related barriers to HV services with a 1-point increase relative to the baseline assessment, indicating an improvement from small scale interventions to programs operating at subnational level. Stakeholder consultations were positive regarding interventions such as the Know your Rights dialogues, training of peer paralegals, and sensitisation of stakeholders regarding prevention of GBV (although the lack of services for survivors was seen as a major gap). The Breaking Down Barriers assessment also highlighted particularly strong progress on the training of healthcare providers. NASCOP trained more than 300 health care workers across 47 counties, seeking to address HCP knowledge gaps of HIV, and law and human rights violations in ten high stigma counties. There are also county level initiatives to train CHVs, with Red Cross having trained 1,000 CHVs on human rights and HIV in Turkana and Meru counties. With support from UNDP, the Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN) also trained 42 community health volunteers in 2020 to document human rights violations including among key populations.

- Kenya has also demonstrated progress on the removal of human rights-related barriers to TB services, but with a score improvement from 1.4 to 1.8 indicating continued small-scale activities (although notably, this involved the design of new interventions for the TB program rather than scale-up of existing interventions as is the case for HIV). KELIN trained 30 community health advocates in five counties on TB, HIV and sexual and reproductive health rights, who then carried out community sensitisation forums. With support from the Global Fund and in collaboration with various NGOs, 31 health care workers, 45 community health volunteers and 10 TB champions were trained on TB-related human rights and the law, TB identification, documentation, and reporting. Between May 2018 and May 2019, with funding from Stop TB Partnership, KELIN also worked in six informal settlements in Nairobi to increase knowledge on rights-based approaches to TB.
- In malaria programming, Kenya made some progress from baseline to midterm assessment with an increase in score from 0.8 to 1.3 (remaining at the one-off activity level, indicating time-limited pilot initiatives.) Malaria programming lags behind TB and HIV programming on HRG, however there were some promising developments. For example, the Kenya Malaria Strategy 2019-2023 considers adherence to the principles of human rights, gender and equity as one of its guiding principles. A newly formed national TWG on HRG includes malaria stakeholders for the first time. In 2021, the Malaria Matchbox assessment was undertaken including assessing capacity of malaria CSOs. However, few programs supported by the GC6 grant target human rights related barriers to malaria services, attributed to limited expertise and resources. Although the prison population has been identified as an underserved population for malaria within the KMS, the National Malaria Program does not directly implement programs in prisons. Similarly, although Kenya has just under 575,000 registered refugees 70% of whom live in malaria endemic areas, programming for refugees remains a gap.

5.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Despite economic constraints, COVID-19 related disruptions, and procurement and supply chain challenges, Kenya is moving progressively towards sustainability in the health sector with renewed commitment and momentum to achieve UHC. The country has made significant progress in the fight against HIV, tuberculosis and malaria, and is shifting away from vertical programming towards a system-wide approach to health sector strengthening. This is being supported by multiple health sector reforms, including increased support and formalisation of CHWs, development of a Primary Health Care and Facility Quality Improvement Bill, and a Social Health Insurance plan. Stakeholders expressed that the recent GC7 funding request is similar to and builds upon GC6 grants, with some newer areas including mental health, scaling up integrated approaches such as HIV and cervical cancer screening as well as nutritional support, and HIV prevention technologies (e.g. dapivirine ring, cabotegravir). The review makes the following key recommendations towards reinforcing some ongoing initiatives but also exploring some implementation arrangements to support community-led approaches. These are:

1. Given the implementation period of GC7 (and GC8) is poised to coincide with significant advancements in UHC, there is an opportunity for Global Fund support to consider modalities for contributing to UHC within Kenya's Global Fund grants. A priority issue to address in GC7 implementation and planning for GC8 in this regard is the less well coordinated RSSH support, split across non-State PRs and multiple Ministry of Health departments. Other areas requiring attention include: procurement and supply challenges where there is a need to effectively implement mitigation measures with close monitoring; and strengthening implementation of RSSH interventions.
2. In view of Kenya's strong network of community-led and civil society partners, alongside noted performance challenges in some interventions requiring deep community engagement (e.g. PMTCT), implementation arrangements could be explored that would better support a range of smaller community-led and civil society partners.
3. Continued efforts to address human rights and gender equality barriers across HIV, TB, and malaria programming are needed - particularly TB and malaria as areas of less progress– noting also the increased threat to KP programs due to the political situation which is negatively affecting this space and requires the Global Fund and its key partners to continue to mitigate these risks.

4. In relation to C19RM reprogramming, which is also contributing to responsive health systems, there is a need to articulate and disseminate to PRs the national vision or strategy around pandemic preparedness to maximise synergies in C19RM funding from now until C19RM end in 2025.
5. Specific areas relevant for the GC8 funding request process directed to the Secretariat (learning from Kenya's experience) are i) to conduct a feedback session with the CCM/CCM Secretariat on the GC7 process and what worked well and less well. From this review, suggestions from a number of stakeholders based on the GC7 experience were i) for the CT to review with the CCM (and/or CCM Secretariat and other key parties) the GC8 materials and what is new/different from GC7, and ii) provide financing to support a fully funded country dialogue given the overall positive views on inclusiveness of the GC7 funding request.

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A.10. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 80 stakeholders from the following entities:

Stakeholder category	Entity
Global Fund Secretariat	Global Fund County Team
KCM Secretariat	CCM (including Ministry of Health, Lean on Me Foundation and Secretariat)
Ministry of Health Representatives and Global Fund-related program implementation units	TB Disease Program
	NASCOP- National AIDS and STI Control Program
	National Malaria Control Program
	M&E and Research, Ministry of Health
	HSS Department
	RSSH Department
PRs/ SRs	National Treasury (PR1)
	AMREF
	AMREF SRs: Population Service Kenya, Malteser International, Lucas Community Development Program, Goma County TB and Malaria Control, Catholic Commission Board, SEMA Limited
	Kenya Red Cross Society
	KRCS SRs: ADEO, Hoymas Kajiado, ICWK, BHESP, SAPTA, DEK
Technical Partners	UNAIDS
	CHAI
Donor Partners	PEPFAR
Community and Civil Society Organisations	Focus Group with 35 participants representing 22 organisations

A.11. TNT Commodity financing commitments and absorption

Table A.11 below presents TNT data on commodities (HTM) co-financing and absorption by Fiscal Year (FY) and disease program. Pending bills are orders placed but not paid, owing to policy of paying on delivery.

Table A.11: TNT HTM commodities co-financing commitment and absorption by disease program by Fiscal Year (FY)

	2017/18	2018/19	2019/20	2020/21	2021/2022	2022/2023
Commitment (KES) by FY						
HIV	2,200,000,000.00	2,129,271,881.00	2,544,458,196.00	2,246,925,000.00	2,062,408,545.00	1,917,976,947.00
MALARIA	300,000,000.00	400,000,000.00	427,770,902.00	466,000,000.00	416,000,000.00	416,000,000.00
TB	300,000,000.00	400,000,000.00	427,770,902.00	465,000,000.00	352,000,000.00	352,000,000.00
TOTAL Commitment	**2,800,000,000.00**	**2,929,271,881.00**	**3,400,000,000.00**	**3,177,925,000.00**	**2,830,408,545.00**	**2,685,976,947.00**
Absorption (Expenditure only)						
HIV	12%	95%	48%	79%	40%	53%
MALARIA	71%	28%	51%	24%	123%	36%
TB	36%	44%	70%	103%	14%	30%
Absorption (Expenditure + Pending bills)						
HIV	92%	101%	48%	no data	67%	100%
MALARIA	95%	88%	51%	no data	142%	77%
TB	87%	103%	70%	no data	30%	48%
Expenditure (KES)						

	2017/18	2018/19	2019/20	2020/21	2021/2022	2022/2023
HIV	265,336,691.63	2,030,996,978.06	1,224,656,021.00	1,770,614,266.00	828,963,503.52	1,014,496,886.95
MALARIA	212,572,832.67	111,587,399.70	216,259,169.30	113,913,341.49	513,679,877.10	148,654,999.00
TB	108,832,636.16	177,996,486.47	300,512,796.10	478,019,410.40	47,536,829.99	105,045,384.00
TOTAL	**586,742,160.46**	**2,320,580,864.23**	**1,741,427,986.40**	**2,362,547,017.89**	**1,390,180,210.61**	**1,268,197,269.95**
Expenditure + Pending bills (KES)						
HIV	2,024,623,732.20	2,157,748,557.61	2,438,270,526.45	no data	1,372,881,671.67	1,918,031,149.59
MALARIA	286,230,791.79	352,013,791.97	348,245,595.93	no data	589,468,087.93	269,645,220.14
TB	261,031,608.69	412,000,147.49	603,935,400.71	no data	104,051,856.67	201,321,166.40
TOTAL	**2,571,886,132.67**	**2,921,762,497.06**	**3,390,451,523.09**	**same as Expenditure**	**2,066,401,616.26**	**2,388,997,536.13**
Overall absorption (Expenditure + Pending) by FY						
Total by FY	**92%**	**100%**	**100%**	**74%***	**73%**	**89%***

*2020/21 pending bills not available. 2022/23 commitment was reportedly fully met.

6. KYRGYZ REPUBLIC CASE STUDY REPORT[242]

6.1. INTRODUCTION

6.1.1. Key country characteristics and HIV & TB context

The Kyrgyz Republic is a mountainous country located in Central Asia with a population of approximately 7 million.[243] According to the World Bank, Kyrgyzstan is classified as a lower-middle-income economy.[244] In 2022, GDP was US$11.5 billion and per capita GDP US$1,700.[245] The country is experiencing a heavy burden of external debt, which amounts to 56.3% of GDP.[246] According to the National Statistical Committee (NSC), 33.3% of the population live in poverty, and 6% in extreme poverty.[247] Poverty is also responsible for the high level of labour migration, which, according to various estimates, accounts for approximately 30% of the country's employable workforce.[248] The country's politics are becoming less tolerant to representatives of key population groups. This is expressed in stigmatizing public statements by political leaders, the initiation of bills directed against key populations and NGOs, unlawful law enforcement practices against sex workers and LGBT communities, etc. One consequence of this deterioration is the disruption of prevention programs and increased risk to successful responses to the HIV and TB epidemics in the Kyrgyz Republic.

Healthcare in the Kyrgyz Republic suffers from insufficient funding. The country's per capita health expenditure is among the lowest in the WHO European Region. In 2018, it amounted to 6.5% of GDP, a decline from 8.5% in 2012.[249] Public spending on health as a share of total government expenditure has declined over the last decade and is now 2.8% GDP, partly attributed to the decreased role of external funders following transition from LIC to LMIC status in 2014.[250]

Challenges with healthcare provision: Healthcare in the Kyrgyz Republic has undergone a number of reforms in order to strength coverage, improve health outcomes, and foster digitalisation. A weak infrastructure, insufficient financial and human resources and a lack of new investments in the modernisation of the services network create obstacles to the implementation of programs and rapid response to emergency situations. The wide network of laboratories requires modernisation, quality improvement and expansion of the range of services. Healthcare organisations suffer from poor capacity at top levels and opportunities for building the capacity of healthcare professionals and monitoring the quality of training are limited. Despite the absolute increase in government funding, available funds are insufficient for the implementation of the State Guarantees Program (SGP). The mechanisms for financing of public health prevention services at the population level are non-existent.[251]

Overcoming HIV infection and TB is one of the priorities of the country's Sustainable Development Strategy. The State Programs on HIV and TB were adopted by the Government of the Kyrgyz Republic for 2017-2021. During 2020-2022 implementation of these programs was complicated by challenges associated with the COVID-19 pandemic.

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[242] The Kyrgyz Republic case study has been conducted by Dr Larisa Bashmakova, PhD.

[243] Kyrgyzstan, BRIEF STATISTICAL HANDBOOK, Bishkek, National Statistical Committee, 2023, p. 8. https://www.stat.kg/media/publicationarchive/e53d756a-592c-461f-8a63-438664e73dde.pdf

[244] https://www.vsemirnyjbank.org/en/country/kyrgyzrepublic

[245] Kyrgyzstan, Brief Statistical Handbook, Bishkek, NSC, 2023, p. 36.

[246] Draft Law "On the Republican Budget of the Kyrgyz Republic for 2023 and the Planning Period 2024-2025", Ministry of Finance of the Kyrgyz Republic. https://www.minfin.kg/posts/345

[247] Kyrgyzstan, Brief Statistical Handbook, Bishkek, NSC, 2023, p. 18.

[248] Challenges of access to sexual and reproductive health and HIV services for internal migrants in Central Asian countries and international migrants from Central Asian countries in the Russian Federation, Kazakhstan, and Turkey during the COVID-19 pandemic. UNFPA, 2021, p. 19.

[249] Health Systems in Action Kyrgyzstan, WHO, 2021, p. 9.

[250] Kyrgyzstan, Brief Statistical Handbook, Bishkek, NSC, 2023, p. 43.

[251] Program of the Government of the Kyrgyz Republic for the protection of public health and development of the healthcare system for 2019-2030 "Healthy Person, Prosperous Country" approved by the Decree of the Government of the Kyrgyz Republic dated No. 600 dated 20 December 2018, para. 5.

Tuberculosis status and progress: According to WHO, the Kyrgyz Republic is among the 18 countries in the European Region with a high prevalence of TB and among the 30 countries in the world with the highest rates of multidrug-resistant tuberculosis (MDR-TB).[252] The rate of MDR-TB in 2021 amounted to 27% of new cases and 59% of previously treated cases.[253] According to the NSC, prior to the COVID-19 pandemic there was a downward trend in TB morbidity and mortality, with a decline in incidence from 90.6 to 78.9 per 100,000 population over 2017 to 2019. However, due to the COVID-19 pandemic, the detection of new cases declined, which caused a sharp decline in notified incidence in 2020 and 2021 to 53.5 and 58.1 per 100,000 population, that is, by 33% and 26.4% respectively, compared to 2019.[254] According to WHO estimates, the incidence was 130 per 100,000 population in 2022.[255]

HIV infection status and progress: The Kyrgyz Republic has a concentrated HIV/AIDS epidemic, with a disproportionate burden among key populations. A population-based bio-behavioural study (IBBS) estimated HIV prevalence among PWID by location at 13.3-25.9% and 10.7% (5.3-16.2%) among the MSM community in Bishkek.[256] The last 15 years have been characterised by a steady increase in the number of cases of sexual transmission of HIV. In 2022, sexual transmission of HIV accounted for 81% of newly registered PLHIV, and the share of injection transmission decreased from 19% in 2018 to 4% in 2022. This is accompanied by an increase in the number of women living with HIV, who accounted for 41% of registered PLHIV in 2022.[257]

Over the past 6 years, the cumulative number of registered cases of HIV infection in the country has increased 1.5 times (from 7,948 in 2017 to 12,231 in 2022). UNAIDS estimates that in 2022 there were 11,000 people living with HIV in the country.[258] HIV infection spreads mainly among people of employable age (20 to 49 years).[259]

6.1.2. Summary of Global Fund support

The Kyrgyz Republic has received funding from the Global Fund since 2004. For the 2017-2022 period, the value of Global Fund support rose from US$21 million in GC4 (2016-2018), to US$23.4 million in GC5 (2018-2020) and US$33.7 million over GC6 (2021-23). For both GC5 and GC6, UNDP serves as PR for the single HIV/TB grant (which includes US$1 million in matching funds for human rights) as well as C19RM funding (Figure 1). UNDP has been the PR for all three most recent Grant Cycles as well as C19RM 2021 support (US$6.6 million).[260]

[252] WHO

[253]https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22KG%22

[254] Women and Men of the Kyrgyz Republic, NSC, 2022, p. 183.

[255]https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22KG%22

[256]Bio-behavioural study of HIV infection among PWID and MSM in the Kyrgyz Republic. Data from the Republican Centre for Control of Bloodborne Viral Hepatitis and Human Immunodeficiency Virus of the Ministry of Health of the Kyrgyz Republic. Bio-behavioural study. Bishkek, AIDS Republican Centre, CDC, 2021

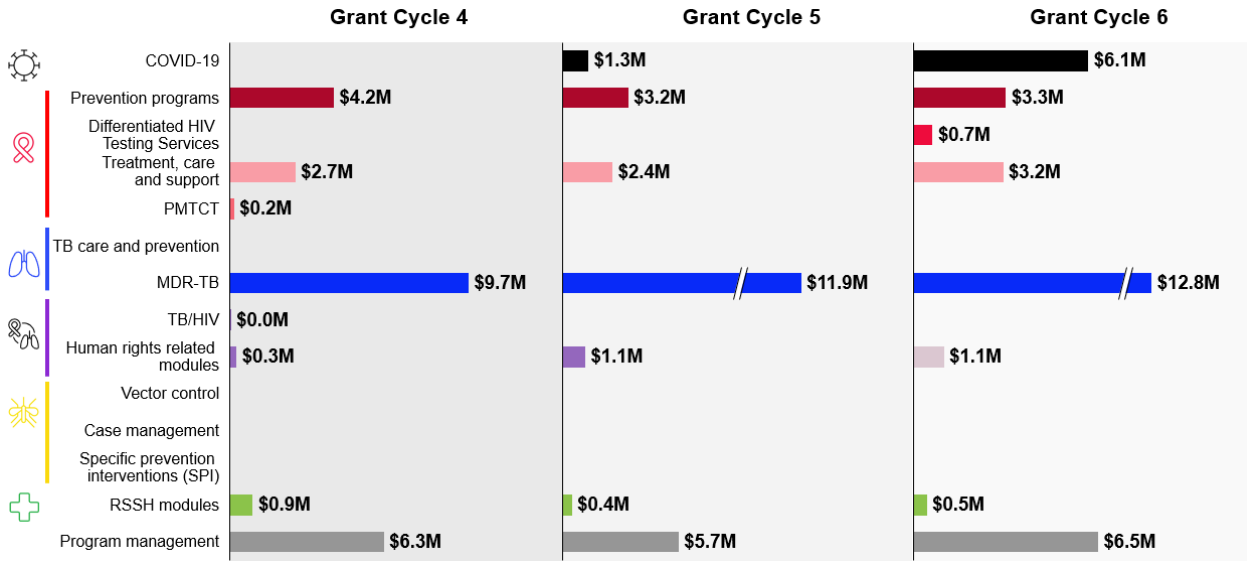
[257] Data from the Republican Centre for Control of Bloodborne Viral Hepatitis and Human Immunodeficiency Virus of the Ministry of Health of the Kyrgyz Republic.

[258] https://www.unaids.org/en/regionscountries/countries/kyrgyzstan

[259] Data from the Republican Centre for Control of Bloodborne Viral Hepatitis and Human Immunodeficiency Virus of the Ministry of Health of the Kyrgyz Republic.

[260] Kyrgyzstan also received C19RM 2020 support of $US0.9 million through the PR UNDP.

Figure 1: Kyrgyz Republic Global Fund budget breakdown by module by Grant Cycle[261]



6.2. KEY FINDINGS

6.2.1. Relevance of Global Fund investments

The Global Fund invested resources in KPs, in accordance with the priority areas of the Kyrgyz Republic, taking into account the burden of the epidemic and the needs of target groups and in line with the priorities of the government policy. Innovations were furthered through the Global Fund support. The Global Fund HIV investments have been primarily for key populations, taking into account the concentrated stage of HIV infection and in accordance with the priorities set forth in the Government Policy.[262] Priority areas included diagnosis, treatment, achievement of viral suppression, care and support, complemented with prevention programs and laboratory monitoring of treatment effectiveness. Civil society sector and community members were used to reach key populations groups. Investments in biomedical interventions were also complemented with social support (in connection with high levels of poverty, needs for services to protect and promote human rights, address stigma, discrimination and gender inequality). As noted above, these investments are highly relevant given the deterioration in the county's legal and social context.

The investment of Global Fund in the provision of assistance across the entire range of services for patients with drug-resistant TB (MDR-TB) was carried out in accordance with national priorities.[263] It included: the purchase of equipment, drugs, reagents for TB diagnosis and drug susceptibility testing, treatment coverage and treatment adherence. Interaction with civil society organisations and communities of people living with TB was initiated for the first time. It ensured a reduction in cases of treatment discontinuation and increased treatment adherence through social and legal support.

Innovative approaches are quickly promoted with the support of the Global Fund. State-of-the-art diagnostic and treatment regimens are gradually being introduced and within a short time replace the previously used ones (for example, TLD for the treatment of HIV infection; bedaquiline for the treatment of MDR-TB).

> *"The purchase of bedaquiline and other drugs for short-term courses of treatment of MDR-TB made it possible to ensure treatment effectiveness, increase patient adherence and prevent cases of treatment discontinuation."* -Government Stakeholder

[261] Global Fund (2023). DnA Factbook Kyrgyzstan August 2023

[262] Program of the Government of the Kyrgyz Republic to overcome HIV infection in the Kyrgyz Republic for 2017-2021 approved by Decree of the Government of the Kyrgyz Republic No. 852 dated 30 December 2017, para. 3, 4, 5; Annexes 2, 3, 4.

[263] Program of the Government of the Kyrgyz Republic "Tuberculosis-V" for 2017-2021 approved by Decree of the Government of the Kyrgyz Republic No. 448-p dated 03 October 2017.

The contribution of the Global Fund grant to infrastructure and equipment of healthcare organisations and increasing human resource capacity also responded to common challenges and contributed to strengthening the health care system as a whole. Improvement of laboratory facilities for HIV and TB; modernisation of equipment; introduction of new methods and algorithms; institutionalisation of internal and external quality control ensured a high level of quality and reliability of laboratory tests. Strengthening the capacity of medical workers was carried out not only in specialised healthcare organisations, but throughout the entire healthcare system.

Funding applications reflected the needs of key populations, which were confirmed during the country dialogue. The investment of the Global Fund made it possible to concentrate efforts on the most significant interventions to reduce the burden of the HIV and TB epidemics, as well as RSSH in the Kyrgyz Republic.

6.2.2. Progress and results achieved

A reduction in morbidity and mortality associated with HIV and TB has been achieved, though TB progress in particular has been affected by the consequences of the COVID-19 pandemic. The HIV/TB grant during the GC5 period (up to 2020) had a constant A performance rating, subsequently rated C during the most recent 2022 reporting period.[264] Results achieved over the 2017-2022 include:

- ART coverage has more than doubled (from 2,668 PLHIV undergoing ART in 2016, to 5,771 in 2022, of which 5,208 PLHIV achieved viral suppression in 2022). The viral suppression rate reached 90% among PLHIV undergoing ART in 2022.[265] This progress is occurring in the context of rising HIV incidence as noted earlier.
- The number of deaths among PLHIV undergoing ART decreased significantly from 39% in 2017 to 9% in 2020.[266]
- Following a decline in TB incidence over the first half of the 2017-2022 period, incidence has risen since 2020, reaching 130/100,000 in 2022.[267] Over the same period (2020-22), TB case notifications declined and have yet to rebound to pre-2020 levels (based on 2022 case notification data).[268] The country has also seen a rise in HIV-negative TB mortality between 2020 and 2022 after close to a decade. TB treatment success rate from the 2021 cohort amounted to 81% among new TB cases, 70% among previously treated cases, and 57% among PLHIV with TB.[269]

Key aspects which have supported these results include:

HIV:

- The detection of HIV infection is reported to have been improved as a result of expanded HIV testing (enzyme-linked immunosorbent assay (ELISA) and rapid testing). There are 34 laboratories in the country that carry out HIV diagnostics and 23 NGO-run labs. External quality control of laboratory diagnostics of HIV demonstrated a concordance of test results of more than 90%.
- Introduction of modern TLD-based treatment regimens has contributed to improved ART coverage and treatment adherence, rising from 11% of people on ART in 2018 to over 90% of PLHIV in 2022 on a TLD-based regimen.

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[264] GC5 performance ratings are reported in the Global Fund confidential materials. Performance ratings for 2022 are from the DnA Factbook Kyrgyzstan Aug 2023.

[265] Republican Center for Blood-Borne Viral Hepatitis and HIV Control: https://aidscenter.kg/dannye/?lang=ru. Note national statistics differ from Global Fund figures which are 4750 people achieved viral suppression among 4953 PLHIV tested.

[266] Analysis of the cascade of HIV services and development of strategies for the identification of new cases of HIV infection in the Kyrgyz Republic. Bishkek, 2021, p. 68-71.

[267] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&iso2=%22KG%22&lan=%22EN%22

[268] Ibid

[269] Ibid

- 2021 Global Fund results on coverage of prevention programs indicate high performance in meeting targets, specifically 101% of MSM reached; 97% of PWID reached; and 89% SW reached with HIV prevention programs.[270]

TB:

- The proportion of bacteriologically confirmed new cases of pulmonary tuberculosis, according to the WHO TB incidence profile of the Kyrgyz Republic, increased from 59.4% in 2012 to 66% in 2021 and to 68% in 2022.
- Shorter course MDR/RR TB treatment was introduced with support of the PSM Innovation SI in GC5 and GC6. Coverage with short-term treatment courses amounted to 45% of the number of patients with MDR-TB in 2022, with the goal to increase this to 60% by 2027, supporting improvements in treatment adherence.
- Since January 2022, the National Reference Laboratory (NRL) has automatically uploaded DST results for new drugs into the Laboratory Data Management Information System (LDIS), which has been implemented at all TB laboratories in the country. It is synchronised with the National Tuberculosis Register and aims to provide integrated patient data management, covering both clinical and laboratory components.
- Laboratory diagnosis of TB is carried out in 104 primary health care organisations throughout the country. Of the 30 GeneXpert express test platforms, 25 were purchased with funds provided by the Global Fund.
- The number of treatment discontinuations has been reduced (from 24% to 4% in 2019 in Bishkek) as a result of the introduction of effective patient management models: case management; video DET with elements of digital feedback; Institute of Case Managers, use of mobile applications and WhatsApp; involvement of NGOs.

Factors hindering grant goals

Key obstacles to achievement of grant objectives were related to the shortage and turnover of medical personnel, their low alertness, insufficient knowledge and skills in the early detection of HIV and TB; persistent stigma and discrimination in health care organisations.

Insufficient coverage of HIV testing is highly influenced by low awareness of clients and health workers of the early detection of HIV infection and TB. Thus, in 2022, 51% of PLHIV were identified at advanced stages of the disease resulting in high mortality rates due to AIDS and/or HIV/TB co-infection. In order to expand HIV testing, the introduction of rapid testing has begun in hospitals and Family Medicine Centres, and incentives for each identified case at the expense of budget funds have been developed.

Other barriers cited by stakeholders and documentary evidence comprised:

- The shortage of medical personnel in the health care system affecting provision of quality health services for PLHIV and TB patients. The loss of trained personnel requires additional training costs and degrades the quality of services. As a result, patients discontinue treatment and do not receive the necessary information.
- The increased workload on medical and outreach personnel with a small amount of material remuneration leads to a decrease in their motivation, emotional burnout, stigma and discrimination in the provision of medical services, as well as the loss of trained specialists.
- Treatment discontinuation and refusal also occur due to social instability, labour migration, and during the transition of care from prison to community. According to IBBS, approximately 50% of migrant workers have never been tested for HIV.
- COVID-19 has also had a significant impact on the achievement of indicators. The reduction in HIV testing in 2020 levelled off in 2021 and increased in 2022. At the same time, the significant decline in TB diagnosis in

[270] DnA Factbook Kyrgyzstan Aug 2023

2020 could not be reversed within two years of the lockdown related to the COVID-19 pandemic. Accordingly, a significant under-detection of new TB cases has taken place.

6.2.3. Funding model and business processes

Funding model

The Global Fund funding model and its implementation is very effective as it provides a platform for KP engagement and funding. Good engagement of KP groups in the preparation and approval of an application for Global Fund funding, as well as in its implementation, supported through community-based monitoring is the best model for donor work in the country.

Aspects of the funding model and its implementation considered to be working well include:

- The **country dialogue** involves NGOs and communities. It allows for a transparent and efficient application preparation process. Applications are adjusted taking into account the needs and requirements of target groups.
- The **three-year funding cycle** is very convenient in terms of updating priorities and methodological approaches.
- The **application format**, according to respondents, makes it possible to adequately substantiate the essence of the application. The forms and modules have become more focused and prioritised, allowing for clear responses.
- Funding applications are prepared on the basis of priorities determined by the Global Fund Secretariat, as well as the conclusions and recommendations of the Global Fund Country Team, based on the needs and specifics of public administration in the country.
- **TRP** responds quickly and constructively to submitted applications. Whenever required, TRP provides comments and clearly stated questions on the merits of the application. The conclusion on the application, which is issued by independent experts, guarantees the impartiality of the consideration of the application and a deep expert approach.

Areas for improvement noted by stakeholders included:

- The **long approval process** for funding requests and reprogramming requests, both at the country level and at the level of the Global Fund secretariat, affects the efficiency and effectiveness of spending funds.
- The funding model **requires more flexibility**. This may not always be possible during the current grant period due to restrictions on the proportion of the grant value that can be used for reprogramming.[271]
- The **application format changes with each grant**, complicating the preparation of the funding request.
- The development of application preparation guidelines is sometimes delayed and **preparation timelines are shortened**.
- KPI targets and **indicators** are viewed by some stakeholders as inflexible and not reflective of the evolution of the epidemic and program models. For instance targets for coverage of PWID by OST were considered not feasible due to significant decrease in use of opioids as a drug of choice. This issue was considered to hinder recruitment and motivation of outreach workers within civil society led programs.

[271] Grant flexibility for focused country portfolios is 30% at intervention level and 10% for discretionary categories (Secretariat communication). There may be different levels of understanding of this policy across key informants interviewed for this case study.

- While the shift to annual PR reporting is seen as supporting greater focus on grant implementation, there are also concerns this will reduce attention to semi-annual performance monitoring and thus timely course corrections.
- The current arrangement of UNDP as PR means that UNDP procedures in addition to Global Fund requirements apply to grant management, which some country stakeholders perceive as process heavy.

There are also a complexities in regard to implementation arrangements:

Given UNDP's PR role, the topic of shifting the PR to national institutions is a near constant undercurrent among country officials. This is a concern to country partners in regards to risk of deterioration of NGO involvement and leadership of Global Fund supported programs.

Over the last strategy period, the CCM provided a platform and mechanisms for interaction between different sectors. Civil society is involved in all areas of activity: planning, development of government policy, mobilisation of resources and monitoring of their use. However, shrinking civil society space and backlash against LGBTQ groups has affected the functioning of the CCM where in April 2023 Kyrgyzstan's cabinet of ministers took steps to dissolve the CCM. Through the CCM, all sectors (government, NGOs and international organisations) work together to implement the National Policy, and in doing so, support and complement each other. This is manifested not only in the work of the CCM, but also in the course of implementation of the main tasks of the state through a beneficial combination of program and advocacy work.

As part of the preparation of the 2024-2026 Funding Request, amidst the shrinking space for civil society in the country, there was a move by Parliament to reduce civil society participation in the CCM. A new regulation on CCM composition has since been adopted and despite the reduction in the number of representatives from the civil sector, its intersectoral composition has been preserved.

> *"CCM is a powerful tool that has enabled the development of partnerships between sectors. It provides a platform for actual dialogue and openness of discussion. Currently, the CCM is subject to strong pressure from the country's Parliament aimed at reducing the participation of the civil sector. The CCM model should be retained."*
>
> -Civil sector representative.

Separately, civil society representatives also expressed that competition for dwindling resources limits interaction with a wider range of NGOs in Kyrgyzstan with focus on human rights, gender and other NGOs. This competition was considered to have manifested in some civil society partners feeling unsupported during this crisis period for the CCM.

> *"We experienced a great shock when we faced external pressure on NGOs and key groups, when the existence of the CCM and the obtaining of the Global Fund grant were jeopardised. However, none of the NGOs from the huge network in the country helped us."*
>
> -NGO representative.

Sustainability and transition to government financing

Increasing government funding for HIV and TB programs is one of the factors for the sustainability of the programs initiated by the Global Fund in the country. This was facilitated by the policy of the Global Fund for a gradual increase in the share of government funding for these programs, as a condition for the allocation of a Global Fund grant. The transition and sustainability plan for HIV and TB was prepared and approved by the resolution of the Government of the Kyrgyz Republic on HIV[272] and the order of the Ministry of Health on TB. These include increased funding, improvement of the regulatory framework, mobilisation of resources, improvement of the

[272] Program of the Government of the Kyrgyz Republic to overcome HIV infection in the Kyrgyz Republic for 2017-2021 approved by Decree of the Government of the Kyrgyz Republic No. 852 dated 30 December 2017, Annex 5.

M&E system, etc. The implementation of the plan is regularly monitored. Key achievements over the last strategy period include:

- State funding for HIV programs increased 7.1 fold: from 27 million soms in 2016 to 172 million soms in 2022. As a result, in 2022, 80% of medicinal products and reagents for laboratory diagnosis of HIV infection were purchased by the state budget. In 2023, approximately 25 million soms (US$ 300,000) was allocated from the state budget for OST programs, as well as 87 million soms for HIV and 60 million soms for TB. The state assumed full financing of the costs for the treatment of drug-sensitive TB, as well as 15% of the cost of second-line drugs for the treatment of MDR-TB; and 80% ARV drugs and routine HIV testing by ELISA.
- The need for healthcare financing is encouraged by a consortium of NGOs through participation in public hearings in the process of approval of the state budget, and is also promoting an increase in HIV funding at the municipal level.[273]
- Amendments have been proposed to the procurement law to allow for purchase of drugs through international organisations, which would help to simplify procurement procedures and support lower prices and procurement of high-quality drugs (WHO prequalified).
- HIV financing sustainability has been aided by price reduction for ARVs, where ARV per-person cost reduced from US$ 197 in 2018 to US$117 in 2021 (48% decline).[274] This was primarily through entry of lower cost generic ARVs following amendments to the Patent Law in 2015 along with advocacy efforts.

Some country stakeholders perceive that state ownership has been strengthened through the SR role of leading state specialised institutions for HIV and TB for the Global Fund grant. The view is this has strengthened the capacity of these institutions in management, planning, execution, reporting, and M&E. Entities cited as having been strengthened over the 2017-2022 period were the Ministry of Health (Centre for the Development of Healthcare and Medical Technologies of the Ministry of Health of the Kyrgyz Republic), the Republican Centre for Control of Bloodborne, Viral Hepatitis and HIV, and the National TB Centre.

6.2.4. C19RM

COVID-19 has had a less pronounced impact on Kyrgyzstan compared to other countries but had an impact on service provision. The COVID-19 mortality rate was 3.7 times lower than the European region as a whole (EuroWHO data).[275] This became possible thanks to adequate and promptly delivered humanitarian assistance from international donors, primarily from the Global Fund. During the COVID-19 period, interaction with civil society organisations increased and volunteering was implemented to assist patients in the delivery of medicines, medical devices and supplies to their homes; provision of food and hygiene products, personal protective equipment; work on helplines; and conducting online consultations on treatment adherence.

COVID-19 impact on access to HIV and TB services included decline in routine HIV testing in 2020 by 7.2%, and decline in rapid testing by 25% compared to 2019. At the same time, the detection of new cases of HIV infection decreased by 19.2%. In 2020, TB testing decreased by 24.1% compared to 2019 and by 32.4% compared to 2018. Accordingly, the reported incidence of tuberculosis decreased from 78.9 per 100,000 population in 2019 to 53.5 and 58.1 per 100,000 population in 2020 and 2021, that is, by 33% and 26.4%, respectively, compared with 2019.[276]

The Global Fund's support was very timely and needed to reduce the pressure on the health care system as a whole, as well as on HIV and TB programs. Despite the challenges, the country managed to maintain coverage of target groups with services, but the ability to identify new cases was compromised. Kyrgyzstan received two grants to overcome the COVID-19 pandemic for a total amount of US$10,109,098. The level of economic recession

[273] Results of budget advocacy in the Kyrgyz Republic for 2016-2019. Bishkek, Soros Foundation Kyrgyzstan, 2020.

[274] https://impact.economist.com/perspectives/sites/default/files/ei_art_hiv_report_final.pdf

[275] Health Systems in Action. Kyrgyzstan. WHO, 2021, p. 18.

[276] Women and Men of the Kyrgyz Republic, NSC, 2022, p. 183.

due to COVID-19 for 2020 in Kyrgyzstan was the highest among the countries of Euro WHO region and amounted to -8.6%.[277]

> *"The purchased equipment, reagents, protective equipment, and assistance to customers had a significant impact on the consequences of the COVID-19 pandemic through the use of protective equipment, prompt detection of cases and adequate treatment for COVID-19, as well as retention of recipients of HIV and TB programs."*
>
> -Government stakeholder
>
> *"The healthcare infrastructure and laboratory services have been improved; NGOs have been engaged thanks to the assistance of the Global Fund. The volume of drugs dispensed has been increased and the delivery of drugs to the patients, including migrant workers, has been ensured."*
>
> -Government stakeholder

C19RM supported maintenance of HIV service coverage during the COVID-19 pandemic, and the 2020 reduction in HIV testing levelled off in 2021 and increased in 2022. However, missed opportunities impacted the ability to achieve target indicators. At the same time, a significant decrease in tuberculosis diagnosis in 2020 could not be eliminated within two years after the lockdown related to the COVID-19 pandemic. Accordingly, a significant under-detection of new TB cases has taken place. Treatment coverage for PLHIV and TB patients has been maintained; the trends of decreasing morbidity and mortality from HIV and TB also continued, due to the support of the Global Fund and other donors.

A number of COVID-19 mitigation initiatives continue to this day. For example, provision of methadone for five days of treatment adherence is continued; video monitoring of the intake of anti-tuberculosis drugs was introduced for DOTS participants receiving anti-tuberculosis drugs at home; labour migrants are supplied with ARV drugs abroad via express mail. Healthcare professionals have also increased their capacity to respond during epidemics. This included: staff mobilisation skills, rapid restructuring of the work of healthcare organisations, allocation and attraction of additional resources, personal safety rules, patient support.

6.2.5. Partnerships

The basis for the development of partnership is the CCM, which has provided a platform and mechanisms for interaction between different sectors. Civil society is involved in all areas of activity: planning; state policy development; resource mobilization, monitoring etc. Strong collaboration with other donors in the area of HIV and TB is also in place.

Partnerships aspects working well:

Some pilot projects are being implemented jointly with PEPFAR and other donors. They include expanding HIV testing, OST support, and promotion ART at the primary health care (PHC) level. Several research studies were jointly conducted by the Global Fund and PEPFAR, as well as the Global Fund and GIZ, and UN Agencies. GIZ also supported the development of documents (e.g. Transition and Sustainability Plan), evaluation of the government program and preparation of applications for Global Fund funding. The openness of the funding and results of the Global Fund grant was considered as supporting greater openness of other programs of international donors (PEPFAR, GIZ, etc.).

According to WHO, in the healthcare system of the Kyrgyz Republic, with the exception of HIV, the role of communities is underestimated.[278] At the same time, the civilian sector is increasingly involved in TB programs, and its importance in increasing treatment adherence is increasing. In accordance with the legislation of the Kyrgyz Republic, the State Social Contracting (SSC) has been introduced, aimed at creating models for financing NGOs from the state budget.

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[277] Medium-Term Forecast of Socio-economic Development of the Kyrgyz Republic for 2022-2024 approved by Resolution of the Cabinet of Ministers of the Kyrgyz Republic No. 47 dated 28 June 2021, p. 6.

[278] Health Systems in Action Kyrgyzstan, WHO, 2021, p. 9

The positions of patronage workers (peer consultants) are also included in the system of care at the primary health care level.

Areas for improvement in the Global Fund partnership in Kyrgyzstan included:

- Need for strengthening leadership among civil society organisations to strengthen advocacy efforts and ability of civil society to engage with and collaborate with government agencies and decision-makers.
- There is a need to unify approaches to program implementation, financial support (remuneration) of personnel and the M&E system among partners.
- Greater transparency of funding and implementation of programs of other donors, whose financial resources still remain opaque..
- Need to develop a communication strategy that demonstrates the evidence base for the role of NGOs and the results of partner activities.

6.2.6. Gender, human rights, equity & communities

Kyrgyzstan has extensive experience in implementing human rights programs and overcoming stigma and discrimination against key populations. The challenges of the present period indicate the importance of this foundation and the need for its strengthening. Political instability and frequent changes of political leaders in the Kyrgyz Republic require constant work on communication and the elimination of legal barriers experienced among key populations. Despite significant efforts in strengthening human rights and community systems in the Kyrgyz Republic which include contributions from the Global Fund grant (US$1 million in Matching Funds for each of the GC5 and GC6 periods, which were matched by the allocation on a 0.51:1 (GC5) and 0.69:1 (GC6) basis)[279], stigma and discrimination associated with HIV, TB and key groups persist amidst an increasingly challenging political and social environment.

The interdepartmental plan for a comprehensive response to human rights-related barriers in the provision of HIV and TB services[280] and the creation of an interdepartmental coordination group, signed by orders of three ministries (MoH, MoJ and MIA) have not yet resulted in a fundamental change in the situation. However, according to the midterm review of the Breaking Down Barriers program: "Over the medium term, Kyrgyzstan has achieved all the milestones necessary to create conditions at the national level that can support the implementation of comprehensive programs to remove human rights barriers to access to HIV and TB services."[281]

Areas of progress noted include the capacity of civil sector organisations in advocacy and participation in decision-making processes has been strengthened. Monitoring is carried out by communities through the CCM Oversight Subcommittee, as well as through work in the field. Legal support for PLHIV and TB patients includes assistance in personal documents restoration (e.g. passport, ID card), legal advice from para-lawyers and professional lawyers, collection of complaints, accompaniment and support in ensuring the rights to public health and social services. Patient training is provided. Social state guarantees, maintaining access to free (or preferential) diagnostics and treatment, ensuring rights and freedoms in connection with HIV and TB have been preserved and optimised as a result of active advocacy in the process of reforming the legislation of the Kyrgyz Republic in the field of health care. As mentioned above, active lobbying to promote legislation on the procurement of medicines, reagents and medical devices through UN agencies to reduce the cost and ensure the quality of drugs takes place.

> *"Key informants universally noted political instability and the rapid growth of conservative movements in Kyrgyzstan over the past five years as a serious problem. The fact that in this difficult political*

[279] Source is Global Fund material (confidential). The Grant Approval Committee (GAC) approved an exception to the 1:1 match condition for the 2017-2019 cycle which was applied to the 2020-2022 cycle.

[280] Interdepartmental action plan to overcome legal barriers to HIV and tuberculosis services in the Kyrgyz Republic for 2022-2025 approved by a joint order of the Ministry of Health, the Ministry of Internal Affairs and the Ministry of Justice of the Kyrgyz Republic, March 2022.

[281] Breaking Down Barriers, BDB, p. 19.

> *environment it was possible to maintain all human rights programs, and even expand some of them, is in itself an achievement and an indicator of sustainability."* -Breaking Down Barriers, p. 23

Challenges include the political instability and frequent changes of political leaders in the Kyrgyz Republic require constant work on communication and the elimination of legal barriers. Second, due to pressure from law enforcement agencies, results in the coverage of HIV prevention services among sex workers have not been achieved. Pressure on the LGBT community, especially on MSM and trans-people exists. In 2023, the law on NGOs, which recognises NGOs receiving grants from international organisations as foreign agents, passed the first reading in parliament. The law also provides for strict control over the activities and financial flows of NGOs. The human rights and gender-based violence situation worsened during the COVID-19 pandemic. Despite the efforts of numerous partners, the situation has not yet been resolved. Work to overcome human rights-related barriers is expected to continue within the frameworks of the new grant in 2024-2026.

Civil society stakeholders view that to increase efficiency and achieve the goals that have been set, partnerships should be expanded to include non-core NGOs working in the field of human rights activities, gender, assistance to youth and migrants.

6.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

The work of the Global Fund in the Kyrgyz Republic, which has been going on for 19 years, has brought approximately US$ 200 million into the country. Significant progress has been made in reducing morbidity and mortality from TB, reducing HIV mortality, diagnosis, early initiation of ART and achieving viral suppression. In addition to these results, grants supported a cadre of highly professional and committed leaders from among government officials, representatives of non-governmental organisations and community organisations. *"We cannot cope without the Global Fund,"* – was remarked by numerous government and civil society stakeholders.

The country is open to innovation and follows all WHO and UNAIDS recommendations to fulfil global commitments and implement best practices for the prevention, treatment, care and support through the development of a national regulatory framework (laws, regulations and orders of the Ministry of Health).

The CCM has made it possible to develop partnerships between government, non-governmental and international organisations. It has ensured transparency of all stages of mobilisation of resources and implementation of the Global Fund grant, ensured country dialogue and broad participation of civil society.

The Global Fund's Sustainability, Transition & Co-Financing policy has already led to an increase in government funding for HIV programs in 2022 of 7.1 fold compared to 2016. This made it possible to ensure the purchase of 80% of ARVs for the treatment of HIV infection and reagents for routine HIV testing. Funding for the TB service has also been increased and all procurement of drugs for the treatment of drug-sensitive TB, as well as 15% of drugs for the treatment of MDR-TB, are currently funded from the state budget.

Global Fund support, alongside technical support for robust implementation of grants, is considered extremely important to Kyrgyzstan's civil society, people living with and affected by HIV and TB, as well as for wider population as it provides not only financial but also **significant political support** to ensure the sustainability of programs, formation of appropriate public policy and promotion of state funding of HIV and TB programmes, and support for developing partnerships and dialogue between different sectors. Reflecting on successes and challenges, the following areas are proposed for strengthening:

Funding model and implementation arrangements

1. UNDP is recognised as having provided strong grant management and enabled significant progress in curbing the HIV and TB epidemic. Increased attention should be paid to building national capacity to ensure the sustainability of programs post Global Fund financing, including development of a plan for the transition of the Global Fund grant management from UNDP to national ownership and ensure transparency of this process.
2. Contribute to capacity building of the government structures (MoH) as an SR for GC7.

Disease programs

4. Expand access to peer support & education through NGO services to people living with TB nationwide (at the national and local levels) for provision of client-friendly services including legal and social support, case management, etc.
5. Invest in prevention and treatment of HIV and TB among migrant workers.
6. Develop a communication strategy and allocate resources to conduct research that will provide an evidence base on the role and contribution of the Global Fund grant in overcoming the HIV and TB epidemic.

Supporting human rights and gender equality

7. Invest in building the capacity of decision makers using innovative approaches e.g. short information sessions, regular distribution of newsletters, video materials, holding weekend meetings.
8. Leverage the capacity of public leaders; authoritative international organisations, the work of the ombudsman institution to provide support and assistance in building a dialogue between parliamentarians and the civil sector, as well as preventing the introduction of discriminatory provisions into the country's legislation.
9. Promote close/aligned communication across the Ombudsman Institute, political, local and religious leaders for promotion of human rights issues, gender equality and the role of prevention programmes for key groups for HIV& TB prevention.

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A.13. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 15 stakeholders from the following entities:

Stakeholder category	Entity
Government Institutions	President's Office of the KR
	MoH
	National TB Center
	National VH & HIV Center
International Organizations	PEPFAR
	GIZ
	UNAIDS
Civil Society	Partner's Network (Partnerskaya Set) Association
	Ranar NGO
	PLHIV network
	ARZ (Reproductive Health Alliance)
PR	UNDP
Global Fund Secretariat	Global Fund Country Team

7. Mozambique case study report

7.1. INTRODUCTION

7.1.1. Key country characteristics and HTM context

Mozambique is situated in Southern Africa and borders Tanzania, Malawi, Zambia, Zimbabwe, South Africa, and Eswatini. Its long Indian Ocean coastline of 2,700 kilometres faces east to Madagascar with a population of approximately 33.8 million people in 2022.[282,283] Mozambique is divided into 11 provinces and 154 districts. Within the districts are the localities, the lowest level of representation of the central state.[284]

Mozambique is one of the countries in Southern Africa that has faced various threats from natural disasters resulting from climate change. Due to its morphology and geographical conditions, the country is exposed to extreme climate-related events, the most frequent of which are floods, cyclones and droughts. In the last 30 years, at least 14% of the population has been affected by a drought, flood or tropical storm. In 2019, two cyclones wreaked major devastation, putting much of the population in need of humanitarian assistance. The country's vulnerability to disasters results from its location at the mouth of nine international rivers, the existence of arid and semi-arid zones, the long stretch of national territory which is located in the intertropical convergence zone subject to excessive weather, as well as the extensive coastal zone which is influenced by tropical cyclones, and the existence of active seismic zones.[285]

In addition to climate change, Mozambique has been struggling with instability in the province of Cabo Delgado due to terrorist activity since October 2017. Since mid-2022, groups with links to Islamist extremism have also carried out attacks in the districts of Memba and Erati in Nampula province. Terrorism has caused many human and material losses in the affected populations. These attacks led to service interruptions, loss of follow-up, destruction of infrastructure and mass migration of the population, causing problems in the coverage of the health system and increasing the incidence of endemic diseases in the country such as malaria, cholera and others.[286]

Mozambique is a low-income country, with a health expenditure of US$40/capita.[287] The country faces significant challenges in guaranteeing the availability of and access to health services. The Government of Mozambique provides healthcare services to most of the population through the Ministry of Health, which manages public hospitals and health care centres. The remaining populace rely on traditional approaches for medical assistance involving community health agents, elementary agents, and birth attendants.[288] Mozambique's strategic plan for the health sector outlines objectives to promote ongoing and sustained improvements in health while addressing challenges associated with demographic discrepancies and epidemiologic changes.[289] In Mozambique 88% of facilities are public and 12% are private. There is a significant gap of human resources for health (6 health workers per 10,000 population in 2018 below the recommended benchmark of 23 health workers per 10,000 populations).[290]

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[282] WorldBank [online] accessible at https://www.worldbank.org/en/country/mozambique/overview#1

[283] UNICEF [online] accessible at https://data.unicef.org/country/moz/

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[285] Manjoro, A., Rosse, M.E., Ferreira, P.A. (2017). Desafios de Moçambique Após os Ciclones IDAI e Kenneth. Universidade Católica Portuguesa. https://iep.lisboa.ucp.pt/asset/4386/file

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[290] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22006_report_en.pdf

Mozambique is one of the countries with the highest HIV, tuberculosis (TB) and malaria burdens in the world.[291] Malaria was the fourth leading cause of death in the country in 2019, accounting for 42% of deaths among children under 5 years of age.292 Mozambique is among the top eight countries with the highest HIV prevalence; with mother-to-child transmission (MTCT) rate of 10%.[293,294] The incidence of TB is rising, with paediatric TB cases almost tripling in recent years. Mozambique has one of the highest global incidences of TB-HIV co-infection, and HIV infection is said to increase the risk of developing TB which in turn raises the likelihood of poor clinical outcomes.[295] The epidemiological profile of malaria, HIV and TB in Mozambique are closely linked to the countries' socioeconomic condition.[296]

7.1.2. Summary of Global Fund support

Since 2002, the Global Fund has signed over US$ 2.2 billion and disbursed over US$ 1.6 billion to Mozambique. Active grants total US$ 927 million for the January 2021 to December 2023 implementation period.[297] Mozambique has made solid gains against HIV, TB and malaria. A significant portion of this investment, approximately US$ 466 million, is dedicated to tackling the HIV epidemic. Global Fund supports two HIV and AIDS grants designed to reduce HIV infections and related deaths, closely aligning with Mozambique's National HIV Strategy. Complementing these efforts, approximately US$ 108 million is allocated to combat TB. This includes funding for both a dedicated TB program and a dual-component program targeting TB and HIV. The focus is on reducing TB incidence and mortality rates while also addressing the link between TB and HIV, aiming to reduce new HIV infections and HIV-related deaths. Global Fund has further channelled approximately US$ 200 million into the "Accelerating and Strengthening the Quality of Malaria Control Interventions" program. This investment seeks to enhance program management, vector control, testing, surveillance, and other key interventions, all in accordance with Mozambique's Malaria Strategic Plan.[298]

In 2020, Mozambique was awarded US$ 60.5 million of C19RM funding as well as US$ 2.5 million in grant flexibilities. These funds were split across the four Principal Recipients, and 74% of funding was geared towards reinforcing the national COVID-19 response. In 2021, additional C19RM funding of US$ 100.5 million was awarded.[299] The Ministry of Health of Mozambique (MoH), Fundação para o Desenvolvimento da Comunidade (FDC), Centro de Colaboração em Saúde (CCS) and World Vision International are the Principal Recipients for Global Fund grants. The Ministry of Health implements grants through national programs for the three diseases. Each disease program is implemented by a government implementer and one or more non-governmental organisations. Approximately 79% of grant funding

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[291] GF data Explorer https://data.theglobalfund.org/location/MOZ/overview

[292] Mugabe, V. A., Gudo, E. S., Inlamea, O. F., Kitron, U., & Ribeiro, G. S. (2021). Natural disasters, population displacement and health emergencies: multiple public health threats in Mozambique. BMJ global health, 6(9). https://gh.bmj.com/content/6/9/e006778.abstract

[293] Fuente-Soro, L., Fernández-Luis, S., López-Varela, E. *et al.* Community-based progress indicators for prevention of mother-to-child transmission and mortality rates in HIV-exposed children in rural Mozambique. *BMC Public Health* 21, 520 (2021). https://doi.org/10.1186/s12889-021-10568-4

[294] Nacarapa, E., Verdu, M.E., Nacarapa, J. et al. Predictors of attrition among adults in a rural HIV clinic in southern Mozambique: 18-year retrospective study. Sci Rep 11, 17897 (2021). https://doi.org/10.1038/s41598-021-97466-2

[295] Moon, T. D., Nacarapa, E., Verdu, M. E., Macuácua, S., Mugabe, D., Gong, W., Carlucci, J. G., Ramos, J. M., & Valverde, E. (2019). Tuberculosis Treatment Outcomes Among Children in Rural Southern Mozambique: A 12-year Retrospective Study. *The Pediatric infectious disease journal*, *38*(10), 999–1004. https://doi.org/10.1097/INF.0000000000002435

[296] Crizolgo De Jesus Salvador, Paulo Arnaldo, Bernardete Xavier Rafael et al. Factors Associated with Prevalence of Malaria Infection among Children under 5 Years of Age in Mozambique: 2015 vs 2018, 03 February 2021, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-168223/v1]

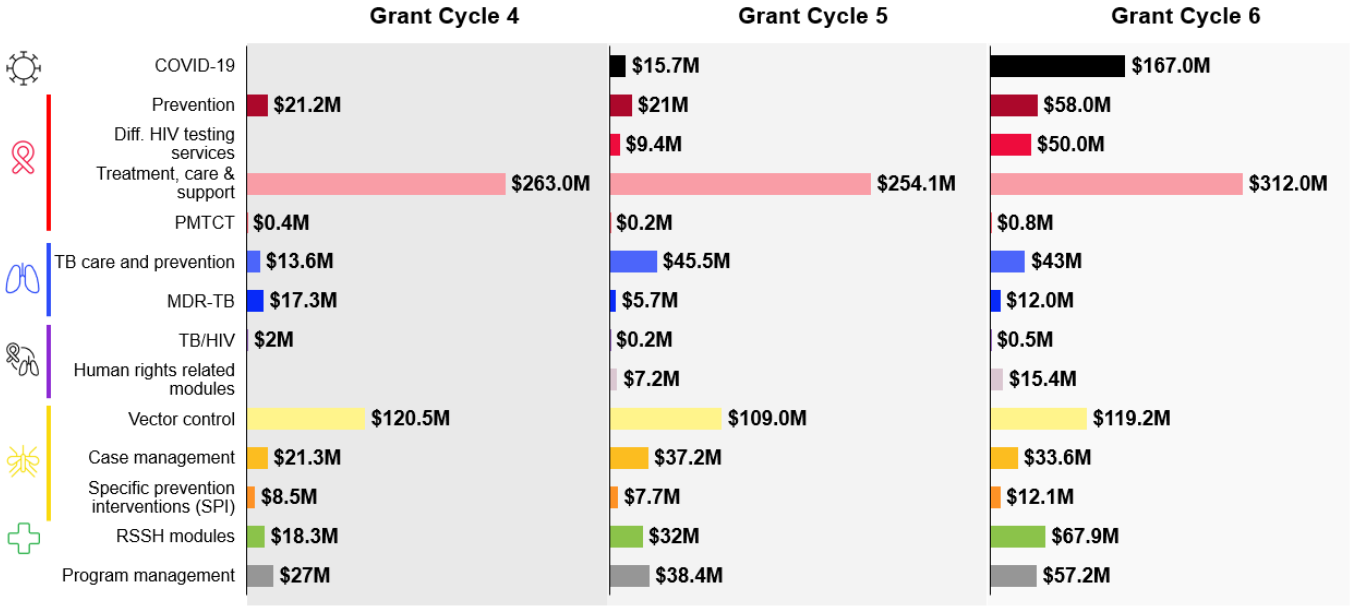
[297] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

[298] Global Fund Mozambique overview https://data.theglobalfund.org/location/MOZ/overview

[299] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

goes towards procuring medicines and health products. Refer to figure 7.1 for a breakdown of Global Fund support by module.

Figure 7.1: Mozambique Global Fund budget breakdown by module by Grant Cycle



7.2. KEY FINDINGS

7.2.1. Relevance of Global Fund investments

Mozambique has the second-largest Global Fund allocation (for the 2020-2022 allocation cycle)[300] to combat HIV, Tuberculosis, and Malaria (HTM), and to strengthen health systems, with its high HTM disease burden, and low-income status. Global Fund's allocation-based funding model has benefited Mozambique, with significantly increased levels of investments in recent years, and with progress in addressing the HTM disease burden largely attributed to the critical support of PEPFAR and the Global Fund. HIV, TB and Malaria are among the main endemic diseases in Mozambique.[301,302] The Global Fund is one of the major donors across these diseases, especially with the 2014 shift in its funding model, from a round-based to an allocation-based model which highlighted Mozambique's significant underfunding in comparison to its disease burden and economic capacity. The current eligibility policy is designed to ensure that available resources are allocated to, and invested in, countries and regions with the highest disease burden, the least economic capacity, and where key and vulnerable populations are disproportionately affected by the three diseases. Over allocation cycles, Mozambique has received a substantial increase in Global Fund investments. During this review period (2017-2022), funding increased from about US$512 million in GC4 to US$948.5 million in GC6, the largest percentage increase since the move to the funding model. The highlight was the increase in allocations for HIV/AIDS from 290 million dollars in GC5 to 496 million dollars in GC6 (71% increase). This underscores the Global Fund's commitment to addressing the high HTM disease burden and bolstering the efforts of the republic of Mozambique. Stakeholders also report that the increase in funding over the years was critical and has further increased the relevance of the Global Fund's investments, since the country's health budget covers just about 10% of HTM needs.

Global Fund's investments are well aligned with national needs and largely with emerging priorities, with a strong focus on community-focused and led interventions and improving the supply chain management of essential healthcare commodities and laboratory systems. Stakeholders however report a gap in the adequacy of funding for human rights, gender equality, and equity initiatives as well as HIV prevention

[300] Global Fund Grants in the Republic of Mozambique. GF-OIG 2022

[301] National Institute of Health https://ins.gov.mz/programas/programa-de-doencas-endemicas-de-grande-impacto-sanitario/

[302] https://www.theglobalfund.org/en/news/2021/2021-02-05-mozambique-and-global-fund-launch-new-grants

services. Stakeholders report that Global Fund's investments are based on the country's strategic plan and also largely aligned with Ministry of Health priorities. There is a strong focus on community-oriented interventions, particularly among most at-risk populations, particularly KPs and vulnerable populations such as AGYW, and a robust set of community engagement and empowerment initiatives. Stakeholders also reported the support to introduce Pre-Exposure Prophylaxis (PrEP) within the HIV program, as well as increasing but inadequate support to human rights, gender equality, and equity initiatives, with additional funding received through the Breaking Down Barriers catalytic investment filling some of the deficit. There was an increase in funding for both human rights and HIV prevention during the review period (from GC5 to GC6 in response to this gap.

There is also significant focus on commodity provision and supply chain management with tangible improvements in procurement and supply chain processes.[303] There have also been significant investments in laboratory equipment and supplies as well as infrastructure construction or improvements. Stakeholders describe greater focus on HIV treatment (especially ART coverage and viral load suppression), than HIV prevention interventions. Stakeholders also report a need to better contextualise the response to address the effects of the evolving global climate change crisis with extreme weather events as well as ongoing terrorism in some provinces that have both affected the malaria program implementation. These are discussed in more detail under the malaria program progress.

7.2.2. Progress and results achieved

HIV Progress

Mozambique has is far from achieving the global AIDS targets, with results at 87%-81%-88% by December 2022. Mozambique has made some progress on HIV over the past three years. At the end of 2022, 87% of people living with HIV knew their status and 81% of those were enrolled on antiretroviral treatment (ART) - around 2 million people. Annual new infections decreased by 35% from 153,000 in 2018 to 97,000 in 2023 September. The country is however still far from achieving global AIDS targets, with gaps across the cascade. These are reported to stem from low retention on ART due to poor monitoring of patients lost to follow-up, limited viral load coverage, as well as low testing coverage for key and vulnerable populations. Mozambique has consistently struggled to retain patients on treatment, an issue raised in the Global Fund OIG 2017 audit[304]

The MoH recently developed a six-pillar approach that focuses on health services-related interventions; however, the national sample-based lost to follow-up study recommends a more comprehensive multi-sectoral response under Conselho Nacional de Combate ao HIV/SIDA (CNCS) to address this issue. Patient tracking and monitoring is limited in its effectiveness as the country still uses a paper-based system. In 2020, only 56% of HIV patients on ART received viral load tests due to challenges around sample and result transportation, inadequate capacities to generate demand and perform viral load testing; further exacerbated by delays in expanding the electronic laboratory information system.[305]

There has also been a reduction in mother-to-child transmission, however the country continues to grapple with unacceptably high infection rates during breastfeeding, also related to service delivery quality, with a large prevention and treatment gap between adults and children. There has been a marked reduction in mother-to-child transmission from 19% in 2013 to 10% in 2022 but this is still very high compared to the 2% global average. Annually 4 out of 10 new infections occur among 15-24 year olds according to Spectrum estimates, with new infections in adolescents and young people being the major challenge. There are also higher mortality rates among children. These poor statistics stem from inadequacies in prevention programming, delays in diagnosing children with HIV, insufficient linkage to treatment, and poor viral load coverage and suppression. There is an urgent

[303] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

[304] The Global Fund. Global Fund Grants in Mozambique, March 2017

[305] Ibid

need to step up efforts to prevent perinatal infections and close the treatment gap for children and adolescents living with HIV.[306]

TB Progress

Mozambique's TB program has been consistent in coverage and treatment success for Drug Sensitive TB, and has experienced improvements in treatment success among Drug Sensitive TB clients. However, there are challenges with high TB rates among children, high rate of loss of potential DR-TB clients during the detection process, as well as GeneXpert maintenance gaps. In 2021, Mozambique was one of six high TB burden countries who had reached or passed the first milestone of a 35% reduction in TB deaths compared to 2015.[307] There was a 12% increase in DS-TB case notification from 86,515 in 2017 to 97,093 in 2020. In 2021, Mozambique recorded TB incidence of 361 cases per 100,000, and most of the TB burden is in the economically productive age group, with a predominance of males (53%), and children (13%).[308] The DS-TB treatment coverage was 85%, below the 90% target, but the success rate at 94% in 2021.[309] Community interventions to find missed TB cases are a strategy adopted by the NTCP to accelerate TB case finding at community level. These activities are implemented by community partners through funding made available by donors (Global Fund, World Bank and USAID).[310] There was immediate progress from this approach, as in 2022, community activities accounted for 43% (47,485) of TB case notifications, of which 10% (4,809) were in children aged 0-14 years. Stakeholders report that additional efforts are needed to scale up community-based services, as health facility-based diagnosis is becoming less effective. The absence of presumptive TB screening at the level of triage, ante-natal consultations (ANC), and child consultation is also said to be a missed opportunity.

The treatment success rate of MDR-TB and XR TB has been improving over the last 5 year**s**, rising from 49% in 2018 to 75% in 2020, and 24% in 2018 to 72% in 2020 respectively. The death rate (12%), although still high, has also shown a downward trend over the last 5 years.[311] There has however been an increase in DR-TB in children, with 108 cases of resistant TB in children were reported - 100 MDR-TB; and 8 XR-TB which represented 15% of the total cases of XR-TB notified in the country in 2022.[312] There have also been challenges with MDR and XDR-TB diagnosis with a sizable proportion of patients lost to follow up. In 2019, 72% of DR-TB suspects were lost to follow-up in the DR-TB detection process, due to poor quality and coverage of diagnosis (i.e. inadequate management of the GeneXpert network). Although the network of laboratories with GeneXpert equipment has been extended to cover almost all the country's districts, the interruption in operation due to module failure has had a negative impact on DR-TB diagnosis.[313] Stakeholders describe the inadequacies of the transportation system for sputum samples, a critical component for diagnosis, leading to poor sample quality and potentially inaccurate test results. They also describe the constant breakdowns of GeneXpert machines, a recurring issue due to maintenance planning gaps. More generally, stakeholders note the limited donor support for TB programs in Mozambique, and the absence of real-time data (heavy reliance on outdated data management systems).

Malaria Progress

Malaria is still endemic, however its prevalence declined between 2018 and 2022-23, from 39% to 32% (among U5s), with marked geographical disparities. Progress in the malaria program is driven by a combination of

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[306] PEPFAR watch https://pepfarwatch.org/wp-content/uploads/2022/03/A-Voz-Da-Comunidade-Mocambicana-COP22.pdf

[307] WHO Tuberculosis Report 2022

[308] WHO TB Profile accessible at https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22MZ%22

[309] WHO TB Profile accessible at https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22MZ%22

[310] Relatório anual de programa da TB 2022

[311] MISAU, 2022 - Annual Report of the National Tuberculosis Control Program

https://www.misau.gov.mz/index.php/relatorios-anuais-pnct?download=1957:relatorio-anual-2022-pnct

[312] Relatório anual de programa da TB 2022

[313] Ibid

factors, including effective prevention measures, digitalization of data, improved collaborative efforts and increased resources, with Global Fund providing over 80% of the funding for the program's treatment components. PMI also provides complementary support for diagnostics and treatments.

[314] The prevalence of malaria in Mozambique varies significantly across different regions. The city and province of Maputo exhibit a low prevalence of malaria, with rates ranging from 0.01% to 0.03%. In contrast, the provinces of Nampula and Sofala are experiencing an increase in malaria prevalence. Nampula has an alarmingly high prevalence rate of 54.7%, and Cabo Delgado's rate is also substantial[315][316]

Prevention measures have played a pivotal role in progress, including the mass distribution of mosquito nets and indoor spraying. Achieving universal coverage in the Long-Lasting Insecticidal Net (LLIN) campaign in 2017 with the support of the Global Fund marked a significant milestone, and this achievement was repeated in subsequent campaigns between 2019 and 2020, as well as in 2023. While overall ITN use in Mozambique has steadily increased from 29.5% in 2011 to 72.2% in 2022-23, a concerning trend can be seen for pregnant women and children (under 5); where their ITN usage peaked in 2018 (76.4% and 72.7%, respectively) but then dropped significantly to 47% and 43% in the most recent 2022-23 survey.[317]

The country has also augmented residential spraying efforts and improved access to malaria services by increasing the number of community health workers. Notably, the proportion of pregnant women who received three doses of Intermittent Preventive Treatment during Pregnancy (IPT) from their last live birth increased from 10% in the 2011 DHS (Demographic Health Survey) to 41% in the 2018 MIS (Malaria Indicator Survey), before decreasing to 25% in the 2022-23 DHS.[318]

Mozambique saw a remarkable rise in children (under 5) receiving ACT for malaria, from 60% in 2011 to nearly universal coverage (99%) by 2018. However, the latest data from the DHS 2022/2023 shows a drop to 85%, highlighting the need for renewed efforts to ensure continued progress against this deadly disease. While the percentage of children tested using RDTs remained high, fluctuating between 88% and 98.4% from 2011 to 2022/23, the percentage of positive cases detected showed a downward trend, dropping from 40% to 32% in the same period.[319] This suggests a potential decrease in malaria prevalence among young children, despite some fluctuations in testing coverage.

The digitalization of data has emerged as another potent driver. It has fostered a culture of data analysis and utilisation in the country's malaria program. Despite challenges at the peripheral level due to staffing shortages and unreliable access to electricity and the internet, the acceptance of the District Health Information Software 2 (DHIS2) system as the health information system has been a substantial success.[320] Stakeholders also report improved coordination between the government and civil society as increasing community participation, and the collaboration of various stakeholders in malaria control increasing awareness at community level through sensitization activities.

Additionally, there has been increased investment in malaria control efforts, however the majority of the funding for treatment is contributed by Global Fund, representing over 80% of the program's financial support. The Global Fund and PMI have complemented each other's efforts, with diagnostics and treatments procured by both parties pooled and distributed nationwide through the national supply chain. The Global Fund procures ITNs and insecticides for IRS, complementing PMI support for IRS implementation. There is also complementary support surveillance strengthening support from the Bill & Melinda Gates Foundation (BMGF).[i]

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[314] National Statistics Institute (INE) and ICF. 2023. Mozambique Demographic and Health Survey 2022-23. Maputo, Mozambique and Rockville, Maryland, USA: INE and ICF. Accessible at: https://www.ine.gov.mz/web/guest/d/01-inquerito-demografico-e-de-saude-relatorio

[316] Ibid

[317] Ibid

[318] Ibid

[319] Ibid

[320] Severe Malaria Observatory https://www.severemalaria.org/countries/mozambique

The major challenges to progress in the Malaria program are supply chain disruptions, limited quality control efforts, and extreme weather events linked to global climate change. There have been disruptions in the availability of crucial malaria products, such as microscopic reagents, with instances of stock-outs lasting more than a year between 2018 and 2019. Additionally, the procurement and distribution of malaria kits for polyvalent elemental agents have been delayed due to the limited capacity of the central drug warehouse. Another significant issue is the limited quality control of services, with just 20-30% of required supervision visits conducted during the period from 2018 to 2021. This lack of oversight may lead to persistent problems, such as the inappropriate treatment of patients with ACTs without a confirmed diagnosis of malaria, which remains unaddressed, potentially hindering progress in the fight against malaria.[321] Stakeholders also emphasised the additional hurdle that extreme weather events such as cyclones present, with the evolving global climate change crisis. These changes disrupt malaria transmission dynamics and pose a considerable setback to elimination efforts. Additionally, the program confronts the complex issue of terrorism in Cabo Delgado, which has security implications and hinders the effective implementation of malaria control measures in the region.

RSSH Progress

RSSH funding in Mozambique has been disease specific, with effective disease area focused interventions, however recent reprogramming of C19RM funding has allowed more health system wide interventions (as discussed below in the section on C19RM funding), with plans to request a standalone RSSH grant in GC7. RSSH improvements in Mozambique span strengthened procurement and supply chain processes, HMIS data quality improvements, and laboratory systems strengthening. The paragraphs below describe these improvements:

Procurement and supply chain processes have been strengthened, particularly with regard to ordering and distribution. This was achieved through the use of third-party logistics providers for last-mile delivery. Stakeholders reported that order processing times at the Medicines and Medical Articles Centre (CMAM) have reduced from three months to the target of within 30 days. They attributed these achievements to the deployment of third-party logistics providers for last-mile delivery (a new logistics management tool was developed to aggregate data at central and sub-national levels) as well as warehouse renovations with new equipment and vehicles. Global Fund invested in the Beira Central warehouse renovation and expansion, provided incinerators in the North and South regions as well as other warehouse equipment and vehicles for the supply chain.[322,323] Stakeholders also report that CMAM has benefited from good coordination and collaboration between the Global Fund, PEPFAR and the government.

However, despite this progress, one key area of weakness is that Mozambique's pharmaceutical and logistics systems have been suboptimal, linked to the incomplete implementation of the 2013 pharmaceutical and logistics strategic plan. Stakeholders describe gaps in the implementation of the 2013 Strategic Pharmaceutical Logistics Plan (PELF), as evidenced by many structural and operational gaps. These include inadequate inventory management and limited infrastructure and storage capacity, which result in limited traceability of products, stocks of expired products and breakages at all levels of the supply chain. Mozambique's Logistics Management Information System (LMIS) is also fragmented into several systems, making interoperability and the use of real-time data for decision-making difficult. The LMIS also does not interface with case management systems to triangulate logistics and patient data. LMIS software upgrades have been supported by other donors, however, they have not been matched by corresponding investments in hardware, maintenance, training and supervision.

HMIS improvements include improved coordination and supervision, the development of the Community Health Management Information System (CHMIS), and the deployment of unique identifiers for Adolescent Girls and Young Women (AGYW) and Key Populations (KPs) linked to community systems strengthening.

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[321] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

[322] Mozambique COP22 Stakeholder Meeting accessible at https://mz.usembassy.gov/wp-content/uploads/sites/182/20220202-GF-coordination-with-PEPFAR-final.pdf

[323] Global Fund Grants in the Republic of Mozambique. https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdfIbid

There have been improvements in HMIS data quality. These are reported by stakeholders to be linked to improvements in coordination efforts of the National Planning and Co-operation Directorate (DPC) / Health Information Department (DIS) for the information strategy and systems support; and the deployment of monitoring officers and supervisors for data collection processes. Further, the Global Fund has also supported the expansion and consolidation of the MoH HMIS - Sistema de Informação para Saúde em Monitoria e Avaliação (SISMA); this also includes the development of a Community Health Management Information System (CHMIS) for community activities.[324]

Stakeholders report that another significant achievement in information systems has been the introduction of unique identification codes, particularly in programs targeting Adolescent Girls and Young Women (AGYW) and Key Populations (KPs). This has greatly enhanced the monitoring and tracking of individuals within these vulnerable groups, enabling more precise and tailored interventions. These improvements in monitoring are part of larger community systems strengthening efforts that also include a concerted focus on enhancing the capacity of Community-Based Organizations (CBOs), especially those led by Key Populations. The capacity building approach is said to be collaborative and not only empowers these organisations but also fosters a more inclusive and responsive approach to addressing the unique needs of AGYW and Key Populations.

7.2.3. Funding model and business processes

Funding model, policies and processes

Overall, there have been improvements in the functioning of the funding model in Mozambique, albeit with some challenges in terms of need for improvement in CCM oversight and government PMU coordination capacity, complexity of and constantly changing Global Fund guidance and requirements (exacerbated by frequent changes in the CT) and weak community participation in the design and implementation of grants. The 3-year funding cycle is also viewed as inefficient and problematic for the country, however it is recognised that this is difficult to change for the Global Fund.

There have been efforts to strengthen the Mozambique Country Coordinating Mechanism (CCM) through the CCM reform, however there are still significant operational challenges such as limited oversight and inconsistent stakeholder participation. Stakeholders report that over time, there have been some improvements in coordination within the CCM, not only for the preparation of funding requests, but also for monitoring activities across the three diseases. The Global Fund sought to reinforce the Mozambique CCM through its CCM reform process; the CCM evolution project. Nevertheless, CCM's supervisory capacity over grants still needs to be improved. For a three-year period from December 2019, the CCM operated under the vice chair's leadership, with the position of Chair vacant. Some of the CCM committees did not have work plans and the consistency of meetings between the CCM's oversight and governance committee and grant PRs have been inadequate. In addition, these meetings often fail to sufficiently focus on strategic issues when they hold. For example, critical supply chain bottlenecks and programmatic challenges related to Antiretroviral Therapy (ART) retention have not been identified or discussed.[325]

The Global Fund Secretariat country team have grown to better accommodate and support the country's larger portfolio, however there are concerns about the frequent changes in CT personnel. The significant increase in allocation created the need to change the CT and LFA structure. This led to the Global Fund providing the CT and LFA more resources (disease managers and specialists) to respond to the country's larger portfolio. Some stakeholders appreciate this expansion, but indicate that the current level of staffing is still inadequate with shared personnel with multiple countries in the region. They also described the frequent changes in CT personnel for Mozambique as challenging, especially in the context of constantly changing guidance, reporting and monitoring tools.

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[324] Mozambique COP22 Stakeholder Meeting accessible at https://mz.usembassy.gov/wp-content/uploads/sites/182/20220202-GF-coordination-with-PEPFAR-final.pdf

[325] Global Fund Grants in the Republic of Mozambique https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

Program management at the Ministry of Health is described as suboptimal and hindered by the rigidity of some of the government policies and processes, with the Project Management Unit (PMU) unable to effectively coordinate the programs and address issues affecting grant implementation. The PMU is situated under the Planning and Cooperation Directorate of the Ministry of Health, and is responsible for coordinating and facilitating grant implementation, as well as ensuring compliance with programmatic objectives, goals, and procedures. There have been significant performance gaps, related to instituting adequate monitoring processes and following up and addressing issues identified. For instance, the oversight for procurement and supply chain is limited to the quantification process and does not cover the supply chain challenges faced at lower levels. In-country procurement processes are long, and there are no work plan tracking tools to monitor procurement status. There have also been challenges with delayed sputum transportation processes, with no corresponding actions taken to identify and address root causes.[326] A major hindrance to grant implementation mentioned by stakeholders is the UGEA (Acquisitions Executing Management Unit) with its protracted standard procurement timelines (including 6-7 months to obtain approvals). Some stakeholders suggest that there may need to be alternate processes within the MoH to enable more efficient implementation of donor grants, however this may create parallel systems that may not be sustainable.

The 3-year cycle is challenging to implement, due to delays related to health systems limitations, especially the protracted government procurement mechanism, as well some delayed Global Fund approvals, resulting in even shorter implementation timelines, which in turn affects program outcomes. Stakeholders emphasised the protracted government procurement mechanism discussed earlier, as one of the most critical factors affecting the health systems. They also noted challenges with delayed Global Fund approvals or slower implementation start up in some cycles. These factors result in further shortening the three-year grant implementation timeline, and affects both financial absorption and the ability of the project to deliver its intended results and targets. The limited progress on RSSH in the 2017-2019 allocation period, where the approval of Matching Funds was significantly delayed and the PR experienced further delays in recruiting key personnel, was shared as an example. They indicate that these challenges will persist in the implementation of context, and there is a need for flexibility in the implementation timeline to address these gaps. They indicated that an extension may not necessarily require increased funding. However, we recognise that the 3-year funding cycle is fixed for the Global Fund given donor commitments and the replenishment cycle and is not possible to change.

The preparatory processes for funding applications in the country are well-designed and have improved over time. There are also effective communication and coordination channels among Global Fund implementers. However, the CCM-led national dialogue across key stakeholders is described as weak, and there are still some limitations in community level stakeholder engagement. The preparatory processes for funding applications are said to be well-structured in their design, and rigorously implemented. Further, during implementation, stakeholders also report effective communication and coordination processes among implementers, the government, and other donors collaborating with the Global Fund.[327] There are however challenges with the CCM led Inclusive National Dialogue with civil society, key authorities, and community-based organisations, and this is described as weak.[328] Stakeholders also reported varied levels of engagement in the Funding Request processes, for instance community level stakeholders channel their inputs indirectly through the Country Coordinating Mechanism (CCM) and/or the FDC, or via consultation meetings. Conversely, other stakeholders exhibit a more substantial engagement, actively participating in proposal design, review, and finalisation. Overall, there is a shared aspiration across all stakeholder types to enhance the inclusivity and comprehensiveness of coordination meetings to facilitate diverse stakeholders' valuable insights and contributions to the success of Global Fund initiatives.

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[326] Global Fund Grants in the Republic of Mozambique https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf

[327] GF-PEPFAR Stakeholder Meeting accessible at https://mz.usembassy.gov/wp-content/uploads/sites/182/PEPFAR-GF-_FR2020-Requisitos-Oportunidades-Recomendacoes.pdf

[328] Perfil de GFATM accessible at https://www.development-finance.org/pt/component/docman/doc_download/711-gfatm-11-09-2009-port

Global Fund's current financial management set up with PRs handling this on behalf of civil society and community-based organisations is said to preclude growth. The grant reporting processes (financial and performance monitoring) are also viewed as complex and increasing in complexity, and the grant revision process is considered burdensome. Stakeholders recognize the need to manage risk and that the stringent financial management requirements are necessary for effective risk management. They however report that the current setup does not allow for institutional strengthening of CBOs and CSOs who currently do not meet these standards. Although financial management is currently carried out at the PR level on behalf of these organisations to enable them to participate, there are no opportunities for these organisations to be strengthened, and this may result in future exclusion from similar implementer opportunities. Stakeholders also described frequent changes in instruments (financial and program reporting models (PUDR), performance framework) to have significantly increased their complexity over time, creating difficulties for implementers. This is also said to be exacerbated by the constant changes made to the CT membership, affecting the continuity in technical support to navigate these tools. With respect to grant revisions, stakeholders view the process as burdensome and attempt to avoid this if possible, resulting in missed opportunities to improve program effectiveness.[329]

2.3.2. Sustainability

The strongest initiative towards sustainability of Global Fund's investments has been the positive progress towards empowering vulnerable communities and bridging gaps through a rights-based approach. However, community organisations struggle with long-term financial sustainability. Stakeholders report that sustainability of Global Fund's investments in Mozambique is multi-layered, and goes beyond the utilisation of country structures for implementation to extensive community engagement for implementation. The Global Fund's model relies heavily on government ownership and other institutional stakeholder involvement. However, in Mozambique, significant headway has been made in empowering vulnerable communities. Notably, the engagement of community members and leaders from various backgrounds has been instrumental to a lot of successes including: raising awareness on human rights, bridging the gap in rights awareness and health outcomes, and notably healthcare personnel have increasingly recognized the importance of providing unbiased care regardless of sexual orientation. Stakeholders also note that community-based organisations struggle to maintain effectiveness without donor funding, and need to explore alternative sustainability approaches that may be fostered by the Global Fund, including economic empowerment initiatives and resilient interventions including human resource training and infrastructure development. These are expected to prime these organisations for longer-term sustainability.

At the national level, the country faces significant challenges related to its heavy dependence on external funding, with limited capacity to implement the co-financing requirement. It is clear that program continuity is currently not feasible without donor investments. Many stakeholders report that without donor funding, approximately 75% of activities could cease. They describe the country's financial landscape as uncertain, as the country grapples with significant debt levels, and a substantial portion of its domestic revenue is allocated to debt servicing, which adversely affects financial stability. Moreover, stakeholders also report that there is a high risk of financial mismanagement in the country in general, which diminishes the nation's financial reputation. Any expectations for donor investments to be transitioned to government should be very long term. They also report that the co-financing policy is definitely beneficial but challenging to implement, with the government only contributing 10% of the HTM funding in the country. There are ongoing discussions on how to navigate this issue. Stakeholders suggest that donors should include economic empowerment interventions in their support for the country or foster partnerships with other donors that support economic empowerment, to potentially improve the country's financial stability and safeguard the sustained impact of their current investments.

2.3.3. Risk Management

The Global Fund has well-established risk management processes, however, there is a need to improve oversight in addressing longstanding country-level systems challenges and bureaucratic processes, which can pose risks during grant implementation. The Global Fund is said to have mature processes for risk management; this is primarily performed by the Country Team with support from various second lines of defence and

[329] TRP - Advisory Paper on RSSH (October 2021) accessible at https://www.theglobalfund.org/media/11447/trp_2021rssh_advisory_en.pdf

the risk department. A national Portfolio Performance Committee (PPC) is the primary forum for decision-making on country level risk trade-offs. The PPC conducts country portfolio reviews (CPR) that combine programmatic, financial and risk considerations to strengthen progress toward achieving impact. While risk management processes are well defined, their effectiveness is limited due to weak oversight arrangements at country level (both at CCM and MoH) in terms of tackling well-known and long-outstanding health systems challenges.[330] Some stakeholders say that the country's bureaucratic processes make execution difficult and is seen as a notable risk during grant implementation. Although the country is also said to have its own control mechanisms to ensure that activities are carried out and mitigate risks, previous reports have shown that the limited oversight, coordination, and management of Global Fund programs by the CCM and MoH is reflected in the sub-optimal ability to manage risks.[331]

2.3.4. Monitoring and Evaluation

There are significant gaps in the monitoring and evaluation (M&E) of Global Funds investments, including the imbalance in resource allocation to M&E in comparison to the total grant allocation; and the technical capacity of implementation teams especially at community level, which have led to lower program quality. Stakeholders describe the documented M&E framework as appropriate, however there are gaps in effectively implementing these systems. The primary gap is said to be the significant imbalance in resource allocation. They reported that despite being one of the largest recipients of funding from the Global Fund globally, a mere fraction (less than 2%) of the investment is dedicated to monitoring and evaluation activities. They also describe other limitations such as the inadequacies in CCM oversight which were discussed earlier and lower technical capacity among implementers. The resulting effects of these gaps are inadequate quality monitoring, with limited execution of scheduled supervision visits (20-30%) between 2018 and 2021.[332] Examples of the impact of inadequate monitoring are varied and include: administration of antimalarial medications without confirmed diagnoses; inaccuracies in batch monitoring at the central medical store (despite repeated identification in Secretariat-commissioned reviews), protracted delays in procurement processes, and inadequate community-based monitoring (i.e. use of paper based system for patient tracking, loss to follow-up, low viral load testing coverage and suppression, inadequate KP program design and testing coverage).[333] Substantial improvements are needed in the implementation of monitoring and evaluation systems, especially towards improving oversight from the CCM, efficient fund management, the quality of programming and ultimately to optimise the impact of Global Fund investments in Mozambique.

7.2.4. COVID-19 Response Mechanism (C19RM)

Mozambique experienced a relatively low incidence of COVID-19 compared to other countries in Southern Africa. However, the pandemic and related lockdown measures still caused initial disruptions in community health activities, making the C19RM funding important. The processes to access C19RM funds were also reported to be more flexible than standard HTM grant disbursement processes. Stakeholders reported that the country had a low incidence of COVID-19 compared to others in the region, but also experienced lockdowns and other restrictive measures that slowed or halted community health activities especially impacting HIV key populations. Key population groups were unable to access community centres where they primarily received services, and people living with HIV could not access treatment centres during these lockdowns, The TB program was also impacted, as the same COVID-19 related restrictions created access barriers to services with declines in TB case notifications through community-based activities. These restrictions were short lived, with community health services restarting in Q3 of 2020.[334] Stakeholders stated that although the C19RM funding was needed, there was initially reduced capacity to utilise the C19RM funding due scarcities resulting from the global demand for diagnostics, which was further exacerbated by the slow MoH procurement processes in the country. However, these challenges were addressed as seen in the next finding. Stakeholders also reported that access, reprogramming and utilisation of these funds was more flexible as compared to the normal disbursements of HTM grants.

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[330] Global Fund Grants in the Republic of Mozambique https://www.theglobalfund.org/media/11838/oig_gf-oig-22-006_report_en.pdf
[331] Ibid
[332] Ibid
[333] Ibid
[334] Ibid

The C19RM funding supported urgently needed COVID-19 response needs as well as additional health systems strengthening to support the country's Covid-19 response. These include additional human resources to implement the mechanism; restructuring health care services to provide COVID-19 related services; establishing surveillance systems; social and behavioural communication activities; and establishing new public health laboratories. Mozambique received C19RM funding for supporting human resources, including program, finance, monitoring & evaluation and procurement and logistics management staff which helped increase the country's capacity to manage the additional funding. C19RM supported the restructuring of healthcare services to provide preventive and curative healthcare at various levels, from community to tertiary care. This restructuring was important to prevent and manage the COVID-19 pandemic. The clinical care measures implemented for the COVID-19 pandemic included intensifying case management in health facilities, improving triage and upgrading isolation areas to temporarily manage moderate to severe cases, while ensuring the continuity of essential health services. Surveillance measures that have been put in place during the COVID-19 pandemic have included improved contact tracing and decentralised sampling and referrals in all healthcare facilities. Risk communication measures that have been implemented during the COVID-19 pandemic include advocating for vaccine uptake, adherence to safety protocols and increased social and behavioural communication activities in healthcare facilities. Personal protective equipment was provided to health and community workers. The C19RM also supported the implementation and acquisition of reagents for SARS-CoV-2 testing in clinical laboratories across the country. Lastly, new public health laboratories were created, and the country was provided with infrastructure and equipment dedicated to SARS-CoV-2 testing. Currently, the laboratories created are useful for monitoring other potential pandemics. Mozambique's Ministry of Health gained access to international stockpiles of COVID-19 PCR and rapid antigen tests. Laboratory staff received training to decentralise antigen testing. This reduced the need to transport samples, provided remote communities with greater access, increased capacity and improved response time.[335]

Prior to the COVID-19 pandemic, Mozambique's public health laboratories had low capacity. The advent of COVID-19 and associated support has dramatically improved laboratory systems capacity and infection prevention facilities. Stakeholders noted that the emergence of COVID-19, created opportunities to improve laboratory infrastructure and equipment, which has been especially beneficial for the TB program. This includes the construction of infection control facilities in five provinces, technical support for data use and triangulation across laboratory, health facility and community, and ongoing engagement with a technology firm to design a dashboard for the National Tuberculosis Control Program. These were all supported by Global Fund. C19RM funding also provided access to international stockpiles of COVID-19 PCR and rapid antigen tests that significantly increased testing capacity and access and strengthened the ability of the laboratory network to respond to increasing demand.[336] There has also been coordination between the Global Fund and PEPFAR in this area towards the development of an integrated sample transport system; expansion of molecular testing systems network expansion (GeneXpert Deployment); and the promotion of integrated testing, maintenance, and purchase of reagents & other consumables. These improvements were complemented with the provision of funding for training courses for laboratory-related health professionals.[337]

7.2.5. Catalytic Investments

The catalytic investments were largely viewed as complementary and helped expand ongoing interventions, however, attributing the specific impact of individual investments within multi-faceted interventions remains a challenge, making it difficult to definitively assess their catalytic effect. Stakeholders believe that catalytic investments, especially matching funds, help increase funding and supplement the main allocation as well as expand ongoing interventions. They report the following outcomes: The corresponding funds for finding missing TB cases

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[335] Mozambique: Transforming the National Laboratory System in Response to COVID-19. https://www.theglobalfund.org/en/stories/2022/2022-02-11-mozambique-transforming-the-national-laboratory-system-in-response-to-covid-19/

[336] Ibid

[337] Mozambique COP22 Stakeholder Meeting accessible at https://mz.usembassy.gov/wp-content/uploads/sites/182/20220202-GF-coordination-with-PEPFAR-final.pdf

has supported the extension of TB screening services to religious organisations, which has contributed to improvements in case notification. For malaria, MCGs have contributed to improving regional efforts to eliminate this disease, as seen in the reduction in the number of deaths from malaria. For HIV, the support to the human rights program has significantly combated stigma and discrimination. CIs, for the most part, are seen as complementary, but stakeholders reported that it was difficult to provide any evidence in isolation that demonstrates a catalysing effect.

The Breaking Down Barriers initiative in Mozambique aimed to address human rights-related barriers through a series of structured steps, but it faces challenges related to inadequate funding. The Breaking Down Barriers initiative sought to create a supportive environment for addressing human rights-related barriers in Mozambique. This occurred through a number of foundational steps to develop an understanding of key barriers and facilitate engagement and coordination among stakeholders. These steps included applying for matching funds to increase funding for related programs (i.e. to remove human rights-related barriers to services); conducting a baseline assessment to identify barriers, populations affected, and existing programs; holding multi-stakeholder meetings to review the findings of the baseline assessment and establishing a working group on human rights, HIV and TB.[338] These activities have created momentum, however stakeholders report that additional funding is needed to make scale up progress.

7.2.6. Partnerships

There is effective coordination between donors, particularly the Global Fund and USG partners (PEPFAR & PMI), to ensure impactful implementation in high disease burden areas. There are also a wide range of other partners collaborating across disease programs, but less support for the TB response. Stakeholders report effective coordination between donors preventing duplication and creating synergies, with a particular emphasis on synergy between the Global Fund and PEPFAR. This collaborative approach ensures more impactful implementation, especially in high disease burden areas.[339] The Global Fund primarily handles procurement, while PEPFAR directly supports implementation at the facility level. This is a complementary partnership, however there are some concerns among stakeholders regarding PEPFAR's strong influence on the allocation of Global Fund resources. There is also a robust partnership with UN agencies, Médecins Sans Frontières (MSF), and national structures for HIV services. UNICEF and UNFPA also play crucial roles in expanding programs for Adolescent Girls and Young Women (AGYW).

In the malaria program, both the Global Fund and PMI play substantial roles, but are also supported by numerous other partners and research institutions, including the Bill and Melinda Gates Foundation (BMGF), which contributes significantly to the National Malaria Control Program (NMCP). Partners are also actively engaged through the Country Coordinating Mechanisms (CCM) and disease specific technical working groups, and play a variety of roles including supporting funding application grant writing, program evaluations, policy advocacy, capacity building, and fostering networks of CSOs and CBOs.

However, the TB response experiences a significant gap in partner support, as well as limited technical support from the World Health Organization (WHO) due to insufficient capacity at both the Regional Office for Africa (AFRO) and country office (CO) levels.

7.2.7. Gender, human rights, equity & communities

There has been substantial progress in empowering communities, reducing stigma, promoting behaviour change, and improving access to health and education in communities; however, there remains a need for enhanced monitoring, technical assistance, and capacity building to sustain and scale up human rights programming. The funding request applications to the Global Fund includes interventions geared towards reducing barriers to human rights, advancing gender equality and strengthening equity. Stakeholders report that working with community-level organisations has enabled Global Fund investments to reach the most vulnerable populations. These

[338] Mozambique Mid-term Assessment https://www.theglobalfund.org/media/11034/crg_2021-midtermassessmentmozambique_report_en.pdf

[339] UNAIDS Global AIDS Update 2022 accessible at: https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf

organisations mainly utilise behaviour change communication and community empowerment strategies and play a central role in promoting actions related to human rights, gender equalities, the reduction of early marriage and equity. Stakeholders report good progress including increased capacity of justice organisations (prosecutors, SERNIC “National Criminal Investigation Service" and the police) in implementing human rights interventions, a reduction in stigma in health facilities, increased awareness of rights for sex workers as well as promoting the health of this group by preventing and combating STIs and HIV. Also, there has been a reduction in early marriage rates and an increase in girls' retention in school. Despite the progress made, stakeholders emphasise the need to engage decision-makers to improve the monitoring and reporting of cases of human rights violence at community levels. There is also a need for substantial technical assistance to further strengthen capacity for human rights programming, across all stakeholders including government, civil society and key populations. They indicate that there is a need for further investments to sustain and scale up human rights programming, especially to roll out rights-related services nationwide.

The Communities, Rights, and Gender (CRG) study in 2020 and a complementary survey in 2022 at the national level identified several barriers to TB services, indicating a need for more focused efforts to address human rights gaps in the context of the different diseases. After carrying out the CRG study in 2020, the PNCT conducted a complementary survey in 2022 at the health facility level, assessing the barriers to accessing TB services linked to human rights and gender issues. The two surveys identified the existence of barriers such as poor TB literacy, poor provision of psychosocial support, transport problems for access to health centres, experiences of stigma and discrimination, and lack of medicines at the health centre level.[340] Efforts to better understand and address rights-related needs are required to better protect and enhance Global Fund investments as well as to strengthen the country's health systems and community delivery mechanisms.

7.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

The Global Fund well addresses the country's HTM needs including emerging priorities and is well aligned with the country's strategic plan and programs. Significant strides have been made in addressing HTM diseases and enhancing the health system's resilience, however, several key issues remain especially gaps in ART retention, loss of potential DR-TB clients during detection, as well as supply chain disruptions and quality control challenges especially for malaria services.

Improved coordination through the CCM is evident, especially visible through the preparatory processes for funding applications, which are reported to be well-structured. However, the CCM still experiences coordination issues during implementation including inadequate oversight, inconsistent stakeholder participation, limited committee operations which potentially hinder program effectiveness. The 3-year funding cycle is also viewed as challenging due to internal and external delays experienced that significantly shorten the available period for implementation. In terms of sustainability, it is clear that program continuity is currently not feasible without donor investments, as the country faces significant challenges related to its heavy dependence on external funding, with limited capacity to implement the co-financing requirement. Also, despite well-established risk management processes, there is an urgent need to improve CCM oversight over implementation, also linked to reported gaps in the sufficiency of monitoring and evaluation (M&E) allocations and the technical capacity of implementation teams especially at community level. There has also been effective coordination between Global Fund implementers and other donors, but less partner support for the TB response. Lastly, there has been good momentum toward strengthening human rights, gender equality, equity initiatives, and empowering communities, but this momentum needs to be maintained through improving investments in this area.

Based on the above findings, the review suggests the following potential areas for strengthening:

1. Provide technical support to systematically improve CCM coordination and oversight functions and strengthen PRs monitoring and evaluation systems, including supporting the operationalisation of the current national eLMIS.

[340] Relatório anual de programa da TB 2022

2. Improve dialogue and engagement with community-based organisations, by increasing their visibility and inputs into funding application processes, as well as incorporating financial management capacity building-utilising fiscal agents to strengthen CSO/CBO financial capacity to meet Global Fund implementer requirements.
3. Conduct regular context analyses to increase alignment of Global Funds investments with Mozambique's changing environmental landscape especially due to climate change and security issues.

A.14. References

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A.15. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 35 stakeholders from the following entities:

Stakeholder category	Entity
CCM	CCM
Government: Ministry of Health, national disease programmes, and other government representatives	MoH - Planning and Cooperation Directorate, Global Fund Management Unit (PR)
	Ministry of Gender, Children and Social Action (MGCAS)
	MoH - STI/HIV NCP (HIV / AIDS disease program)
	MoH – NMCP (Malaria disease program)
Non-state PR/ SR	FDC - Fundação para o Desenvolvimento da Comunidade
	FH - Food for Hungry
	ADPP Ajuda de Desenvolvimento de Povo para Povo
Donor Partners	USG/PEPFAR
	USG/PMI/CDC
	USG/USAID
Technical Partner	UNAIDS
Community and civil society organisations	ARV - Niassa Province
	ADPP
	Ovarelelana - Nampula Province
	Igreja Anglicana - Tete Province
	Unidos
	Kenguelekeze / Ecosida Consortium (CKE) - Gaza Province
	Ajulsid - Sofala Province
	Estamos - Niassa Province
	Reencontro

8. NIGERIA CASE STUDY REPORT

8.1. INTRODUCTION

8.1.1. Key country characteristics and HTM context

Nigeria is situated in West Africa with a population of approximately 211 million people in 2022.[341] Nigeria comprises 36 self-governing states and the Federal Capital Territory. These states are subdivided into 774 Local Government Areas (LGAs). In the healthcare system, the Federal government is responsible for health policy formulation, planning, and coordination at the national level. Meanwhile, individual states are tasked with managing curative care and essential medical specialties. LGAs have the responsibility of delivering primary healthcare services, operating under state-level oversight and coordination.

Nigeria faces significant health challenges, including a high burden of HIV, tuberculosis (TB), and malaria, with an estimated 1.9 million people living with HIV, a TB incidence rate of approximately 219 cases per 100,000 people, and the country also accounts for 27% of global malaria cases. [342,343,344] These diseases have profound socio-economic impacts, resulting in high mortality rates, reduction in disability-adjusted life years (DALYs), economic losses due to healthcare costs and reduced productivity. Access to healthcare services in Nigeria has been marked by disparities between urban and rural areas, and the availability and distribution of essential health commodities is inconsistent, affecting the quality of care.[345] Nigeria has several health policies and plans that outline strategies for prevention, diagnosis, treatment, and care, and are implemented at both the federal and state levels. Some of these include; the National Health Policy, the National Strategic Health Development Plan (NSHDP II); the National HIV/AIDS Strategic Framework; National Strategic Plan for Tuberculosis; National Malaria Strategic Plan; National Vaccine Policy, and the National Family Planning Blue-Print. Health financing in Nigeria is a complex mix of government domestic financing, out-of-pocket (OOP) payments, and donor financing. In 2020, government domestic financing for healthcare accounted for approximately 15% of the current health expenditure, while OOP payments made up a significant portion (75%), posing financial barriers for many Nigerians[346]. Donor financing has played a crucial role in supporting health programs, including those aimed at combating HIV, TB, and malaria. The National Health Insurance Authority (NHIA), was established to improve access to healthcare services and provide financial risk protection. However, there are several challenges anticipated in the implementation of this initiative, including; low government allocation of funds to healthcare, a scarcity of healthcare professionals, limited healthcare access, and difficulties in enforcing mandatory enrolment for all Nigerian citizens.[347]

Nigeria's economic situation is worsening due to factors like declining oil production, exchange rate issues, fiscal deficits, and high inflation, leading to increased poverty levels. Development challenges persist, ranging from overreliance on oil to revenue source diversity issues, infrastructure gaps, weak institutions, and governance problems.[348] Nigeria also continues to face security challenges, posed by Boko Haram and Islamic State in the northeast, banditry, and kidnappings in the north-west and parts of the southwest, along with unrest in the southeast due to separatist movements.[349]

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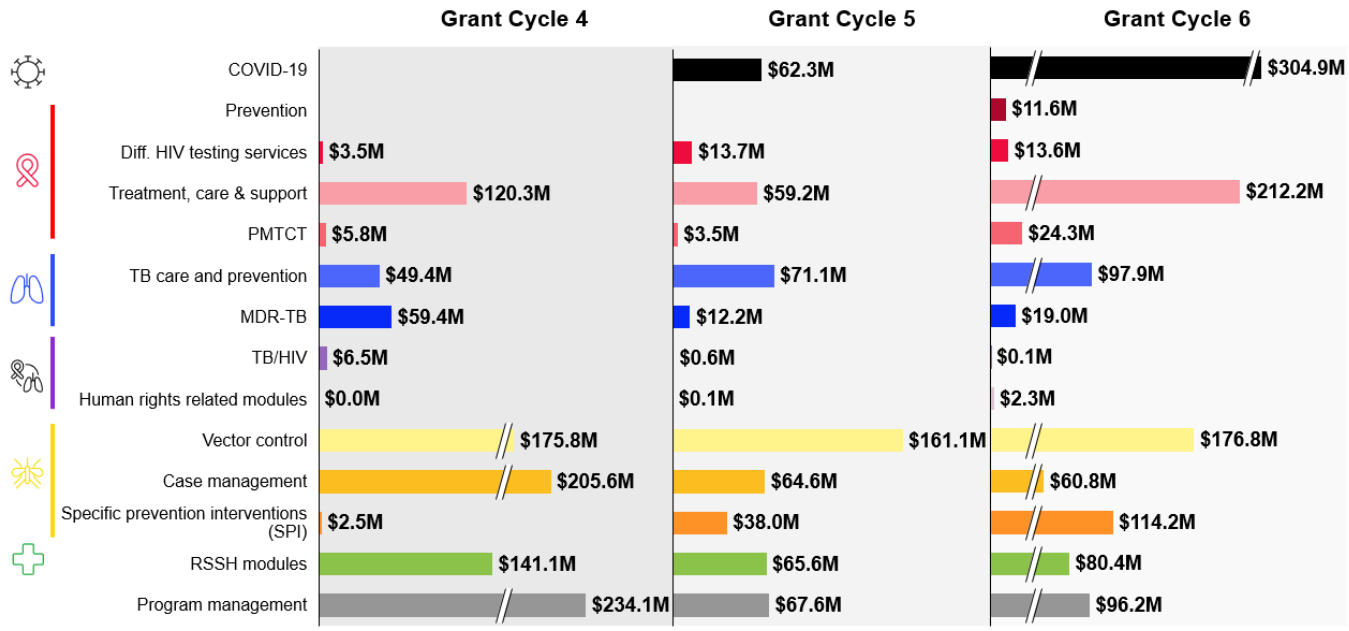
8.1.2. Summary of Global Fund support

Nigeria has been eligible for funding from the Global Fund since inception due to its high burden of HIV, tuberculosis (TB), and malaria, coupled with its status as a lower-middle-income country.[350] The Global Fund classifies Nigeria as "High Impact" (very large portfolio, mission-critical disease burden), "challenging operating environment" (characterised by weak governance, poor access to health services, and manmade or natural crises) and also a country operating under the "Additional Safeguard Policy", which affords the Global Fund an extra set of measures to strengthen fiscal and oversight controls in risky environments.

Nigeria is the single largest recipient of Global Fund grants, with over US$1.8b allocated in the strategy review period (2017-2022) (Figure 1). The allocation increased by 121% from Grant Cycle 5 (US$546m) to Grant Cycle 6 (US$1.2b), with all disease area budgets increasing. A significant portion of the increase was Covid-19 investments (almost US$300m). A larger proportion of the budget was allocated to Malaria, followed closely by HIV.[351] The main focus of investments within disease areas are: differentiated ART service delivery and HIV care (65% of HIV allocation); case detection and diagnosis (50% of TB allocation); vector control, primarily LLIN mass campaigns (52% of Malaria allocation); and Covid-19 (88% of Standalone RSSH allocation) in GC6.

Figure 1: Nigeria Global Fund budget breakdown by module by allocation[352]



There are currently eight active grants across seven PRs, a reduction from 9 PRs in GC5, with the other two PRs serving as SRs in GC6, these are Society for Family Health (SFH) and Management Sciences for Health (MSH). HIV grants are currently managed by the National Agency for the Control of AIDS (NACA) and by Family Health International (FHI); TB grants by the National Tuberculosis and Leprosy Control Program (NTBLCP), the Institute of Human Virology Nigeria (IHVN) and the Lagos state Ministry of Health (LSMoH); Malaria grants by the National Malaria Elimination Program (NMEP) and Catholic Relief Services (CRS). The Resilient & Sustainable Systems for Health (RSSH) grant is managed by NACA (and was managed by MSH in GC5).

[350] Estimate. Range: [1,300,000 – 2,300,000]. UNAIDS Aidsinfo 2020

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8.2. KEY FINDINGS

8.2.1. Relevance of Global Fund investments

Evidence base and value for money in addressing HIV, TB and Malaria needs

Global Fund investments are largely considered to be relevant to the country's needs across the disease areas, as they are evidence-based and predicated on the National Strategic Plan. There is wide recognition across stakeholders (implementers, government, civil society, and other donors) that Global Fund's investments are relevant to the country context at National and sub-national levels, as they are evidence-based, and derived from the National Strategic Plan (NSP) which serves as the platform for funding requests. However, several stakeholders note that the alignment to the NSP is great, but the process of developing the NSP has its drawbacks, with stakeholders arguing for their premade plans often aligned to their interests to be included in the plan, as opposed to reviewing the health system holistically to inform the strategic direction. The funding requests (especially GC6) were based on data from several recent data sources including Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS); Key Population size estimates; HIV in Prisons study and; Harm Reduction Technical Working Group and NSP pilots).

Global Fund's approach is unique especially due to its focus on fostering country ownership, however there are instances where stakeholders feel strongly that Global Fund has pushed against the country ownership principles, and question if the most relevant investments have been selected in a few cases, including inadequate consideration of systems issues and integration and continued investments in ITN campaigns.

- The current RSSH standalone allocation is widely considered to be helpful to address key health system challenges, however, majority of stakeholders (implementers, government, donors) feel the allocation should be larger, potentially pooling more RSSH funds from the RSSH components of the three disease areas to further enhance integration of systems strengthening efforts that not only benefit the disease areas, but also the health system holistically. The country had requested a higher proportion of funds from each of the diseases to be allocated to RSSH, however, the Global Fund Secretariat considered the requested increased allocation to be overly ambitious and unrealistic, based on the track record of absorption of RSSH grants, with a lower allocation subsequently approved. The pushback was based on a thorough program analysis, reviewing the current RSSH budget, its low absorption rate without clear plans on how the associated issues will be tackled, coupled with available funding from the recently approved C19RM funds, and considering the principle for equity across the other components (HTM).
- Stakeholders perceived the Global fund as overtly commodity focused, with a significant proportion of allocations ring fenced for commodities, sometimes at the expense of other activities especially prevention and community engagement efforts. The country team however described achieving a balance between the proportion of funding for commodities vs soft activities in GC6, but admit to redirecting funds harnessed through efficiencies in travel related cost during the grant making process (as recommended by the TRP) towards increased investment in commodities to reduce budgetary gaps in GC7. Commodities are critical to address the existing disease burden, and there is a very heavy reliance of the country on donors including the Global Fund for HTM commodity security. It is however important to note that with improving indices especially in the HIV response where the country is close to epidemic control, there is a need to begin pivoting to more prevention interventions especially focusing on high-risk populations. However, it will be important to see increasing country commitments towards commodity security before this pivot commences.
- Lastly, stakeholders question the consistent focus on ITNs, despite the consistently low net usage (36% in 2021[353]) and the high cost of mass campaigns.[354] Majority of stakeholders feel there is limited interest in other vector control tools (Attractive Targeted Sugar Baits (ATSB), indoor residual spraying (IRS), Spatial

[353] Nigeria Malaria Indicator Survey (NMIS) 2021

[354] DnA Factbook Nigeria - LLIN mass campaign is the highest disease investment at $173.5M

repellents) that could be game-changing for Nigeria.[355,356,357,358,359,360,361,362] There are however significant cost considerations for introducing these other tools that are the main barrier.

The Global Fund takes a more passive approach to innovation compared to other donors, mostly scaling up evidence-based innovations ideally with proof-of-concept in the local context. Stakeholders report that the Global Fund has a passive approach to innovation, with many stakeholders reporting that the application process sometimes felt like a recycling of last year's activities with an emphasis on protection of commodities. There is also a subtle acknowledgement to design based on the Country Team's expected interventions as this will enable a hitch-free completion of the cumbersome task of funding request preparations. There have however been several examples that showcase the introduction of evidenced-based innovation, often after a successful pilot was completed to demonstrate effectiveness e.g. expansion of TB services to the private sector, as well as a scale up of TB services in the public sector, with immediate impact of increasing case notifications, support for the TB sample transportation network through the development of a dashboard that monitors sample movements. The use of sample transportation riders to improve sample delivery timelines, reducing frequent health worker absences from health facilities for sample transport runs. The pilot of next generation nets through a research project, funded via a catalytic initiative, which is planned for scale up, and has been included in the GC7 applications. There are also plans to commence Perennial Malaria Chemoprevention in GC7 for locations ineligible for SMC.

8.2.2. Progress and results achieved

HIV Progress

There has been a significant improvement in Antiretroviral Therapy (ART) coverage, from 67% in 2019 to over 95% in 2021,363 with declines in HIV incidence and HIV related mortality. The country has experienced a significant increase in ART coverage, and is now close to reaching epidemic control, but there are sub-population variations, by age groups and locations. This increase is multifactorial, with the most prominent driver being the recalibration of HIV prevalence through the 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS). This

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[355] Fraser, K.J., Mwandigha, L., Traore, S.F. *et al.* Estimating the potential impact of Attractive Targeted Sugar Baits (ATSBs) as a new vector control tool for *Plasmodium falciparum* malaria. *Malar J* **20**, 151 (2021). https://doi.org/10.1186/s12936-021-03684-4

[356] Achee, N.L., Perkins, T.A., Moore, S.M., Liu, F., Sagara, I., Van Hulle, S., Ochomo, E.O., Gimnig, J.E., Tissera, H.A., Harvey, S.A., Monroe, A., Morrison, A.C., Scott, T.W., Reiner, R.C., Grieco, J.P. (2023). Spatial repellents: The current roadmap to global recommendation of spatial repellents for public health use, Current Research in Parasitology & Vector-Borne Diseases (3), 100107, doi: 10.1016/j.crpvbd.2022.100107.

[357] Indoor Residual Spraying has been introduced in a targeted manner with cost-effectiveness considerations as seen in Zambia or a combination of vector control tools (as seen in Ghana, Tanzania, Kenya or Rwanda) still including ITNs to a limited extent in areas where they are needed and used.

[358] Okumu, F.O., Moore, S.J. Combining indoor residual spraying and insecticide-treated nets for malaria control in Africa: a review of possible outcomes and an outline of suggestions for the future. Malar J 10, 208 (2011). https://doi.org/10.1186/1475-2875-10-208

[359] Tiedje K.E., Oduro A.R., Bangre O., Amenga-Etego L., Dadzie S.K., Appawu M.A., *et al.*, (2022) Indoor residual spraying with a non-pyrethroid insecticide reduces the reservoir of Plasmodium falciparum in a high-transmission area in northern Ghana. PLOS Glob Public Health 2(5): e0000285. https://doi.org/10.1371/journal.pgph.0000285

[360] West P.A., Protopopoff N., Wright A., Kivaju Z., Tigererwa R., Mosha F.W., Kisinza W., Rowland M., Kleinschmidt I. (2014). Indoor residual spraying in combination with insecticide-treated nets compared to insecticide-treated nets alone for protection against malaria: a cluster randomised trial in Tanzania. PLoS Med.11(4):e1001630. doi: 10.1371/journal.pmed.1001630. PMID: 24736370; PMCID: PMC3988001.

[361] Dulacha D., Were V., Oyugi E., Kiptui R., Owiny M, *et al.,* (2022). Reduction in malaria burden following the introduction of indoor residual spraying in areas protected by long-lasting insecticidal nets in Western Kenya, 2016–2018. PLOS ONE 17(4): e0266736. https://doi.org/10.1371/journal.pone.0266736

[362] Hakizimana, E., Karema, C., Munyakanage, D. *et al.,*(2016). Susceptibility of Anopheles gambiae to insecticides used for malaria vector control in Rwanda. *Malaria Journal* 15, 582. https://doi.org/10.1186/s12936-016-1618-6

[363] Global Fund Nigeria Portfolio analysis 2022

provided a more reliable estimate/denominator for ART coverage targets.[364] Another important and major contributing factor is the improvement in coordination of donor investments (PEPFAR, Global Fund and Government of Nigeria-GON) through the Alignment 1.0, which optimised resources and increased the reach of the program. The country also deployed a wider variety of service delivery modalities including: One Stop Shops (OSS) for KPs, increased community-based testing, multi-month dispensing (MMD), and community refill sites/pop-up pharmacies.

There has been limited progress in PMTCT, Paediatric, and Early Infant Diagnosis (EID) programs, with Paediatric ART coverage stalled and PMTCT ARV coverage declining. Despite the improvement in ART coverage, there is limited progress in these other HIV service delivery areas. Paediatric ART coverage was 28% in 2018 and 31% in 2021, PMTCT ARV coverage declined from 41% in 2018 to 25% in 2022; and EID yields only 28% of infected infants at two months.[365] These slower progressing areas are reported by stakeholders to be due to the internally vertical nature of HIV programming, with these services not fully integrated. There are also other health care seeking and health systems factors including low ANC and facility deliveries that also affect the delivery of these services.

TB Progress

The country has also experienced a significant increase in DS-TB case notification since 2018, with growth even during the Covid-19 years. Despite the progress, there is still an estimated gap in TB case notifications of about 42%,[366] with DR-TB and Childhood TB detection stalled. The main factor driving improvements was the extension of TB services to private health facilities, and the associated performance-based approach utilised to incentivize these facilities. These performance-based incentives were also deployed in community (door-to-door) case finding. These approaches were responsible for 56% of notifications in 2021 (28% private sector, 28% community) and 65% of notifications in 2022 (24% private sector, 41% community)[367]. The increase in case notification was consistent even during Covid-19 years because of the private sector and community focus, as the community and private sector continued to operate when the public health facilities were closed or providing limited services. It is not clear what the actual burden of TB is, as there is no recent prevalence data to inform estimates, so the current 42% projected gap in TB case notifications is likely to be inaccurate. There continue to be gaps with regard to DR-TB and Childhood TB detection. These areas are also consistently supported by Global Fund. The DR-TB estimate is also questionable due to the same data quality concerns highlighted earlier. These two areas require sample movement to laboratories for testing with referral delays experienced, in addition to client's financial and geographic access constraints towards getting baseline investigations. Low childhood TB notification rates is also reported to be due to inadequate screening of children, as health workers are not trained on childhood TB diagnosis, coupled with inadequate use of chest X-rays to diagnose children. Chest X-ray use is linked to unsustainably low cost and retirement issues within Global Fund supported locations. NTBLCP introduced the childhood TB testing week to increase notification among children, and plans to invest further in equipment towards improved testing and notifications at community level in GC7. There are also conversations about a national TB prevalence survey but no clear funding commitment has been made by any stakeholder towards this.

There are emerging challenges with the performance-based incentives in the TB program, this includes attrition of private sector providers to community services and attrition of demotivated private sector facilities from the program, as the country's economic situation worsens. All stakeholders applauded the private sector engagement and use of the performance-based approach as innovative and impactful, however it has its drawbacks especially due to the variations in the performance incentive amounts between the private health facilities and community providers for similar work. Although there is a clear rationale for higher incentives to community providers,

[364] Majority of stakeholders agree that the new denominator is more accurate, however a few suggest that the denominator may be an underestimation, as certain states are overachieving their targets which should not be the case if the estimates are correct.

[365] Global Fund Nigeria Portfolio analysis 2022

[366] Global Fund Nigeria Portfolio analysis 2022

[367] Global Fund Nigeria Portfolio analysis 2022

there are providers such as patent medicine vendors[368] who can be classified in either category. This has resulted in a lot of providers moving away from serving as private facilities to becoming independent community providers. Implementers report that this might be the reason for the sharp increase in case notification from community services and slight decline in private sector notification proportions in 2022. There are also data quality concerns with some potential for double counting the same clients as facility and community notifications, as well as public health facility clients also being reported through community providers. This is however somewhat addressed in the next grant cycle with the community and private sector model managed by the same PR who will have sufficient visibility and potentially harmonise the incentives and documentation systems across modalities.

Malaria Progress

There has been a gradual decline in malaria prevalence[369] (including among children under 5 years) during the strategy period, albeit an insecticide resistance-related increase from 2016-2019. There are also geographical disparities with prevalence declines in 13 states, and increases in 24 states,[370] and suboptimal coverage of key prevention interventions. The key driver of the decline in prevalence is said to be the increase in Seasonal Malaria Chemoprevention (SMC) for children under the age of 5 years. This has been scaled up to all 21 eligible states. The other major intervention is the Mass ITN campaigns, which cover all GF supported states and have been consistently supported by the Global Fund, with the introduction of next generation nets in pilot states to assess their impact on combating resistance. However, the use of ITNs in Nigeria is consistently low (36% in 2021)[371] irrespective of ITN type, with many reports of communities repurposing ITNs for economic purposes; by selling them as they are, or converting them to sponges before selling. ITN coverage does not meet current country needs, with leftover ITNs from campaigns are repurposed for routine distribution. The proportion of the de facto population with access to an ITN in the household decreased from 55% in 2015 to 43% in 2021.[372] WHO GMP are supporting stratification of interventions using epidemiological data, especially determining where to deploy different net types. There are future plans to address the inadequate ITN coverage through the exclusion of high-income urban settings where ITNs are not needed or used, in favour of increasing coverage in rural and slum communities where they are most needed, and this began with a pilot in Kwara state during GC6. Another prevention intervention with implementation challenges is IPTp which continues to have suboptimal coverage. This is currently not supported by Global Fund. The government agreed to take this on during GC5 as part of their co-financing contribution, but has been unable to provide adequate funding to meet IPTp needs.

There has also been a decline in malaria mortality, despite the challenges posed by the Covid-19 pandemic. The malaria mortality rate (i.e. deaths per 1000 population at risk) fell by 33% from 1.2 per 1000 population in 2019 to 0.9 per 1000 population in 2021.[373] The interventions attributed to this, per stakeholder perspectives are firstly, the scaling up of testing through increased RDT availability to confirm malaria, allowing for more targeted treatment, even though test positivity rate has been declining. Secondly, the regular deployment of free RDTs and ACTs to health facilities and drug therapeutic efficacy monitoring for ACTs through the support from Global Fund and PMI, and lastly improvements in malaria case management commodity security. **Malaria services have consistently been deployed through existing health system's structures, with fewer parallel elements as seen in HIV and TB services. This however affects delivery, with sub-optimal performance of malaria indicators that depend on iCCM, ANC and EPI platforms.** There are chronic missed opportunities to adequately meet the needs of the most vulnerable populations through integrated services, due to the numerous challenges within the health system as earlier described.

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[368] In Nigeria, patent and proprietary medicine vendors (PPMVs), defined as "a person without formal training in pharmacy who sells orthodox pharmaceutical products on a retail basis for profit", provide the main source of medicine for many common illnesses. https://www.pcn.gov.ng/registration-and-licensing/patent-and-proprietary-medicine-vendors-ppmv/#:~:text=Definition,medicine%20for%20many%20common%20illnesses.

[369] NMIS 2021

[370] Report on malaria in Nigeria 2022. Brazzaville: WHO Regional Office for Africa; 2023.

[371] NMIS 2021

[372] Global Fund Nigeria Portfolio analysis 2022

[373] Report on malaria in Nigeria 2022. Brazzaville: WHO Regional Office for Africa; 2023.

RSSH Progress

Supply chain and laboratory support investments have been positive with increasing ownership by National and state actors, but a few key elements still reliant on third party contractors who are not a formal part of the health system. Infrastructure across the supply chain have been outdated for decades, with parallel storage facilities previously used for donor funded program commodities. Global Fund has invested in facility upgrades in collaboration from the GoN and other stakeholders. This included the review of the PSM governance structure with the development of the first national 5-year strategic plan for PSM[374] and the renovation of 22 warehouses (funded through the RSSH and C19RM grants). Majority of stakeholders (CCM, Implementers, donors) report increased accountability and ownership for warehouse management at state level since these renovations, with state actors working closely with third party contractors to ensure effective delivery to designated service delivery points. The distribution systems are however still largely hinged on the use of third-party logistics companies. Seventy-four (74) health facility laboratories (two laboratories per state), have undergone thorough infrastructure assessments, and are currently enrolled in an External Quality Assessment (EQA) process[375], towards improvement of laboratory systems across the country. There have also been investments towards the establishment of a robust sample transportation network. These networks are also supported by private transportation providers who are not a formal part of the health system.

There has been some improvements in the use of technology especially within some disease areas, including surveillance systems, routine reporting tools and service delivery applications. These tools are however not fully integrated into existing national information systems. The HIV program has previously led the development and upgrade of electronic data collection tools including electronic medical records and health information systems, with these systems optimised to collect HIV data, and inadequately prepared to cater to other disease areas, resulting in fragmented data systems with autonomous operations within diseases, and across HTM and the health sector at large. During this review period there were massive improvements in the use of Information and Communication Technologies for Development (ICT4D) for Malaria with partial integration of these within existing structures[376]. These include digitalizing SMC and ITN mass campaigns with community workers utilising these electronic applications for service delivery. Also, the National Malaria Data Repository (NMDR) which serves as a data warehouse for malaria data, was linked to enable access to data from the DHIS2 (National HMIS), and further upgraded to hold surveillance data.

RSSH in disease specific grants is considered not to be ideal as it reinforces vertical systems. Disease focused RSSH works well in terms of short-term results for the respective programs but rarely contributes to stronger national systems. Some of the most critical health systems gaps reported are the absence of a robust data management system, which has resulted in a reliance on poor quality routine data or inaccurate estimates based on outdated surveys. Also outdated supply chain infrastructure and equipment means there are inadequate storage facilities and transportation mechanisms. There have been investments in addressing these issues through disease specific RSSH grants, with the short-term needs within the disease areas largely met, however the outcomes for the larger health system are poor. For instance, data systems developed through disease areas are primarily focused on the disease area resulting in parallel and fragmented data systems across the health system. The supply chain infrastructure and management has relied heavily on third party contractors who are contracted primarily for the commodities within the respective disease areas, resulting in sections of government warehouses improved to cater to specific commodities. Stakeholders reiterated that this approach was likely not contributing to VFM. The RSSH standalone grants, though challenging to implement, (due to the variety of stakeholders involved, and the varied health systems gaps) are considered by many stakeholders to be the right way to go in principle, as they offer better opportunities to address integration and will optimise available resources. The progress seen in PSM through the

[374]https://nscip.gov.ng/products/national-psm-strategic-plan-with-cover-page/

[375] GC6 - Progress of Current RSSH Grant Interventions (Annex 22)

[376] Achieving Health Impacts at Scale. Accessible at: https://www.crs.org/sites/default/files/tools-research/digitized_mass_campaigns_one-pager_march_4_2021-_english.pdf

RSSH standalone grant was cited as a good example. Stakeholders recommend that the majority of RSSH funding should be bundled within the RSSH standalone grant.

8.2.3. Funding model and business processes

CCM Constitution, Secretariat and Implementers

The CCM has evolved from over 40 members to a 16-member board with representatives from four broad constituencies, resulting in more efficient processes and increased stakeholder participation, however there are still gaps in engagement. The CCM secretariat is also thinly stretched given the increasing country portfolio size, with funding allocation to the secretariat reduced across cycles. The CCM has streamlined its core membership into four constituencies comprising 1) Government, 2) Partners (UN and donors), 3) CSOs and 4) Private Sector. Each of these are represented by 3-4 key institutions. Each constituency is required to hold its own meetings semi-annually, prior to CCM meetings, to ensure representatives can effectively communicate the views of their constituencies. However, these constituencies do not meet regularly due to resource constraints. These pre-planning engagement meetings are the norm with other organisations (RBM, GAVI), and are said to be very effective. Also, the CCM is still viewed as political despite the restructuring processes that have taken place, with potential conflicts of interests among members as their institutions may also benefit from Global Fund investments. More than half of stakeholders interviewed, perceive that this inclination has an impact on prioritisation of interventions, as organisations representing the different constituencies are said to prioritise based on their own interests, especially during budget finalisation when activities are cut to fit the budget ceiling. A few stakeholders described the level of participation of the government in CCM to still be inadequate (despite being CCM members) with the CCM driven more by civil society which may affect sustainability. Also, the country portfolio has grown progressively through the last two funding cycles; however, the secretariat funding levels have declined. Stakeholders (CCM, donors) report that the size of the CCM secretariat is inadequate to effectively play their administration role across the many actors involved in Global Fund investments in the country. They also acknowledge that additional personnel should be recruited by the government but this is not happening, as the CCM is not seen by government stakeholders as owned or led by the government.

There are also lessons learned in optimising PR-SR partnerships, including PR- SRs ratio, pairings, power dynamics, and frequent PR switching gaps. These lessons indicate a need for additional considerations on pairing PRs and SRs, and better transition planning across cycles between PRs. The current RSSH PR has 16 SRs, this includes INGO SRs who receive their grants directly from the Global Fund and government institutions (new SRs) who are funded through the PR. The PR has struggled significantly with managing these SRs, with significant delays in approval and payment processes. This has also been exacerbated by the restricted cash policy currently applied to the new government institution SRs. These challenges are reported by stakeholders to be due to inadequacies in the leadership and capacity of the PR, limited staffing dedicated to managing the project, especially after the grant was expanded to include C19RM and difficulties coordinating with the CCM and country team. Other stakeholders however report that the scope was too large for a single PR to manage effectively; ***(PR-SRs ratio)***. Stakeholders also described the pairing of MSH (RSSH PR) an international NGO with government SRs in GC 5 as not effective, as the government institutions did not agree in principle to report to a non-governmental entity on work that is primarily within their portfolio as government (managing and strengthening health systems), and there were also conflicts in organisational policies between these institutions**; *(PR-SR pairings)*.** In GC6 there is a government PR for RSSH which has addressed the issue in GC5. However, there are now government institutions that are similarly classed with similar levels of leadership working as PR and SR. A few stakeholders report that this is creating some rifts in management with similar issues emerging, since these institutions do not usually report into each other within the government system; ***(PR-SR power dynamics)***. There has also been frequent switching of RSSH PRs without strong transition planning and limited continuity of interventions. The country has experienced changes from GC5 to GC6, with a new PR expected in GC7. The change from GC5 to GC6 is reported by stakeholders to not include any transition planning, with outgoing PRs not involved in the new cycle's applications, and no opportunity to handover. A number of interventions supported through these grants are also reported to end abruptly, with a similar trend expected in the transition from GC6 to GC7; ***(PR-PR transitions)***.

INGOs and select local NGOs demonstrate heightened responsiveness, while government PRs encounter bureaucratic challenges, with the exceptional performance of NTBLCP highlighting the pivotal role of leadership and grant prioritisation. International NGOs are perceived by stakeholders as responsive and effective program managers. Their hands-on approach, coupled with guidance from parent organisations is said to have provided a heightened vigilance and adaptability that has translated into significant progress in grant performance, but this is not always the case with a few examples of INGOs with suboptimal performance experience in GC5 and GC6. Likewise, local NGOs have demonstrated a commendable dedication to the cause, albeit slightly trailing behind INGOs. However, a distinctive challenge arises when assessing government PRs. These entities, while entrusted with grant management, often confront bureaucratic obstacles such as cumbersome, inflexible paper-based approval processes, often requiring multiple signatories. These hurdles tend to impede their efficiency in executing grant-funded programs. Yet, amidst this bureaucratic landscape, exceptions emerge, exemplified by the outstanding performance of the NTBLCP. The NTBLCP's exceptional success, despite bureaucratic processes, underscores the potential for government PRs to excel when equipped with effective leadership and a prioritisation of the grant's significance. The success experienced by the NTBLCP has been attributed by the majority of stakeholders to the current leadership of the institution. It is however important to ensure that systems are set up for continuity post the current leader.

Funding Requests Design and Processes

The funding request preparatory processes are robust by design and the country has benefited from improved guidelines provided between cycles. However, the process is reported to be taxing, with some stakeholder engagement gaps. There are also emerging contextual issues that need to be considered. Some of the engagement challenges are reported by stakeholders to have been addressed in the GC7 preparatory processes happening at the time of this review; with the process becoming more inclusive. However, challenges remain, such as the more top-down (prescriptive) than bottom-up approach to design; thus, inadequate pre-consultations with lower- level stakeholders prior to larger preparatory sessions. There were also reports of rushed designs in GC6 leading to conditional approvals and ring-fenced funds – especially for RSSH standalone grants, as well as AGYW and Harm reduction budgets where activities were designed virtually during the pandemic and a number of unresolved issues remained post-approval. The funding request process is also considered very taxing to stakeholders with some impact on program implementation as it takes several key personnel away from their routine job functions for a few weeks. The in-country review and finalisation process, results reportedly in a lot of arbitrary cutting of budget items in a bid to meet the suggested envelope, with seemingly limited technical/programmatic oversight leading to important elements of certain activities being cut (e.g. the facilitator fees are removed and the rest of the training budget is left in). The impact of this is delayed implementation as reprogramming requests are needed to fill the gaps. Lastly, an emerging challenge that urgently needs to be addressed is the use of historical costs to determine budget inputs. The rising inflation in Nigeria over the last few years[377] with costs becoming obsolete in the course of the same year, necessitates an intervention either in the budgeting or implementation to cater to rapidly changing costs.

Implementation Processes, Policies and Challenges

The engagement of the implementers with the CCM and Global Fund Country Team has been largely positive, with reports of extensive guidance and a close and effective working relationship. Majority of implementers report working well with the Global Fund Country Team, describing the depth of local context knowledge amongst the current team, the accurate judgements and guidance provided, and the access they have to the team with improved communication (more frequent in-country missions, biweekly check-in meetings) increasing implementer accountability. There are however a few government actors who feel the CT are leading decision making, with very limited country leadership. This is however mostly as a result of the country currently being under the ASP. There are also instances where there was some disagreement with CT guidance by implementers, however the guidance provided was appreciated at a later stage during implementation. There was also feedback that CSS technical assistance from the CT was limited, with no dedicated/focal person for CSS. The CCM is also reported to be playing

[377] Sienaert,Alexis; Joseph-Raji,Gloria Aitalohi; Saldarriaga Noel,Miguel Angel. Nigeria Development Update : Seizing the Opportunity (English). Washington, D.C. : World Bank Group.

an increasing role in coordination with other donors and participating more consistently in relevant national Technical Working Groups (TWGs).

The Additional Safeguarding Policy, including the presence of Fiscal Agents (FA) is viewed as very useful by most stakeholders. An important element of the ASP from the perspective of stakeholders was the presence of an embedded fiscal agent and this has enabled better alignment with Global Fund processes, eliminating errors in their requests and submissions. This is echoed more strongly amongst state SRs who are new to the process. Fiscal agents report that there have been improvements, but there are still many deviations in policy and procurement processes, especially conflicts of interest in procurement plans. The KPIs developed by the FAs now provide an opportunity for mutual accountability between fiscal agents and the implementers they support. A few stakeholders emphasised the need to rebuild trust between the Global Fund and the government, through addressing the capacity gaps in accountability. They also feel there is a lak of clarity on the transition plan from the ASP.

Implementation challenges during the review period included extensive budget reprogramming related delays, high health worker attrition rates, lower civil servant motivation, importation bottlenecks and insecurity. These causes and effects of these challenges are expatiated below:

- **Extensive reprogramming needs and delays in the reprogramming processes that have affected timely program implementation, with reprogramming timelines ranging 6 to 12months mostly due to in-country bottlenecks between PRs and SRs.** Reprogramming needs have increased significantly, primarily due to the rising inflation in the country, with most activity budgets quickly becoming inadequate for the planned scope of work. Implementers seem to always be on the search for savings from one budget line to be moved to another and have previously been unclear about budget flexibility guidance, especially among government PRs, and SRs in general. The gap in knowledge has been addressed, however the need to reprogram persists with no provisions made for inflation in grant cycle applications.

- **High health worker attrition rate and inadequate numbers of ad hoc-program focused staff (adherence counsellors, data clerks, mentor mothers, patient trackers, peer educators, that threatens program quality across all disease areas.** The current economic climate in the country has led to a lot of attrition of health workers, estimated by stakeholders to be as high as 70% in some areas. Stakeholders link challenges implementing community led monitoring in malaria programs, and lower detection of TB cases to health worker attrition and capacity gaps.

- **Low motivation and interest of organisational staff outside of Global Fund PR's Program Management Unit e.g., finance and procurement teams who play a critical role in facilitating the delivery of program activities, has created additional delays in program implementation.** Government PRs report challenges with coordinating program needs across organisational units that are critical to program implementation but are not part of the PMU or remunerated through the program. These departments have sometimes stalled on processing program requests leading to delays in program activities; more pronounced amongst government institutions implementing the C19RM and RSSH grant, especially with the short timelines required for the C19RM.

- **Insecurity in many states where Global Fund investments are being implemented has led to the loss of lives of some implementer staff.** This is however already being addressed with national risk mitigation plans and COE considerations in place, and the implementers working closely with relevant state security actors.

- **The program has also faced significant challenges with bringing in commodities and equipment through Nigerian ports authority with protracted delays in obtaining customs clearance and waivers,** often resulting in incurring additional expenses through demurrage payments and delayed implementation.

8.2.4. Sustainability

Progress towards ownership and long-term sustainability

The Global Fund model, with programs implemented with and through government systems is very unique and is structured with sustainability at its core. However, there is a strong view amongst stakeholders that

sustainability will require stronger government ownership especially around implementation, especially as the development community works towards achieving the 2030 agenda for sustainable development. Although Global Fund's investments are implemented through country actors, these have historically been private sector INGO actors, who have recorded a lot of short-term successes towards immediately addressing the high disease burden across the diseases. As the country progresses towards achieving HTM targets, with key elimination goals progressing, there needs to be a trade-off between these short-term successes and longer-term sustainability, more deliberate efforts to build necessary capacity at government level, and there are already some positive developments in this direction that could be built on. These include consistent engagement between implementers and government, with IPs roles becoming increasingly focused on technical assistance and capacity building in place of direct service delivery, state government leadership signing off engagement letters for project staff at health facility and community level. However, a more concrete achievement is the increased role of government institutions as IPs and the use of states as PR and SRs, especially since service delivery and funding decisions take place at this level, with state institutions managing 80% of the government budget, responsible for 90% of services, and managing 90% of HRH. This is working well, with the majority of stakeholders describing increased accountability and ownership of program activities by Government actors, e.g. Malaria State SRs leading last mile commodity distribution, reverse logistics, warehouse management and SBCC. The State PR also reported a unique ability to tailor strategies better to the state content due to their role. The states are expected to take on increased responsibilities in GC7. There are however some concerns that the current state PR (Lagos SMOH) and State SRs (Gombe and Kwara SMEP) are exceptions with these states already somewhat more progressive, and that many states are not ready for this level of responsibility. However, there are a few others with potential.

The alignment strategy of the major sources of support (PEPFAR and Global Fund) with the Government of Nigeria to optimise the countries' HIV response, referred to as Alignment 1.0[378] has been considered a step in the right direction, although it had its demerits especially with respect to government ownership and accountability. It is currently evolving into Alignment 2.0[379] which addresses this gap. Alignment 1.0 has improved and harmonised service delivery packages, delineated responsibilities amongst donors, and contributed to programmatic improvements especially increasing ART coverage. However key gaps in this plan were: Non-inclusion of empowerment objectives for Governments, private sector, state, or communities; also inadequate numbers and capacity of key HIV-program focused staff. These cadres are directly supported by implementers and not in the official Government HRH, with no clarity on how these personnel might be sustained. Alignment 2.0 aims to achieve a more holistic HIV response with state and community entities also playing a significant role in leadership, ownership and management.

Increased engagement of private sector providers is a new initiative that not only increases access to services but also promotes sustainability as private providers are equipped to provide these services and their longevity is not necessarily hinged on donor support. There are however concerns about attrition of providers due to rising inflation. The expansion of TB service delivery to over 20 thousand private sector facilities is expected to contribute to sustainability. These providers receive equipment and training to support TB services although at a fee. The skills and capacity built will be retained beyond the program timeline, however current performance-based incentives are losing value to the rising inflation in the country. This has resulted in high levels of attrition of individual providers and entire private institutions who are for profit. The original value of the incentives on engagement was already low and providers also put a public health and social good face on as they entered into the partnership.

Beyond Government leadership in implementation processes, steady and increasing financial commitment from the government is also critical to sustainability. There are several examples of government commitments, however this is only happening in pockets with co-financing the primary financial sustainability mechanism said not to be effectively implemented. Domestic financing for HTM and supporting RSSH has been a key challenge both for program delivery as well as sustainability. The autonomy of states creates an additional level where commitments and release of funding must be actioned. The co-financing policy is largely considered helpful

[378] Based on internal Global Fund documents (confidential)

[379] New Business Model for the Nigerian HIV/AIDS National Response 2023-2030, March 2023 Draft

but not well implemented; as written commitments are rarely followed with disbursement of funds and there are no clear mechanisms to verify contributions in most cases. Also, there is an unspoken agreement by experience, that Global Fund will disburse their grant irrespective of the government meeting its 15% commitment, in contrast to other donors who insist on upfront contributions. Some examples of domestic financing commitments that are contributing to sustainability, include:

- A private sector funding mechanism through NACA (the HIV trust fund), inclusion of comprehensive HIV treatment in the health insurance scheme in Lagos,
- Dedicated budget lines and accounts for co-financing amongst the state PR and SRs.
- The recent development loans from the World Bank and Islamic Development Bank have also contributed to closing some of the financing gaps, but also experiencing other implementation roadblocks.
- Operating basket funds or revolving funds used by the National Product Supply Chain Management Program (NPSCMP) with State Warehouses.
- Social contracting used for condom programming as a commodity security initiative.
- Community stakeholders also make in kind contributions to their catchment health facilities.

Many stakeholders describe inadequacies in the level of advocacy towards financial contributions. It is said that for co-financing to be effective with released and verifiable funding, then advocacy must be targeted to the highest levels of government (the presidency, state governors, Ministry of Finance, the executive and legislative arms), and preferably an annual visit from the highest offices in the Global Fund. Stakeholder view engagement above the Ministry of Health level as more impactful towards accountability of funding and decision making around domestic funding contributions.

The current RSSH approach strengthening parallel HTM systems will threaten sustainability in the long-term, especially as the gaps seen in some HTM indicators are related to wider health systems gaps. The continued funding of disease specific RSSH is expected to promote siloed and fragmented health systems solutions that only cater to HTM. This will further increase the divide in the quality of services across service delivery areas/clinics. Health workers are reported to migrate to preferred HTM service delivery points. Commodity availability is stronger for HTM, than essential medicines which are also needed by these clients. Currently these parallel systems cut across data management, supply chain management, community service providers, increasing complexities for health facility management and delivery, as health workers attempt to navigate the variety of tools and processes across these disease areas.

8.2.5. Risk Management

Financial Risk Management, Program Suitability and Sustainability

There are mixed reports about Global Fund's risk management processes, with some reports that they are focused more on managing financial risk than on program suitability, and others disagreeing. These views may actually be indicative of a somewhat balanced approach. All stakeholders acknowledge that the risk assessment, mitigation and management mechanisms and systems are effective; however, a few stakeholders are of the view that these systems impede innovation and flexibility in program design and implementation, especially in reference to the ASP, fiscal agents and conditional approvals. Others however applauded the balance struck between financial risk and program suitability as optimal, describing the Global Fund's risk management structures as generous and flexible with adequate protections. The following paragraphs detail some examples given by stakeholders that are indicative of how risk management within the program is somewhat balanced.

- **The increasing reliance on government entities as implementing partners, with plans to expand on this in subsequent cycles** is an example of how sustainability is prioritised above potential financial risk. However due to the ASP, this risk is well contained, with state SRs appreciating the presence of fiscal agents. Some stakeholders suggest an adoption of fiscal agents as a part of the capacity strengthening of public institutions to effectively fulfil these implementer roles, even after the ASP is lifted.

- **Frequent transitions and the absence of continuity planning between RSSH PRs across grant cycles is indicative of a stronger focus on managing financial risk.** There were several changes in PRs from grant cycle 5 to 6, with further changes expected in GC7 as well, and a major factor for these changes is related to inadequacies in grant performance including budget absorption. The changes have been implemented without any systematic handover process and consultations to ensure continuity in strategies or communication of critical lessons learned in implementation. This is not a trade-off situation, as handover processes can easily be instituted.

8.2.6. Monitoring and Evaluation

Global Fund's M&E Requirements and National M&E Systems Gaps

Global Fund's M&E requirements are aligned to the country's systems, even though these are varied and vertical. There have however been investments to strengthen data systems. Global Fund's M&E requirements are met through utilising the country's own systems. However these are varied, as there are parallel data management systems within and across the diseases and wider health systems as previously discussed. These systems are managed autonomously by different actors with limited attempts to integrate them. This may be an area for intervention that Global Fund's standalone RSSH grant. A good initiative towards integration within HIV, although still parallel and disease specific, is PEPFAR's provision of access to their data system (DATIM) to Global Fund and the GON, so there is "one version of the truth" for data reviews. Global Fund has also supported digitalization of data management systems and the introduction of digital applications for surveillance and service delivery. The HIV program has historically benefited from investments in improving its data management systems, with HIV data better collated through HMIS and EMR systems, through support from several donors including Global Fund. In this review period, the EMR has also been improved and now collects biometrics. Also, there have been significant investments in digitalizing and integrating the malaria program's M&E system, with malaria surveillance data included in the NMEP data warehouse, malaria data from HMIS also liked to the data warehouse, SMC service and ITN campaigns using mobile applications and supervisory activities including DQA and IMSV now digital. These were led by the NMEP but implemented through Global Fund's support.

The reporting and program review processes are reported to be robust, especially with the recent inclusion of the Global Fund partners reporting portal. There are however gaps, including the absence of specific RSSH indicators, the need to streamline some reporting requirements, inadequate denominator estimates and challenges delineating the result of Global Fund's investments from other donor contributions. Implementers and other in country RSSH stakeholders report:

- **Strong program monitoring and review processes towards ensuring effective program delivery, including oversight meetings, situation room meetings and check-in meetings.** These mechanisms are viewed as very helpful in keeping progress on track and maintaining accountability. They also applauded the partners reporting portal as very useful. A few respondents however suggested that the reporting process could be further streamlined especially where 6 monthly and quarterly reports overlap, suggesting that these reports could be combined as they have some overlap in content.

- **The absence of specific RSSH indicators to measure RSSH, with RSSH performance currently measured through the impact on health outcomes for HIV, TB, malaria and by how much these interventions promote integrated, people-centred services.** If the Global Fund continues to facilitate RSSH stand-alone grants going forward, more holistic indicators measuring impact on health systems would be needed.

- **Inadequate denominator estimates to base program targets due to poor routine data quality and outdated surveys, with targets based more on program requirements than disease burden.** The target setting process is reported to be robust, but has struggles with poor data quality. This included uncertainty around the actual disease burden, which has now been addressed for HIV through the 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) and for Malaria through the 2021 Nigeria Malaria Indicator Survey (MIS), amongst others. The use of historic performance was also not necessarily a good predictor, as the targets here were also based on uncertain estimates. The TB program is the most impacted by this, with the most recent TB prevalence survey over a decade old, and routine data systems for TB in a poorer state than the other two diseases, where more significant investments have been made.

- **Difficulty delineating the result of Global Fund's investments from other donor contributions.** Donor funded programs have co-existed in the same locations and supported similar and complementary services. This has resulted in challenges determining which results are attributable to which donor. Even with the Alignment 1.0 agreement, there continues to be some level of co-location, with one donor supporting technical delivery and another providing commodities. This challenge is however expected to be well addressed under the Alignment 2.0 agreement, with common national targets set and included in a national Performance Framework, and clear delineation of GF specific targets in a PR-specific Performance Framework.

8.2.7. C19RM

C19RM implementation challenges and contribution to mitigating impact on HTM

Overall, Nigeria adapted well to the Covid-19 challenge by redirecting existing funding (e.g., bidirectional C19RM / TB testing, more community engagement etc.) with TB being the biggest benefactor. Global Fund's investments became even more relevant during the Covid-19 pandemic as they were leveraged to address emerging needs as the pandemic evolved. The timely Covid-19 response, using grant flexibilities enabled timely provision of urgently needed PPE, oxygen therapy and also put in place a response mechanism; there are however gaps in coordination across states, especially with respect to referrals and data management. The TB program benefited from this grant, as it supported improving diagnostic capacity, emergency services, ambulances (mobile intensive care unit), bi-directional testing (also with the support of the WHO and other partners), as well as increasing awareness of TB, resulting in an increase in TB case notifications. These funds have also been directed towards purchasing commodities and equipment to improve TB testing and notifications, the conduct of the Malaria Indicator Survey (MIS), strengthening community modalities for HIV service delivery, potentially reducing the impact of Covid-19 on these services.

C19RM Wave1 showed limited results due to many implementation challenges it faced, ranging from rushed applications, rapidly changing priorities and reprogramming requirements to new IPs unfamiliar with GF processes and procurement delays, leading to low absorption. Stakeholders report that the implementation of the C19RM grant has been very challenging. The application processes were rushed per the emergency, and the pandemic evolved rapidly resulting in changing needs and a lot of reprogramming requests and unsurety on how to proceed with implementation. There were many new implementers such as the Department of Health Planning Research and Statistics (DHPRS) for HMIS, Department of Food and Drugs for HPSC, National Primary Health Care Development Agency (NPHCDA) for CSS, and the National Centre for Disease Control (NCDC) and the Laboratory Unit of the Department of Hospital Services at the FMoH for Laboratory systems. These SRs were not familiar with Global Fund processes and policies and a lot of coordination issues between the PR and the SRs especially in procurement. Implementers also reported not having adequate staffing within their programs and having to bring on consultants or get technical support from other partners in the country. There were also external challenges with suppliers declining orders due to the global disruption in supply chains, thereby delaying procurements, program activities and fund absorption.

The current approach with C19RM funds being reprogramming into RSSH has been welcomed and has established collaboration with key actors in the HSS space that usually interacted less with the Global Fund. The C19RM resources and flexibilities to reprogram have benefitted a variety of HSS endeavours. These were critical unfunded activities largely unrelated to Covid-19, such as the expansion of the Community Systems Strengthening efforts from 12 to 18 states, the digitalization of SMC campaigns in some states, and the conduct of the National Malaria Indicator Survey. Looking forward use of RSSH reprogramming is considered helpful and an opportunity to further strengthen RSSH.

8.2.8. Catalytic investments

Progress and added value of Catalytic Investments

The interventions implemented under the catalytic investments portfolio were largely reported to have worked well; These funds were mostly not viewed as catalytic, neither is there any evidence to show a catalytic

effect, instead they only served to increase available funding to expand ongoing interventions. The matching funds for TB case notifications, supported the extension of services to faith-based organisations, which contributed to improvements in cases notified. The matching funds enabled extension to almost 100% saturation of the faith-based organisations, with the associated capacity building activities to commence implementation. The low rate of notifications has been a priority of the TB program and similar efforts were already underway to address the gap through scale up to private sector health facilities. The matching funds for HIV Self-testing were also perceived to be effective, but also considered timely due to Covid-19 related restrictions to service delivery. This created a continuation in access to testing services even during the peak of the pandemic. The dual-AI nets strategic initiative was however viewed as catalytic, with a new intervention that showed significant impact in pilot locations. The country attempted to begin the scale up of these more expensive new nets which have been included and budgeted for in the GC7 funding request.

8.2.9. Partnerships

Collaborative funding and scaling coverage

There have been strong collaborative and impactful partnerships for HIV programming, notably the Alignment 1.0 and 2.0 agreements on the country's HIV response. There is however lesser collaboration seen amongst TB donors and implementers. The major donors in the HIV/AIDS response in Nigeria are PEPFAR and the Global Fund, with PEPFAR responsible for about 90% of investments, and significant overlaps in service delivery components and locations resulting in duplication of efforts. As described in earlier sections of this report, the 3-way coordination agreement between Global Fund, PEPFAR and GON is an important demonstration of a shared vision of these partners towards key program outcomes and is structured in support of the Government of Nigeria's new national strategic framework for HIV. The alignment has already begun to optimise both donors' investments in the country and harnesses key strengths of the different organisations e.g. Global Fund program's experience with key populations and ability to fund harm reduction programming, as well as its commodity security focus and procurement processes (Wambo), as well as PEPFARs larger service delivery budget and large commodity logistics project. Although Alignment 1.0. achieved some successes, there are some inefficiencies and gaps that are expected to be addressed by Alignment 2.0. For instance, there is still some co-location by design with each donor focused on different services and questions around cost-share and accountability for expired commodities or attribution of results. Other gaps have been discussed in earlier sections of the report. There are other HIV collaboration initiatives including the PEPFAR and MOH led clinical mentorship program which is also supported by the National AIDS and STDs Control Program (NASCP) mentors through Global Fund support.

Improved funding landscape, closing malaria funding gaps and increasing coverage to more states and effective coordination and collaboration across funding partners under NMEP's leadership. Global Fund has historically been the largest donor in the malaria space, almost single-handedly funding mass ITN campaigns across the country. The new support from the Islamic Development Bank (IsDB) and World Bank (WB) loans is complementary to Global Fund's efforts, especially in ITN distribution, but also supporting other case management and malaria prevention services including the provision of SP for IPTp. The coverage of donor support now spans 36 states with Global Fund supporting 13, PMI 11, WB 7, and IDM 5. There is only one state in the country not supported by any donor, and the development banks are facing some initial start-up challenges especially with IsDB negotiating government processes, and both IsDB and WB procurement policies not aligning with governments requirement to purchase ITNs locally. NMEP and partners also developed a framework for loaning and swapping commodities/health products to prevent expiries, especially ACTs and RDTs, across all donor investments. PMI and Global Fund have also supported entomological monitoring studies in different states. There are also several other donors working in the malaria space implementing specific intervention and research on a smaller scale including UKAID and BMGF. The malaria TWG and its subcommittees (PSM, M&E, Case Management, IVM, Advocacy SM, PM) have also been very effective in coordination, harnessing the strengths and contributions of different funders and implementing partners in the country.

Implementation and technical assistance partnerships

Increased engagement with domestic institutions including states as PRs and SRs, as well as the private sector engagement through scale up of services to private health facilities. In previous cycles, Global Fund had engaged primarily with international NGOs as technical implementers who controlled the administration of

investments, with the government institutions only playing policy and coordination roles. This dynamic with financial resources given to other non-government entities diminishes the leadership of the government and does not create an environment that fosters growth and transitions towards sustainability. The increasing engagement of these domestic government institutions has been discussed extensively in earlier sections. This collaboration is contributing towards scaling up progress and potential sustainability of Global Fund's investments, however there are challenges in new partnerships with different government entities that are less familiar with Global Fund, with all stakeholder emphasising the need for deliberate and systematic capacity building endeavours focused on these institutions, and focused high level advocacy to the leadership of these organisations towards maintaining their commitment, including domestic financing. These government institutions expressed feeling empowered and recognized by virtue of their more direct relationships and role as implementing partners.

Technical assistance support for Global Fund investments by UN agencies and other partners have worked well for most implementers, however there are a few cases where IPs felt consultants were not accountable to them or meeting their needs. The WHO, UNAIDS and other technical support organisations have consistently provided support to Global Fund IPs. The support ranges from preparatory work for grant application (Strategies, Performance Reviews, etc), providing evidence/estimates to guide strategic planning and implementation, mobilising the other cosponsors to complement available resources as needed. The state PR and SRs also appreciated the external technical assistance support. One government PR however felt a need for more control over the management of consultants providing technical assistance, through joint hiring and direct supervision.

8.2.10. Gender, human rights, equity & communities

Progress and Gaps

Design of Global Fund applications include clear considerations towards reducing human rights barriers, advancing gender equality and enhancing equity. These initiatives are more robust and actively implemented within the HIV program than TB and malaria. Human rights violations, stigma and discrimination and other similar manifestations of inequity have been more strongly associated with HIV, than TB and malaria. Stigma within the TB community is often based on the knowledge of TB/HIV co-infection. As a result, the HIV programs have mature interventions in place to address these barriers: from policies, to beneficiary safeguarding mechanisms, differentiated service delivery options and evidence generation initiatives to improve their response towards achieving these objectives. The design of GF applications requires inclusion of these interventions at policy/structural level and service delivery/operational level with clear budget lines. This has resulted in strong programming and a robust set of interventions implemented within the HIV program. There are lesser interventions within the TB program, but a few proactive initiatives related to male centred approaches (as men are disproportionately affected) were described. Stakeholders report that stigma and discrimination have limited applicability in malaria programming since malaria affects everyone, with services provided to the general population. Also, pregnant women and children under 5 who are disproportionately affected are already prioritised, and M&E systems collect gender and age disaggregated data. There are however reports of inequity in ITN distribution and inadequate considerations for family composition in allocation processes that could benefit from more deliberate solutions.

About 85% of GHR cases are resolved within the HIV program, with a variety of interventions implemented to reduce human rights barriers, advance gender equality and enhance equity. There are also improved processes to document these outcomes. Interventions within the HIV program are somewhat stable and consistent, and have contributed to these results. These include the one stop shop (OSS) for safe access to services for KPs, safeguarding trainings, a client feedback mechanism, legal vendors and paralegals to provide services to KPs, security agencies training, health care workers training, community gatekeepers sensitization (tradition and religious leaders, women groups) and GHR demand creation workshops. Although many reports detailing the effectiveness of these interventions are anecdotal, the feedback mechanisms set up have enabled documentation, analyses and tracking of outcomes on cases. Also, a national rapid assessment on stigma and discrimination was conducted. Stakeholders also report that improvements in ART coverage and TB treatment success rates are also proxies for reducing human rights related barriers that need to be recognized.

The NACA led gender and human rights strategy, created a framework for implementation, with state level teams established to respond to gender and human rights issues. The NACA designed gender and human rights strategy to ensure all people have access to services irrespective of their diversity and orientations currently serves

as a policy platform to address rights and related barriers. NACA designed this strategy working closely with the National Human Rights Commission (NHRC) and other partners such as UNDP, and UNAIDS. This has resulted in high level engagement with national policy makers with about 2 human rights bills in progress. It has also cascaded into the establishment of state level implementation teams that respond to gender and human rights issues. Similar policy and advocacy work is being done by the STOP TB partnership for TB with engagement with legislature, that could benefit from a stronger relationship with the NHRC.

Community involvement has improved over the last 3-4 years, but there are further opportunities to engage grassroot actors CSOs and CBOs in GHR. Community actors are more engaged in application processes, planning and implementing, and monitoring programs, with the proliferation of community led monitoring. They are an active part and represented within the CCM, with Umbrella CSOs representing each of the three disease areas. Key populations are also now represented through a proxy NGO. Also, the KP network is now a formally registered organisation. The increase in the level of inclusion is acknowledged, but CSO stakeholders report a need for more meaningful engagement. These organisations feel excluded from key conversations where final decisions are taken, and report that the PRs and proxy organisations do not adequately represent them and are often disconnected from realities within some KP communities. There are also critical interventions such as legal services that are reported to be well implemented by HIV SRs, but seem grossly inadequate or even completely absent from the perspective of CSOs especially for key populations.

8.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Overall, Global Fund investments targeted evidence-based interventions which were aligned to the country's NSP, with concerns about the robustness of NSPs vis-à-vis their suboptimal development process. The funding model and business processes are generally working well, but there are some issues with pre-engagement prior to applications, CCM composition and ability to be unbiased and representative of their constituencies, PR-SR pairing choices, and the frequency of reprogramming budgets. There is also the growing challenge in balancing short-term and long-term results for instance utilizing government as implementers instead of INGOs, investing in disease specific RSSH versus standalone RSSH, as well as the heavy reliance of the country on Global Fund for commodity security. There needs to be a tilt to long-term results and increased country ownership for these interventions, with growing momentum toward elimination goals in 2030 sustainable development agenda. Further, the co-financing mechanism is seen as helpful, but not effectively implemented, with a few examples of State PRs and SRs who are more accountable for their contributions. Lastly new partnerships were fostered and existing ones strengthened; with increased engagement with domestic institutions, private sector engagement, strong donor collaboration notably the Alignment 1.0 and 2.0 agreements on the country's HIV response.

The review highlights the following suggested areas for strengthening to reinforce Global Fund interventions:

1. Apply a bottom-up approach to funding request applications, by improving the engagement with stakeholders at lower levels (especially SRs and CSOs who are closer to implementation), with more deliberate and meaningful pre-engagement meetings utilising pre-collated and user-friendly evidence packages.

2. Increase efficiency in the budget development segment of the funding request process through allocating sufficient time for budget finalization with technical/program experts involved in streamlining the budget, and potentially reinstituting inflationary adjustments, thus decreasing frequent reprogramming and implementation delays.

3. Increase engagement with domestic partners especially public institutions (National and State Government departments and CSOs) as implementers, with deliberate organisational development/support mechanisms targets promising government departments, agencies and states where there is already political will. This process should also be complemented with a clear and well communicated exit plan for the ASP

4. Pivot gradually towards increased investments in standalone RSSH grants, focusing investments on integration of health systems components. This will foster longer term sustainability of Global Fund's investments towards earlier transition/take over by the country.

5. Elevate advocacy efforts to the highest levels of government (e.g., Presidency, Ministry of Finance, state governors) to establish relationships, realign expectations, and to also leverage these to enforce co-financing requirements.

6. Explore alternative financial sustainability approaches e.g., operating basket funds, revolving funds, or social contracting, which are already being used in the country by other actors, especially around commodity security. Another alternative may be linking co-financing to specific outputs / outcome areas that the government is held accountable for.

7. Strengthen partnerships with other donors, with similar partnership agreements as the HIV response alignment, for other funding areas e.g. TB and RSSH. The HIV response alignment can potentially be leveraged to coordinate TB partnerships at its next iteration.

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A.17. List of interviews

The case study was informed through consultations and focus group discussions with 64 stakeholders from the following entities:

Stakeholder group	Entity
CCM	CCM
HIV PRs	FHI360
	NACA (HIV disease program)
TB PRs	Institute of Human Virology
	NTBLCP (TB disease program)
Malaria PRs	Catholic Relief Services
	NMEP (malaria disease program)
RSSH/C19RM PRs	NACA
	LSMOH (Lagos State Ministry of Health) TB& RSSH state PR
HIV SRs	ECEWS (Excellence Community Education Welfare Scheme)
	SFH (Society for Family Health)
TB SRs	TLM (The Leprosy Mission)
	REDAID
	KNCV
	DFB (Damien Foundation Belgium)
Malaria SRs	Malaria Consortium
	State Malaria Elimination Programs
RSSH/C19RM SRs	NPHCDA (National Primary Health Care Development Agency)
	NCDC
	NPSCMP (National Product Supply Chain Management Programme)
Technical Partners and Donors	UNAIDS
	GiZ
	World Bank
	Islamic Development Bank
Community and civil society organisations	NEPWHAN
	TB-Network
	APYIN
	ANAYD
	TRANS/Intersex
	Creme de la Creme
	COSRWAN
Fiscal Agent & Local Fund Agent	GFA
	PwC

9. PAKISTAN CASE STUDY REPORT[380]

9.1. INTRODUCTION

9.1.1. Key country characteristics and HTM context

Pakistan is located in South Asia with a population of approximately 230 million people as of 2022. The country is administratively divided into four provinces—Punjab, Sindh, Khyber Pakhtunkhwa, and Balochistan, and the administrative territories of Azad Jammu and Kashmir and Gilgit–Baltistan - along with the Islamabad Capital Territory. These provinces are further subdivided into administrative units, including districts and tehsils. Pakistan is the fifth most populous country in the world yet ranks 161 out of 191 countries on the UNDP's Human Development Index (HDI). Pakistan's population growth rate of 2.1% per year is one of the highest in South Asia, placing pressure on the country's resources and infrastructure. Pakistan's Global Health Security Index ranks it at 130 out 195 nations, with specific index decreases in environmental risks, socio-economic resilience, and Joint External Evaluation (JEE) since 2019. Pakistan's political economy is characterized by a complex interplay of socio-economic and political challenges that have far-reaching implications for the country's development trajectory.

The country's slow progress on the Sustainable Development Goals is attributed in part to low health investment (1.1% of GDP), which was aggravated by the COVID-19 pandemic and regular climatic shocks. Pakistan has a devolved healthcare system, with the federal government having the key role of formulating health policies, while the provincial health departments are responsible for planning, and implementation at the provincial level. Each province is responsible for managing healthcare and essential medical specialties within its jurisdiction. Districts and tehsils (sub-districts) are actively involved in the delivery of healthcare services. Pakistan has several national and provincial health policies and strategies that outline approaches for prevention, diagnosis, treatment, and care. Some of these include; the National Health Vision (2016-2025), Pakistan AIDS Strategy 2021-2025 (PAS IV); The HIV & AIDS Prevention, And Treatment Act, 2007; National Strategic Plan for TB Control, 2020-2023.

Pakistan's healthcare system is mixed, with both public and private sectors providing services, though Pakistanis overwhelmingly prefer seeking care in the private sector. In 2020, the main sources of health expenditure in Pakistan included 54.29% out of pocket (OOP) spending, 34.51% government transfers, 6.69% external aid, 2.48%other, 1.09% social health insurance contributions, and 0.95% voluntary health insurance contributions. Catastrophic health expenditure accounts for more than 70% of the economic shocks for poor.[381] Households with lower incomes are increasingly at risk of becoming poor as a consequence of health payments even though they spend less than rich households and generally seem to have less access to health care. New models, like the Sehat Sahulat Programme (Social Health Insurance) have been created to address the problem of catastrophic health expenditure. Devolution of the Federal Ministry of Health, along with several other federal ministries, took place as a consequence of the 18th Constitutional Amendment in 2012 which endowed full authority and resources to the provincial health departments, while the role and structure of the federal health ministry was reduced dramatically.

Donor financing has played a crucial role in supporting health programs, including HIV, TB, and malaria interventions. Post devolution, coordination mechanisms between the federal and provincial governments were established in Pakistan to attempt to ensure that policies and programs related to health services were effectively implemented across the country. However, their implementation remains precarious. Grounded in lessons learned from the Disease Control Priorities 3-Universal Health Care Project, the Ministry of National Health Services Regulation and Coordination (MoNHSRC) was established as a health sector coordination mechanism to define a governance structure for national and provincial health departments, frame policies and set guiding principles for implementation and decision making. However, its scope was limited to decision making in the national health sector, without influence over provincial health departments, health emergency autonomous bodies or international health regulations.

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[380] The Pakistan case study has been conducted by Simon Azariah and Mariyam Sarfraz of Youth, Rights and Health, UK.

[381] National Health Accounts, Pakistan 2019-20 (https://www.pbs.gov.pk/publication/national-health-accounts-pakistan-2019-20)

The federal government forms Technical Working Groups (TWGs), to address specific technical challenges in the health sector. The primary role of these TWGs is to provide technical support to the Ministry in developing policies, strategies, and programs related to health. These groups are comprised of subject matter experts and stakeholders from different sectors, including government, civil society, academia, and the private sector. These include RMNCAH, Infectious Diseases, Nutrition, Inter-sectoral, NDC, hospital, and health systems groups. Over the past couple of years, the working groups remain largely defunct, activated rarely by interested stakeholders.

9.1.2. Summary of Global Fund support

Considering the intricate landscape of Pakistan's healthcare challenges, the Global Fund designated Pakistan a Challenging Operating Environment (COE)[382], characterized by significant hurdles in planning, coordination, governance, budget management, and achieving key disease targets. Underperformance of the HIV grant and subsequent to the program review and an audit by the Global Fund Office of the Inspector General (OIG), Pakistan was placed under Additional Safeguards Policy (ASP) in 2020. Implementation of the ASP aimed at refocusing the discourse in country on the HIV, TB and malaria programs and allows the Global Fund a set of crucial prerogatives, enabling it to take a lead role in identifying and determining implementation arrangements.[383] This includes the selection of PRs and SRs, and other implementing partners, as well as the establishment of fiscal agents/trustees, and utilization of the pooled procurement mechanism policy. Simultaneously, the COE provides the Global Fund with differentiated operational approaches to enhance program effectiveness and maximise investments, particularly in countries or regions facing extreme emergencies or acute/chronic instabilities. Country stakeholders have expressed disatisfaction with the concurrent application of the ASP and COE in Pakistan and the range of resulting controls. Aspects pertaining to the ASP and the role of UNDP as PR are discussed in Section 9.2.1.

As of February 2023, six grants for the three diseases are active across six PRs (table 9.1) with a cumulative budget of US$ 365.7 million.

Tabe 9.1: Overview of current Global Fund grants in Pakistan[384]

IP Dates	Disease area	PRs	Type of PR	# of SRs	Signed IP amounts (US$)
From 01-Jan-21 to 31-Dec-23	HIV	Nai Zindagi Trust	Private	2	US$ 22.72M
	Malaria	Indus Hospital & Health Network	Private	3	US$ 22.77M
	Malaria	Directorate of Malaria Control, MoNHSRC	Public	6	US$ 57.82M[385]
From 01-Jul-21 to 31-Dec-23	HIV	United Nations Development Programme	Private	28	US$ 47.10M
	TB	Mercy Corps	Private	8	US$ 30.53M
	TB	National TB Control Programme Pakistan	Public	14 (including 5 for C19RM)	US$ 202.68M[386]

Two PRs are engaged for each disease (one government and one non-government), with the exception of the HIV grants which are both led by non-governmental entities, a private entity (the Nai Zindagi Trust) and a UN agency (UNDP) due to arrangements in place for HIV grants under the ASP and reflecting the nuanced approach taken to address the complexities of HIV grant implementation. UNDP has the largest number of SRs illustrating the complexity of the HIV grant.

A centralised unit, the Common Management Unit (CMU), housing all three national programmes for HIV, TB and Malaria, was established under the MoNHSRC for monitoring and supporting programme implementation across the

[382] TERG Position Paper, Management Response and Final Report, December 2022

[383] PAK MoH ASP Communication, Aug 2020

[384] Global Fund (2023) DnA Factbook / Pakistan

[385] Figure updated to include emergency funding approved in 2022.

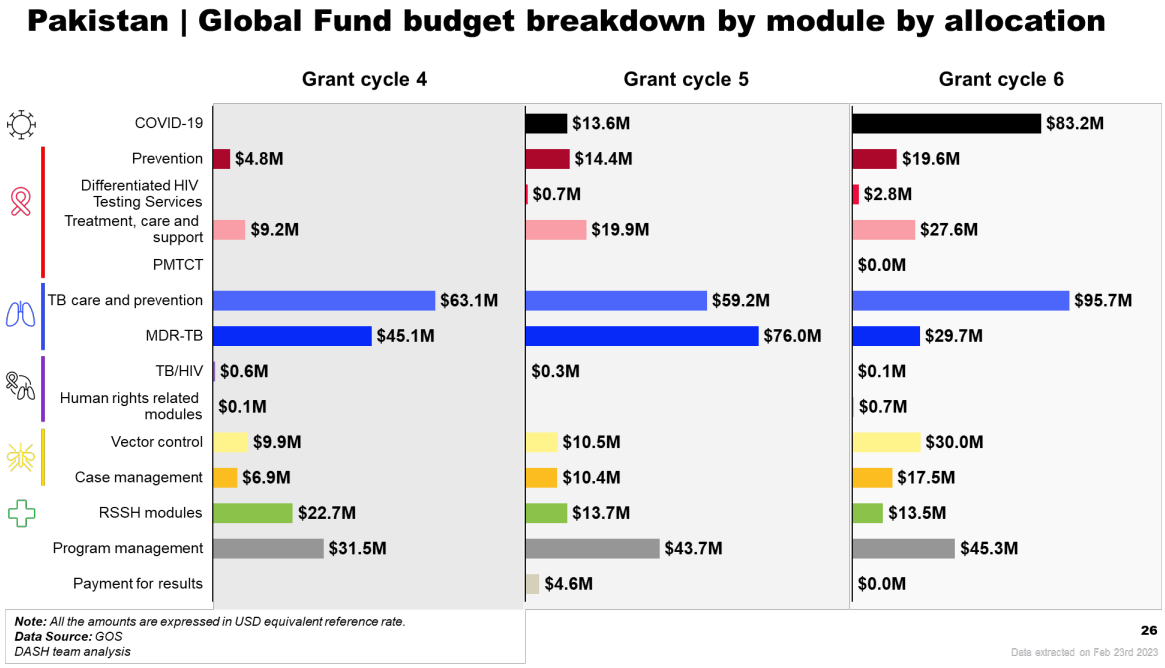
[386] This amount represents combined TB and C19RM funds.

country and acts as the main focal point for coordination with the Global Fund. It has also been reported that the establishment of the CMU was partly in response to the belief that provincial departments (some if not all) did/do not have the capacity to become PRs. The challenges, based on the available information, pertain to the overall implementation structure of the country and coordination issues between the public and private sectors. The CMU assumes crucial responsibilities encompassing strategic planning, coordination, central procurement, and grant management for the Global Fund. By centralizing the PR function, the Global Fund benefits from streamlined processes and enhanced collaboration, making it more operationally efficient compared to a scenario where each province functions as an independent PR. The extensive provincial involvement is however recognised with provincial governments acting as sub-recipients (SRs) to support implementation of the programmes at provincial level. This consolidation ensures a more cohesive and coordinated approach, addressing challenges associated with numerous provincial PRs.

Whereas it is recognised that from the perspective of Global Fund, liaising and working with one entity (PR) for a country is pragmatic and efficient, the MoNHSRC established at the federal level following devolution has a limited role in the actual delivery of healthcare in the country. Difficulties in the model of the federal-level PR given the significantly limited role, influence and resources of the MoNHSRC continue to remain a matter of debate.

Figure 9.1 presents an overview of the types of activities being undertaken within the three disease grants over the past three grant cycles and respective budgets by module.

Figure 9.1: Overview of Global Fund interventions across allocation periods in Pakistan[387]



Between GC5 and GC6, HIV allocations experienced a notable increase, signaling a significant upswing in funding for HIV prevention efforts. Funding for specific HIV modules increased by nearly 250% from GC4 (US$ 14.6M) to GC6 (US$ 50.8M), including a significant increase for prevention. This substantial shift indicates a strategic focus on preventative measures as a key approach to tackling the epidemic. Malaria vector control and case management modules also saw an increase in funding of 180% between GC4 and GC6 (US$ 16.9M in GC4 to US$ 47.5M in GC6).

Allocations for TB have remained relatively stagnant in recent rounds (US$ 108M to US$ 125M). While they might have seen minor fluctuations, the overall growth hasn't matched the significant jump in HIV prevention funding. This disparity raises concerns about ensuring balanced progress across all three diseases.

[387] Global Fund (2023). DnA Factbook / Pakistan

9.2. KEY FINDINGS

9.2.1. Relevance of Global Fund investments

Global Fund investments are considered relevant in Pakistan, enabling evidence based and value for money interventions to address HIV, TB and malaria needs. In the context of a high and rising burden of the three infectious diseases in Pakistan, the Global Fund grants are considered relevant to the objectives of the National Health Vision (NHV) and pivotal in steering the country's efforts to combat the three diseases. Key stakeholders widely acknowledged the relevance of Global Fund investments to the country's context and their alignment with National and Provincial priorities as highlighted in the NHV and programme/disease specific strategies. For example, the TB interventions under the ambit of National Programmes and Global Fund grant were indicated to be multi-faceted and extending beyond case notification to encompass a comprehensive strategy. Engagement with the private sector, community awareness initiatives, and public outreach programs to remote areas, in collaboration with Provincial Programmes and other implementing partners, were said to demonstrate a holistic approach to effectively address the rising burden of infections.

HIV

Overall the Global Fund HIV grant aligns with the country epidemiological context and has been described as highly relevant for Pakistan, though with potential areas for improvement to better adapt to the country context. Data on HIV in Pakistan emphasizes the significance of prevention, treatment, and care components targeting specific populations. Pakistan's ongoing efforts against HIV/AIDS have led to significant progress although stakeholders raised remaining critical areas that demand targeted interventions for epidemic control. A key focus is on bridging populations which connect high-risk groups to the general community, potentially facilitating HIV transmission. These bridging populations, such as sexual partners of key population members, clients of sex workers, and partners of people who inject drugs (PWID), serve as intermediaries in the virus's transmission dynamics.[388, 389] Effective strategies to address these bridging populations necessitate a tailored approach, considering their unique needs and experiences.

The HIV response in Pakistan has political and technical dimensions. Political and governmental factors hinder progress despite clear technical solutions. Coordination gaps also exist between UNDP, UNAIDS, and syndication approaches in the HIV prevention response, pointing to the need for a unified national approach. Building trust among key stakeholders, employing community-based outreach, and incorporating culturally sensitive communication are paramount. Involving peer educators and local leaders can enhance intervention outcomes. Simultaneously, promoting general awareness within the broader population is essential to reduce HIV-related stigma, encourage safe behaviours, and advocate for early testing and treatment. Issues also exist in data accuracy and the effectiveness of prevention programs, highlighting the newness of the prevention programme in Pakistan, initiated in 2019. There is an ongoing effort to expand prevention services from 16 to 53 sites and potential improvements seem likely.

Stakeholders hold mixed views on UNDP-led HIV responses for the Global Fund, favouring national governance. Concerns include coordination challenges, perceived funding model inflexibility, and inadequacies in adapting to Pakistan's health system. The governance and structure of HIV responses under the leadership of UNDP as the PR for the Global Fund grant have generated mixed sentiments among national stakeholders, with some viewing management under UNDP less favourably than governance under the National AIDS Control Programme (NACP). In the context of the ASP (in place since 2020) and UNDP's role as PR, tensions exist within this implementation arrangement, particularly regarding coordination challenges, perceived inflexibility in the funding model, and mandated collaboration between diverse programs supported by the Global Fund. With respect to mandated collaboration, it was learnt that, for example, there is a request for collaboration between the three

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[388] UNAIDS Country progress report – Pakistan. Global AIDS Monitoring 2020.

[389] Kteily-Hawa R, Hawa AC, Gogolishvili D, Al Akel M, Andruszkiewicz N, Vijayanathan H, et al. (2022) Understanding the epidemiological HIV risk factors and underlying risk context for youth residing in or originating from the Middle East and North Africa (MENA) region: A scoping review of the literature. PLoS ONE 17(1): e0260935. https://doi.org/10.1371/journal.pone.0260935

disease programmes in relation to community health workers (CHWs) funded through the Global Fund, which is made challenging by the limited human resources and financial allocations (domestic and international) for strengthening and enhancing the CHW workforce and its scope of work. Some stakeholders viewed that while collaboration between the HIV with TB programmes is logical due to co-morbidity, collaborating for example with the Hepatitis programme instead of Malaria would make more sense. The HIV PR in Pakistan, UNDP, frequently serves as both a partner and implementing agency for Global Fund grants, specializing in areas such as capacity building, program management, and community engagement. In this capacity, UNDP undertakes tasks like implementation of programs and ensuring ongoing funding support. However, criticisms extend to the funding model's implementation in Pakistan, where concerns have been raised about its insufficient adaptation to the country's unique devolved health response. This lack of alignment, in turn, is considered by many as to have an impact on the overall responsiveness of the HIV grant to specific needs and governance structures in the country.

TB

Global Fund investments in Pakistan are a significant source of funding in the context of low government co-financing. The Global Fund has provided approximately 32% of the estimated TB financing need as based on the National Strategic Plan for Tuberculosis Control, 2020-2023. Notably, the domestic funding for the TB program has remained low, and due to relatively low release of funds from government, the Global Fund support actually accounts for about 60% of the funding need for the TB programme with a significant financing gap across all programme areas. Global Fund-supported investments have supported a wide range of interventions in public and private sector settings, including procurement and distribution of TB medicines, training of healthcare workers, strengthening of TB diagnostic services and, expansion of community-based TB identification and care amongst other interventions. The Global Fund remains the largest financier of TB medicines and molecular diagnostics for TB for the Pakistani Tuberculosis Control Programme. Global Fund investments have also helped to improve the quality of TB care in Pakistan in an increasing number of districts, in both public and private health sector.

Malaria

Malaria interventions are comprehensive and have been successfully implemented, however there is a large funding gap hindering efforts to eliminate the disease as the number of malaria cases has been increasing in the country. In the period of 2016-2017, substantial strides were achieved in the effort to reduce the burden of malaria and lower its incidence in high-burden areas. The Annual Parasite Index (API) demonstrated a notable decline from 10.3 per 1000 population in 2016 to 6 per 1000 in 2018. [390] Despite this progress, the lingering challenge of outbreaks persisted due to ongoing transmission. According to the World Health Organization (WHO), Pakistan has witnessed a significant surge in malaria cases. Between January and August 2022, over 3.4 million suspected cases of malaria were reported in Pakistan, compared to the 2.6 million cases reported throughout 2021. Of these, more than 170,000 cases were laboratory confirmed and the majority of confirmed cases attributed to Plasmodium vivax.[391] Moreover, a rapid upsurge in malaria cases occurred in Balochistan and Sindh provinces after devastating floods in mid-June 2022. These two provinces accounted for 78% of all confirmed cases in Pakistan. The risk remains very high, especially considering the impact of the flood crisis on the national health system.[392] The estimated number of

[390] Based on Global Fund internal documents (confidential)

[391] WHO Disease Outbreak News: Malaria – Pakistan. 17 October 2022 (https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON413)

[392] *Ibid*

malaria cases in Pakistan was projected to reach 3 million annually by the end of 2023 due to this surge.[393,394,395,396] To prioritize efforts within GC6, the Malaria Programme classified high burden and high priority districts as "Stratum 1" districts and most resources are directed towards these districts. "Stratum 2" districts are lower in priority and burden of disease and therefore lesser resources are made available to these districts.

Key informants expressed concerns in the size of the Global Fund malaria allocation compared to need. For instance, the approved PAAR (US$84 million) for GC6 far exceeds the initial allocation raising concerns for sustainability, particularly in light of the program's heavy reliance on external donor funding and limited domestic financing. Overall in Pakistan, the malaria response and vector control specifically is underfunded and Global Fund funding analysis[397] shows a US$155 million national shortfall for vector control alone. [398] Some of this could be financed through the PAAR, but a funding gap remains. In terms of composition of the Global Fund grant, there is a perceived under-prioritisation of IRS during the 2017-2022 period, particularly in districts prone to outbreaks, despite reported longstanding communication by the Global Fund that the government and other partners are responsible for IRS in the context of outbreak control. A new 2023-26 malaria plan has since been developed which aims to bridge the post-flood malaria response to Pakistan's malaria NSP (2021-2035) (which includes both phases of burden reduction and elimination), and clarifies malaria investment priorities.

9.2.2. Progress and results achieved

HIV Progress

Pakistan reported some encouraging progress in the fight against HIV including increased ART coverage facilitated by intervention scale up and integrated community-based approaches to reach PLHIV and KPs. Global Fund funded interventions are said to have directly contributed to the progress in HIV, for example the harm reduction interventions and rights-based services for marginalized communities implemented by the Nai Zindagi Trust, which have led to improved access to ART for PLHIVs and KPs. Key positive developments reported for Pakistan include:

- 60% of the estimated 211,501 (2011) PLHIV who know their status are on treatment[399] and ART coverage has steadily increased in recent years, from 3% in 2013 to 13% in 2022.[400] This progress is attributed to various factors, including:
    - Expansion of ART sites and service delivery models. This includes One Stop Shops (OSS) for KPs and community-based testing which are under-development and which the Global Fund has been supporting the government to initiate.
    - Improved coordination among stakeholders through the National AIDS Control Programme (NACP), PACPs and CDC.
    - Increased access to multi-month dispensing (MMD) and community refill sites

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[393] Global messaging briefing kit: World malaria report 2023 (https://cdn-auth-cms.who.int/media/docs/default-source/malaria/world-malaria-reports/world-malaria-report-2023-global-briefing-kit-eng.pdf) 30 November 2023

[394] Pakistan faced five-fold surge in malaria cases post-floods: WHO. The daily DAWN. Published December 1, 2023 (https://www.dawn.com/news/1794060)

[395] Malaria – Pakistan: Disease Outbreak News, WHO (https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON413).

[396] Current Malaria Statistics, Pakistan (https://www.cmu.gov.pk/dmc-directorate-of-malaria-control/)

[397] Available funding and gaps for the Malaria Program in 2021-2023 as per Funding Request.

[398] Global Fund GC6 support for IRS is US$8.4 million (and reportedly $US5.5 million for GC7 per communication by Global Fund Pakistan CT).

[399] Global Fund (2023). DNA Factbook. Pakistan

[400] UNAIDS (2022). Country factsheets. Pakistan

Despite the reported progress, significant challenges remain including a concentrated epidemic and slow progress.[401] The HIV epidemic is concentrated mostly in key populations (KPs), especially PWID (22.9%) and MSM (17.2%) as well as being geographically concentrated in 2 provinces in the country, Punjab and Sindh, where 91% of PLHIV live.[402] Recent estimates also show gender differences in the disease prevalence with men accounting for 70% of PLHIV. Women are reported to be less likely to be on ART (8%) compared to men (11%). The proportion of KPs accessing treatment is estimated to be only 9%[403], as low as 3.4% for men who have sex with men, yet this group accounts for over 17% of PLHIV.[404] In the context of large unmet need for prevention and treatment services among KP groups driving the epidemic, stakeholders are concerned over to the limited funding available for HIV as well as persisting issues related to social stigma, and discrimination of the PWID population. In addition, the dynamic nature of HIV in KP communities such as its linkages with drug use epidemics, further hampers progress.

Key reported issues include:

- *Low testing rates:* Despite progress in ART coverage, a significant gap remains in testing rates. Only an estimated 23% of people living with HIV (PLHIV) know their status[405], highlighting the need for increased awareness and access to testing services.
- *Weak services:* The coverage and quality of prevention services for KPs is sub-optimal. Linkage between prevention and treatment remains weak, and policy related barriers related to differentiated services and multi-month dispensing, contribute to high rates of lost-to-follow-up.[406]
- *Weak HIV surveillance*: The country relies on integrated bio-behavioural surveillance rounds and has been attempting to set-up sentinel surveillance systems which still have not been fully functioning.[407]
- *Lack of multisectoral approaches to HIV prevention:* The so-called episodes of outbreaks are grounded in lack of multi-sectoral approach to prevent further spread of HIV from routes in addition to sexual transmission.[408]
- *Limited progress in key areas:* While ART coverage has shown improvement, other critical areas like PMTCT have seen limited progress.[409,]
    - Coverage of pregnant women who receive ARV for PMTCT remains low, at 12%.[410]
    - Paediatric ART coverage remains low at 31% in 2021.
- *Sub-population variations* exist in access to HIV services, especially for KPs (e.g., people who inject drugs (PWID), sex workers, transgender individuals, and men who have sex with men (MSM)) and for people living in rural areas. Addressing these disparities is crucial for achieving equitable access to HIV prevention, treatment, and care.

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[401] UNAIDS (2022). Country factsheets. Pakistan

[402] Global Fund (2020). Funding Request Form. HIV. Pakistan

[403] Global Fund (2020). Funding Request Form. HIV. Pakistan

[404] UNAIDS (2022). Country factsheet. Pakistan

[405] Global Fund (2023). DNA Factbook. Pakistan

[406] *Ibid*

[407] Funding Request Form: Allocation Period 2021-2023 Pakistan

[408] *Ibid*

[409] Based on Global Fund internal documents (confidential)

[410] UNAIDS (2022). Country factsheet. Pakistan

- *Social stigma and discrimination:* HIV-related stigma and discrimination remain significant barriers to testing, treatment, and adherence. Addressing stigma through social awareness campaigns and community engagement is critical for improving access to services and promoting social inclusion.

Based on KIs inputs it is inferred that a more efficient and centralised approach may be needed due to the lack of a unified prevention programme. KIs highlighted the importance of analysing data for yield from testing sites and discussing the need for a unified surveillance system in Pakistan. With respect to the challenge of lost-to-follow-up cases, an evaluation is needed of Punjab's strategy of opening ART centres to address the issue. There is a clear need for a comprehensive review of the HIV programme's impact, especially after considerable investments in prevention and treatment expansions.

There are challenges in measuring programme effectiveness due to the absence of specific indicators, highlighting the importance of indicators for care, yield, and linkages to care. Though improvements in linkages to care, addressing a previous deficiency in getting individuals into treatment after testing positive have been observed.[411]

TB Progress

TB burden in Pakistan remains high although some recent efforts fight the disease have been seen positive results including an increase TB case notification through private health facilities engagement and community-based interventions. Pakistan has the highest TB burden in the SEA region and accounts for nearly 6% of Global TB burden (5.7%).[412] WHO data indicate a 4.5% decline in TB incidence over 2015-2022 (compared to the 20% global target), and 1.5% decline in TB deaths (vs. target of 35%).[413] Estimated new TB cases were 608,000 in 2022,[414] of which 2,200 were HIV-positive and 15,000 MDR/RR-TB cases.[415] New TB cases notification had been declining since 2018 (from 62% in 2018 to 47% in 2020) but showed a recent rebound in 2021, increasing to 55% in 2021.[416] The expansion of TB services to private health facilities in an increasing number of districts, and performance-based incentives for case detection, are reported to have contributed to this positive result. Community-based case finding, facilitated by door-to-door outreach programs through Lady Health Workers (LHWs) and Community Health Workers (CHWs), has also played a pivotal role in identifying and notifying TB cases, especially during the pandemic when public health facilities faced limitations. Consistent support from the Global Fund was considered instrumental in providing crucial financial resources for TB control efforts through private sector health care providers, and expansion of the MDR-TB programme.

Persistent challenges exist in the detection and management of drug-resistant TB (DR-TB), marked by delays in sample movement and referral, restricted access to baseline investigations, and insufficient training for healthcare workers on TB referral and diagnosis. Improving the overall TB control strategy requires addressing these logistical challenges and exploring cost-effective diagnostic tools, as well as providing additional training to healthcare professionals. Simultaneously, stakeholders reported continued issues with underdiagnosis, limited access to diagnostic services, and social stigma. The challenges in treating DR-TB compound these issues, encompassing a high burden of DR-TB, treatment regimens, and restricted access to treatment facilities. Additionally, childhood TB encounters obstacles in detection rates, treatment adherence, and vulnerability factors such as poverty and malnutrition. An integrated approach is imperative to overcome these challenges and fortify the TB control strategy comprehensively. The healthcare system encounters resource constraints, weak infrastructure, and inefficient coordination, further hindering the expansion and quality of TB control services.

Emerging challenges surround the performance-based incentive approach, necessitating evolved coordination mechanisms and addressing data quality concerns. Legislative steps for TB case notification in the private sector are underway, highlighting the need for comprehensive legal frameworks encompassing public and

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[411] AIDS Strategy Pakistan IV 2021-2025

[412] WHO (2023). Global Tuberculosis Report

[413] Tuberculosis Profile – Pakistan, WHO https://worldhealthorg.shinyapps.io/TBrief

[414] Tuberculosis Profile – Pakistan, WHO (https://worldhealthorg.shinyapps.io/TBrief

[415] World Health Org (2022). Tuberculosis profile: Pakistan

[416] Global Fund (2023). Country DNA factbook

private sectors. Moving forward, harmonizing performance-based incentives, and strengthening data collection and reporting mechanisms including through a national TB prevalence survey, planned to be conducted in coming year, are essential to ensure accurate monitoring and evaluation of progress.

Malaria Progress

Pakistan is reported to have made significant progress in malaria reduction in the last decade including through an increase of case management services and increase use of RDTs. However, malaria remains a concerning issue in Pakistan especially in light of the growing number of malaria cases in the country. Between 2016 and 2017 (GC4), there was a significant expansion in case management services, covering 72 districts compared to the initial 43 districts in 2016. This growth coincided with an increased use of Rapid Diagnostic Tests (RDTs), which contributed to a rise in confirmed malaria cases. Notably, during this period, the Annual Parasite Index (API) declined from 10.3 per 1000 population in 2016 to 6 per 1000 population in 2018.[417]

2021 data[418] showed that 505,620 estimated malaria cases were reported, along with 460 estimated malaria deaths, out of which 80 deaths were reported. Despite making progress in malaria treatment and achieving targets for suspected cases receiving parasitological tests, only 4% of the planned bed nets (ITNs/LLINs) were distributed[419] due to COVID-19 restrictions.

Looking ahead, the National Strategic Plan (NSP) for Malaria Elimination (2021-2035) indicates that some districts are ready to engage in an elimination phase. Twelve higher performing districts had been moved from Stratum 1[420] to Stratum 2, but this 'scaling back' strategy backfired following the 2022 flooding in which malaria cases surged in these districts due to insufficient planning, including inadequate assessment and investment in residual capacity and systems post-scale back. The ongoing transmission as described in Section 9.1.2 above remains a matter of concern.

RSSH

Stakeholders reported ongoing efforts to strengthen public infrastructure, capacity and coordination to support programming, though they articulated persistent challenges related to poor human resources for health to ensure effective delivery of interventions. There has been an increase in reported cases of malaria due to an increase in engagement of public health facilities and of private health facilities (15 private health facilities per district for diagnosis, case management and reporting), implementation of updating reporting tools as well as increased capacity of the Directorate of Malaria Control (DOMC).[421] In particular, reporting though the private sector has been cited as a key success, with a 50% increase in the number of confirmed malaria cases reported from private health sector facilities alone between 2016 and 2018.[422] The proportion of confirmed malaria cases that received first line treatment at public and private health facilities has been reported at 98%, exceeding the target of 80%. Over the past six years, there has been a massive scale-up in public facilities at all levels, with training and government infrastructure improvements, under the program specific RSSH components. Public sector program implementation, malaria surveillance system and monitoring capacity has been enhanced at the district level, with one malaria focal person per district to support program implementation. This approach has been successful, with more regular reporting and the submission of slides for microscopy centres. The KIs opined that the quarterly inter-district reviews followed by semi-annual provincial meetings have proven effective for coordination, and this mechanism was implemented across all Stratum 1 districts. The private sector was reported to have witnessed scale-up of Malaria and TB services through private healthcare providers in 10 districts in 2016-17, followed by 15 more covering all Global Fund-supported 63 districts and 40 private centres in each of the Global Fund districts from 2021 to 2023.

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[417] Based on Global Fund internal documents (confidential)

[418] Global Fund (2023). Country DNA factbook

[419] *Ibid*

[420] The Malaria Programme has classified high burden and high priority districts as Stratum 1 districts and most resources are directed towards these districts. Stratum 2 districts are lower in priority and burden of disease and therefore lesser resources are made available to these districts.

[421] Based on Global Fund internal documents (confidential)

[422] Global Fund (2020). Pakistan Funding Request Form_Malaria

However the Human Resources for Health (HRH) challenges within the programme are multifaceted, particularly with the expansion of districts to 72 in 2017.

RSSH support provided opportunity for enhancing HRH capacities and strengthened HMIS However, some challenges persist in including the limited focus on HRH strengthening to support malaria service provision, as the Global Fund is instead investing in the government's existing infrastructure. Engaging the private sector has also presented some challenges, including the limits of incentives and loose reporting regulations, leading to non-compliance with case reporting and record maintenance in only 20-30% of centres, necessitating changes.[423]

RSSH investments such as Health Resources for Health (HRH) strengthening efforts through the use of community health workers (CHWs) such as Lady Health Workers (LHWs) as well as efforts to consolidate the HMIS are promising however key elements are not allocated sufficient budget. LHWs are actively involved to support malaria interventions in both diagnosis and treatment and play a crucial role in the TB referral mechanism, raising community awareness and identifying suspects for further action. Stakeholders reported recent reprogramming efforts that aim to better integrate management of TB, malaria, and COVID-19 with the support of LHWs and CHWs. Under the Global Fund's private PR initiative, piloted in six districts in 2021, there have been challenges faced, particularly in Khyber Pakhtunkhwa (KP) and Balochistan, where the physical presence of LHWs has been a hindrance, yielding mixed success. A proposed pilot, accepted by Global Fund, suggests involving Community Health Workers (CHWs) who will be volunteers, alongside LHWs, for early warning and diagnostics. Thus two models are being explored: one involving only LHWs and the other incorporating CHWs utilizing the existing network of organizations like National Rural Support Programme (NRSP) and Balochistan Rural Support Programme (BRSP), engaged in microfinance activities. The main role of CHWs is in the community, which is being planned to make up for the 30-40% shortfall of HRH. Exploring how these established volunteers can be empowered through financial support and capacity-building initiatives to contribute to the management of TB, Malaria, and COVID-19 is being explored with a view their role will include conducting Rapid Diagnostic Tests (RDTs), provide initial treatment, and make referrals as needed. Although this approach has promising results, the overall RSSH allocations are low, with just 0.11% allocated for community systems strengthening.[424]

Whilst an official approval for the CHW strategy is awaited form government, concerns remain over the sustainability and reliability of these initiatives since they depend upon volunteer CHWs albeit under NRSP and BRSP micro-finance programmes for iCCM.

In addition, since June 2019 a malaria module was developed and is functioning within the DHIS 2 with the server hosted at CMU. It was the first to go online and has been used for reporting to Global Fund since 2020. There are >4000 sites from where data on malaria originates leading to a huge dataset. Initially the database which was excel-based presented challenges in managing huge datasets but now with the use of DHIS 2, data handling and analysis is more reliable and issues with database accuracy and management have largely been resolved. Due to floods, weekly reporting has been instituted since May 2023 and working successfully for both the public and private PRs. The success of this concept in supporting all three diseases and building a referral mechanism remains to be seen. The engagement of Lady Health Workers (LHWs) and the progress of the Management Information System (MIS) in outreach and the Reaching the Sustainable Development Goals (RSSH) program are integral components of the Tuberculosis (TB) initiative. LHWs play a crucial role in the TB referral mechanism, raising community awareness and identifying suspects for further action.

9.2.3. Funding model and business processes

CCM and CMU structures and functioning

The Country Coordinating Mechanism (CCM) in Pakistan suffers from persistent changes in top leadership and thereby weakness in vision and strategic direction. Frequent changes in CCM leadership are recognised as the root cause for the lack of vision and direction by the CCM for strengthening of national programmes. Rapid change in top leadership has become a rhetoric and is used as a reason to explain the lack of strong leadership exhibited by

[423] Based on Global Fund internal documents (confidential)

[424] Based on Global Fund internal documents (confidential)

the national programmes. It is contended that rapid postings and transfers is a known and well-established feature of the public sector in Pakistan and will not change despite decades long advocacy against it.

Stakeholders have raised some issues hindering effective coordination including the lack of a robust mechanism for effective collaboration with provinces and poor engagement of private actors through the CCM. Challenges were indicated by the stakeholders, particularly within the coordination framework. The transition to a devolved system has introduced obstacles, notably impacting the coordination landscape. Pre-devolution, national programmes played a vital role in effectively coordinating with private sector partners and monitoring ongoing efforts. However, the post-devolution period has witnessed a weakening of this coordination aspect, underscoring the urgent need to establish a robust mechanism for effective collaboration with provinces. The CCM serves as the designated forum for coordination. While the CCM has a defined role, stakeholders, especially those involved in private sector engagements, have identified weaknesses as noted above. Having just completed years of training and capacity building for the CCM, it was acknowledged that while the CCM plays a vital role, the intrinsic challenges in the country's coordination processes need innovative solutions. This underscores the need for targeted and responsive initiatives to bolster the effectiveness of the CCM and strengthen its role as a cornerstone for cohesive coordination in the complex post-devolution landscape.

The Common Management Unit (CMU) at federal level facilitates the coordination, funding and monitoring of all three national programmes, however stakeholders have highlighted a number of issues with the CMU including a lack of leadership and capacity as well as limited funding hindering it effectiveness. The CMU, housing all three national programmes for HIV, TB and malaria, was established under the MoNHSRC for monitoring and supporting implementation across the country and acts as the main focal point for coordination with the Global Fund. The challenges, as per key informants, pertain to the overall implementation structure of the country and coordination issues between the public and private sectors. The CMU assumes crucial responsibilities encompassing strategic planning, coordination, central procurement, and grant management for the Global Fund. By centralizing the PR function, the Global Fund benefits from streamlined processes and enhanced collaboration, making it more operationally efficient compared to a scenario where each province functions as an independent PR. The extensive provincial involvement is however recognised with provincial governments acting as sub-recipients (SRs) to support implementation of the programmes at provincial level. This consolidation ensures a more cohesive and coordinated approach, addressing challenges associated with numerous provincial PRs.

However, given that the funding for CMU is not adequately shouldered by government resources, the sustainability of CMU needs to be carefully reviewed. At the same time concerns have been raised about the lack of leadership and strategic direction given by CMU for the national programmes and by extension to the provincial programmes. Capacity issues include limited human resources and lack of strategic collection, review of evidence and response limit the effectiveness of the CMU. Given devolution, the CMU needs to enhance its role to that of a vibrant and technically advanced centre that strengthens the devolved units as compared to the more limited role of grant development and management for Global Fund, central procurement and reporting.

Grant management and PR relationship

The dynamics of accountability and the role of UNDP in the context of the HIV response in Pakistan is complex. The appointment of UNDP as the HIV Principal Recipient under the ASP has heightened tensions within the government. Notably, the MoNHSRC and the National AIDS Control Programme (NACP) should continue to play a pivotal role in leading discussions including scrutinizing evidence related to the HIV epidemic, strategically utilizing existing resources and partnerships (including UNDP), and addressing the most urgent issues and challenges for Pakistan’s HIV response. The decision to invoke the ASP in the Global Fund Pakistan portfolio in 2020 was driven by concerns about recent programmatic and operational risks. Designed to safeguard investments, enhance program implementation, and combat stagnant epidemiological trends in tuberculosis and HIV responses, the ASP sought to redirect discussions. The subsequent involvement of a non-government PR is seen as less favourable by many country stakeholders and there are lingering uncertainties among country stakeholders about whether public or private entities should act as Principal Recipients (PRs). Stakeholders view a critical task now is to thoroughly reassess and address the rationale behind implementing the ASP, however issues related to lack of commitment, leadership, and capacity at the national level remain. More detailed recommendation on this aspect is beyond the scope of this study but discussions need to be matured and solutions developed.

Similarly, the rhetoric of devolution, and the inferred less than adequate capacity of the provinces, has been omnipresent in most all discussions with the conclusion that therefore the national tier is necessary to bridge leadership, strategic and coordination gaps. The relationship of UNDP with the provincial SRs is good and provincial efforts within limited resources, demonstrate a positive view of their commitment. The current model responds to Global Fund analysis that risk of provinces as PRs were insurmountable and administratively burdensome. However, given that devolution has been in place for more than a decade there is an evidenced need for efforts to assist the provinces in achieving the level of capacity and quality that enhances their ability to not only implement with excellence but also fully take charge of their responsibility to plan, resource and execute their contextually appropriate strategies. Despite this challenging context, **the relationship between PRs/SRs and the Global Fund was indicated to be robust, characterized by responsiveness and collaboration. This partnership has been instrumental in navigating the complexities of infectious disease control in Pakistan.**

Dual track financing through public and private PRs has helped enhance the complementarity between the government and private implementers, however stakeholders shared that the division of labour between PRs has been suboptimal and could be improved. Stakeholders pointed out a basic flaw in the structure of the Global Fund grant as division of tasks between the public and private PRs is based on districts rather than technical role. This means that the private PR is managing whole districts including government facilities which creates disparity in the minds of public health facilities as to why they are being managed by a private entity and creates challenges in streamlined performance. The malaria programme therefore had been advocating a matrix structure where a private partner is responsible for private facilities and government PR is responsible for public facilities.

The LFA is reported to have played a useful role in the Global Fund's support for strengthening programs. Stakeholders reported a good relationship with the LFA, particularly in the context of TB. There were some views the LFA may exhibit some bias towards the private sector, as recommendations from this sector are perceived as being better received, though despite this perception, the relationship with the LFA is positive and improved, and is characterized by mutual cooperation and a shared commitment to the success of the program.

Stakeholders expressed a need for flexibility to reallocate excess budget arising from fluctuations in USD rates to support grant optimisation – such as piloting new interventions relevant to the country context and emerging evidence. In the context of financial management, the Global Fund grant presents an opportunity for optimization. Although the use of foreign exchange was defined in both the previous and updated GF budgeting guidelines, country stakeholders interviewed did not express an awareness of mechanisms permitting grant recipients to reallocate excess budget arising from fluctuations in USD rates. These stakeholders expressed such reprogramming could be used for piloting alternative interventions relevant to the country context and emerging evidence. Whereas updated Global Fund Guidelines for Grant Budgeting published in 2023 increase PR flexibility in reallocating budget, respondents in this case study were not (yet) aware of this development.[425] This adaptive financial approach would enhance the flexibility and efficiency of the programs. Despite these challenges, the relationship between PRs/SRs and the Global Fund was indicated to be robust, characterized by responsiveness and collaboration. This partnership has been instrumental in navigating the complexities of infectious disease control in Pakistan.

Sustainability

Sustainability of the HIV response is characterized by high dependence on donor financing and internal challenges including tension regarding management of the HIV grant. Whist there is wide recognition of the instrumental role of external funding to support effective implementation of national HIV responses, the high dependence on external funding has also been criticized by some stakeholders, who argue that it stifles the development of sustainable and locally-led HIV initiatives.

Whilst there are trade-offs in UNDP's role as the HIV PR, concerns remain about the agency's capacity to effectively manage the HIV response under the current budget structure and staffing levels. Recent budget cuts have further exacerbated these challenges, potentially compromising the PR's ability to deliver on its objectives and ensure the

[425] Global Fund (2023). Guidelines for Grant Budgeting
https://www.theglobalfund.org/media/3261/core_budgetinginglobalfundgrants_guideline_en.pdf

sustainability of HIV programs in Pakistan. In addition, stakeholders have reported internal challenges in the management of the grant which has led to inefficiencies and added challenges. An example cited was burdensome processes such as a suboptimal budget structure, with over 1300 line items in the UNDP Global Fund budget (this transcends the UNDP budget and is understood to be applicable to all Global Fund grants as per budgeting guidelines), requiring approvals from the Global Fund for even minor issues and adding substantial complexity and workload for implementers. The trade-off in reduced fiduciary risk is increased inefficiency in use of resources, and stakeholders noted this approach also hinders long-term planning and investment in core HIV prevention and treatment programmes. Additionally, the lack of regularization for Global Fund positions within MoNHSR&C has led to high staff turnover and a lack of continuity in programme implementation.

There are challenges in capturing malaria domestic contributions accurately, with responses underway to address this issue. The existing system for capturing government contributions to malaria did not capture all provincial contributions. This is further complicated by the fact that significant investments from provinces like Sindh and Punjab, including those not classified as 'malaria' but those which include malaria components, are not adequately reflected in the larger programme. The GC7 grant is reported to address these gaps by capturing provincial contributions through the Controller General Accounts (CGA), though it will take time. CGA are said to be centrally maintained and will have details of all funding and spending from provinces and reflecting the district level.[426]

Sustainability challenges involve donor dependency, emphasizing the need for integration of TB control into primary healthcare and fostering community engagement and ownership. Stakeholders flagged that the prevalent dependence on external funding sources poses a looming risk of programme disruption should funding decrease or become uncertain. The integration of TB control into the broader framework of primary healthcare emerges as a pivotal consideration for long-term sustainability. Community engagement and ownership, fostered through Strategic Initiatives (e.g. Finding Missing Cases), are paramount in effecting sustained behaviour change and ensuring adherence to treatment regimens. These measures are vital for long-term sustainability, ensuring continued progress in TB control efforts in Pakistan.

9.2.4. C19RM

Global Fund investments through the C19RM have been used to support COVID-19 responses and contributed to mitigate its impact on the diseases. Pakistan was awarded US$ 107.6 million[427] through C19RM, earmarked for COVID-19 control and containment efforts, strengthening health and community systems, mitigating the impact on disease programs, and effective program management. C19RM funds were significantly allocated for case management, clinical operations and therapeutic interventions, with half of the funds allocated for the delivery and installation of 36 PSA oxygen plants to meet critical healthcare needs. Other support under C19RM included diagnostics, strengthening lab networks for integrated disease testing, provision of incinerators, and supply of personal protective equipment (PPE) for effective infection control. The grant utilization rate stood at around 9% as of June 2022, with the funds managed through the TB program's government Principal Recipient (PR) grant, the National Tuberculosis Programme (NTP).[428] The strategic redirection of resources, encompassing bidirectional C19RM and TB testing, as well as heightened community engagement, demonstrated a thoughtful allocation of funds. Mercy Corps engagement of the private sector for the TB program emerged as a significant contribution, capitalizing on C19RM finances to catalyse onboarding of private sector TB care providers, improving skills development and diagnostic capacity using digital platforms, and deployment of mobile outreach units. Apart from the inputs from the TB PR, other stakeholders were not available to provide additional evidence on C19RM relevance and performance.

9.2.5. Partnerships

There is good coordination between the state and non-state TB and malaria PRs. Despite design challenges in the governance of the malaria program, the malaria PRs have made efforts to effectively leverage their

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[426] The CGA was not available at the time of this evaluation, therefore, no assessment of any change in domestic contributions could be made.

[427] This figure includes C19RM 2020. The value of the C19RM grant is US$ 102.9M.

[428] Mercy Corps also delivered some C19RM activities but the funds are managed through NTP.

respective comparative advantage. Partnership between the public and private malaria PRs was considered to be successful and complementary. It was recognised that this was not due to the structure of the grant but more attributable to the will of each partner to recognise the strengths and needs of the other and extend support. For instance, to circumvent impediments of slower government processes, the public PR leveraged the faster management and decision-making systems of the private partner (Indus Hospital & Health Network) in fast tracking provision of health kits and implementation of bednet campaigns. While the public and private PRs for TB maintain positive relations and mutually complement their roles, the private PR has emphasized challenges in coordinating monitoring and reporting activities with provincial TB programs, particularly in the aftermath of the devolution.

Still, the design of the malaria programme which splits PR responsibilities geographically and not based on comparative advantage, is an area of friction. The public PR has expressed concerns related to the distribution of responsibilities within the Global Fund grant whereby the PRs are responsible for all interventions and management of public and private health facilities in their allocated districts. There was a report that such distribution is creating issues with government health facilities under the management control of the private PR as government staff find it difficult to navigate duplicative reporting lines and variances in public and private sector management methods and norms. This reduces overall opportunity to leverage technical comparative advantages of the PRs. The Malaria Programme is convinced that a technical distribution of responsibilities and resources would generate much better results.[429]

Clarity and improvement in the way UNAIDS coordinates with UNDP would bring cohesiveness in the HIV response. UNAIDS plays an important role in coordinating the national HIV response. Tensions between UNDP and UNAIDS and the exclusion of UNDP from critical discussions are noted. Better coordination among stakeholders for an effective HIV response is needed.

9.2.6. Gender, human rights, equity & communities (crosscutting)

The focus on community investment is highlighted as a key strategy to better reach communities however stakeholders voiced there continues to be limited interventions to mitigate gender-related disparities and enable equitable access to services. Stigma and discrimination against people living with HIV and people from key populations remain the most challenging barriers to controlling the epidemic and for people to access HIV prevention, testing, treatment and care services. The Pakistan Demographic and Health Survey (PDHS) 2017-2018 found extremely high levels of discriminatory attitudes against people living with HIV among 61% of women and 60% of men. Sex between men, sex work, and drug use are criminalized, with punishments including the death penalty. People from key populations experience severe stigma and discrimination, including highly discriminatory attitudes from health workers. Access to justice for most key populations and people with HIV is very challenging. In 2018, a new law was passed which included recognition of transgender people and protection of their rights, in line with the constitution; this includes the right to inheritance.[430]

The social context in Pakistan is highly challenging to an effective HIV response. High levels of stigma impede access to quality services and information. The effects of this stigma on disclosure of HIV status and treatment adherence further contribute to high levels of loss-to-follow-up and weak viral suppression among those on ART.

The focus on community investment by the Global Fund and the government is identified as a key strategy for eliminating malaria especially as the reduction of disparities in access to services in hard-to-reach areas remains a challenge. While Human Resources for Health (HRH) shortfalls persist, especially at the community level, efforts are underway to address the challenges posed by stigma and discrimination in the context of the HIV epidemic among key populations at risk. Despite strides in integrating gender-related issues to improve access and participation, stakeholders have raised concerns about the insufficiency of these efforts, acknowledging that discriminatory attitudes, prevalent among healthcare providers, the justice system, and wider society in Pakistan, pose significant barriers to controlling HIV.[431] Strong gender-related disparities persist, and there is limited concrete evidence of

[429] This alternative arrangement was not proposed in the recent GC7 submission.

[430] Based on Global Fund internal documents (confidential)

[431] Based on Global Fund internal documents (confidential)

interventions targeting these issues, including the broader challenges related to human rights, which hinder progress in the programs. The funding requests, including RSSH elements, have also largely remained silent on interventions to address human rights and gender-related barriers. While the planned interventions, outlined in the Prioritized Above Allocation Request (PAAR), include engaging with key stakeholders and enhancing the capacity of service providers, the analysis contends that these efforts may not be comprehensive or scalable enough to tackle the entrenched challenges.

9.3. CONCLUSIONS AND SUGGESTIONS FOR STRENGTHENING

The Global Fund is pivotal in addressing Pakistan's health challenges outlined in the National Health Vision (NHV), aligning efforts to combat HIV, TB, and Malaria. Stakeholders acknowledge the Global Fund's alignment with national and provincial priorities and specific disease control strategies. The Country Coordinating Mechanism (CCM) faces challenges due to persistent changes in top leadership, resulting in weakness in vision and strategic direction. Initiatives to address gender-related disparities are seen as insufficient and HRH shortfalls at the community level remain a challenge despite recent investments to strengthen community health workforce through CHWs and LHWs to support program delivery in communities.

Stakeholders express concerns about the influence on governance of programmes in response to Global Fund requirements, coordination issues, and the funding model's lack of flexibility as perceived by the grant recipients (indicating potential low awareness of guidance issued). Despite challenges, the relationship between PRs/SRs and the Global Fund is characterized by responsiveness and collaboration. The HIV response also faces political and technical challenges, with coordination gaps among UNDP, UNAIDS, and syndication approaches, necessitating a unified national approach.

The Global Fund HIV grant is relevant to Pakistan's epidemiological needs but encounters challenges in broader governance and capacity-building issues. Positive developments include decentralization of services and increased coverage through scaling up of ART centres. However, challenges persist in low testing rates, limited progress in key areas, and unequal access to services. Stigma and discrimination are significant barriers in the HIV response, while

TB faces challenges in detection, treatment, and healthcare system constraints, particularly for drug-resistant TB. Positive developments have been seen in increased case notifications through private health facilities and community-based interventions. Challenges though exist in detecting and managing drug-resistant TB, sample movement delays, and inadequate training for healthcare workers. Sustainability challenges involve donor dependency, the need for integration into primary healthcare, universal implementation of case notification, and fostering community engagement for long-term success.

In malaria control, despite progress in reporting, challenges persist including funding gaps, shifting priorities, coordination issues post-devolution, and concerns about the sustainability of disease control efforts amid a rising burden in the aftermath of the catastrophic floods. Stakeholders appreciate the multi-faceted approach under the National Programmes and Global Fund grant, and advocate for a matrix structure between public and private partners to enhance performance and streamline operations. The expansion to 77 districts with Global Fund support raises questions about HRH, with no dedicated additional funding. Lady Health Workers (LHWs) play a crucial role in both diagnosis and treatment, but challenges exist in engaging the private sector.

In light of the above findings, this report highlights the following suggested areas for strengthening.

Funding model and in country coordination:

Considering that rapid postings and transfers is a known and well-established feature of the public sector in Pakistan and will not change despite decades long advocacy against it, it is prudent and opportune to start developing mechanisms and strategies to respond to such systemic idiosyncrasies. Suggested efforts include:

1. Explore the establishment of an enhanced mechanism outside of LFA to undertake a purposive institutional assessment of national and provincial tiers with a view to strengthening disease responses and formulate scenarios that best respond to country needs.

2. Extend fast track technical assistance to CCM, CMU and provincial tiers for addressing critical governance and technical issues that will allow sharply focused evidence-driven response development and implementation. Given devolution, the CMU needs to enhance its role to that of a vibrant and technically advanced centre that strengthens and facilitates the devolved units as compared to the more limited role of grant development and management for Global Fund, central procurement and reporting.

3. Through the existing Global Fund funding model and the levers at its disposal (e.g. policies, catalytic initiatives), encourage more robust and effective collaboration with provinces, especially in the post-devolution landscape.

4. In view of the structural issues emanating from devolution and repeated postings and transfers noted in this case study, there is a need to further strengthen the CCM and address perceived weaknesses, building on work already underway where a consultant has been providing support to CCM for several months.

5. In line with Global Fund policy frameworks, provide support to country grant recipients to facilitate their understanding of how to utilise Global Fund financial mechanisms effectively to reallocate excess budget for flexibility and efficiency in programme implementation. This includes optimising financial management aspects to better respond to fluctuations in USD rates within Global Fund grants.

HIV Awareness and Governance:

6. Encourage country grants to strengthen awareness and access to HIV testing services, focusing on bridging populations and addressing broader country needs related to governance and capacity-building.

7. In the context of the ASP, take steps to address concerns regarding the Global Fund's requirements for governance and structure of HIV responses.

TB Control Strategy:

8. Encourage country partners to improve detection and management of drug-resistant TB (DR-TB) by addressing delays in sample movement, referral, and providing additional training for healthcare workers.

9. Support country efforts to harmonize performance-based incentives, conduct a national TB prevalence survey, and strengthen data collection and reporting mechanisms.

10. Encourage the integration of TB control into primary healthcare, foster community engagement, and promote ownership for long-term sustainability.

Malaria Programme Structure:

11. Consider adopting a matrix structure for the Malaria programme, where private partners handle private facilities, and government Principal Recipients (PRs) manage public facilities. This aims to streamline performance and reduce disparities in the management of health facilities.

Enhanced Reporting Mechanism:

12. Continue to support and evaluate the success of the online reporting mechanism from the malaria module to DHIS 2, ensuring its effectiveness in supporting all three diseases and building a reliable referral mechanism, and regularly assess the accuracy and management of the database.

A.18. List of references

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A.19. List of interviews

The case study was informed through consultations and focus group discussions with 7 stakeholders from the following entities:

Stakeholder category	Entity
CCM	Health Services Academy
PRs (National and Civil Society)	National TB Programme, Central Management Unit
	National Malaria Programme, Central Management Unit
	UNDP
	Nai Zindagi Trust
	Mercy Corps
LFA	KPMG
Global Fund Secretariat	Global Fund Country Team[432]

[432] The Global Fund Country Team were not available for an interview but were consulted to support the planning of the case study.

10. PHILIPPINES CASE STUDY REPORT

10.1. INTRODUCTION

10.1.1. Key country characteristics and HTM context

The Republic of the Philippines, an island archipelago in the Western Pacific, is classified as a lower-middle income country with a population of 113.9m (2021)[433] and is made up of over 7,000 islands[434]. The Philippines population is largely young with a median age of 25.7 in 2020[435]. The geography of the Philippines makes it highly susceptible to natural disasters and climate change, including volcanic and seismic activity and frequent typhoons. Its Gross Domestic Product (GDP) per capita is US$ 3,550 (2021) [436] and GDP growth is, along with Vietnam, one of the fastest in the region. The national Department of Health (DOH) is the overall technical authority on health and is tasked with protecting and promoting health and wellbeing of citizens. Its mandate is to set national policy direction standards and guidelines on health and regulate health services. It has responsibilities for providing tertiary and some specialist services and provides support to Local Government Units (LGUs) through the provision of technical and operational assistance for their health services[437].

The Philippines has made progress towards achieving Universal Health Coverage (UHC), underpinned recently by the passing of the Philippine Universal Health Care Act (also known as Republic Act 11223) in 2019. While implementation of the UHC Act has been delayed owing largely to the dominance of COVID-19, progress has been made and this is now a central driving force. The Act aims to support universal access to a comprehensive care package without financial hardship to all citizens. UHC is supported by PhilHealth, the national social health insurance program, established in 1995. PhilHealth is progressively expanding coverage with the aim of covering all people in the Philippines with basic and supplementary service packages[438]. PhilHealth also has a role in setting policies and regulations to uphold quality of care and is set up to receive and manage grants and development assistance[439].

There has also recently been some significant restructuring of the DOH to enable a more horizontal approach to health care delivery, orientated around the 'life course' approach. While this is broadly popular, the shift has been a significant process of adjustment as roles internally have been reshaped and partner engagement processes have been altered[440]. In particular, the disbanding of vertical disease programs has led to a shift in engagement for the Global Fund. Though disease focal people remain in place, this restructuring has been challenging for disease-specific planning, coordination and leadership in the transition period, though this is expected to improve as the restructuring becomes more embedded. These challenges were further hampered by the delayed appointment of the Secretary of Health during the strategic review period which slowed leadership and decision making within the DOH, though this appointment is now in place.

Alongside the UHC agenda, a full devolution process, enshrined in the Constitution[441], has commenced across the strategy review period. The devolution process enables greater programmatic and financial autonomy to LGUs, and in 2020, LGUs were receiving up to 60% of health funds[442]. Tensions exist between the UHC Act and devolution processes in strategy setting and implementation, in that the devolution process supports LGUs to receive non-earmarked funding for health (and other areas), while the UHC Act outlines a central role for the DOH in direction

[433] World Bank data, 2021
[434] https://www.sciencedirect.com/science/article/abs/pii/B9780081008539000518
[435]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9368427/#:~:text=The%20Philippines%20has%20taken%20great,%2D19%20pandemic%20%5B1%5D.
[436] World Bank, 2022
[437] https://ro1.doh.gov.ph/transparency-seal/9-transparency/2-mandates-and-functions
[438] Netherlands Enterprise Agency (2021). Healthcare in the Philippines
[439] https://www.philhealth.gov.ph/about_us/mandate.php
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[441] https://issuances-library.senate.gov.ph/sites/default/files/2021-08/20210601-EO-138-RRD.pdf
[442] Republic of the Philippines National Economic and Development Authority. Commission on Population and Development Devolution Transition Plan. 2022-2024.

setting for health. Emphasis is now being given to strengthening coordination at the local level to finance and steward health services[443].

Domestic government health expenditure has been steadily rising since 2010, after a decade of slow decline. Health expenditures comprised 5.6% of its gross national product (GNP) in 2020, from 4.7% the previous year 2019.[444] Government schemes and compulsory contributory health care financing schemes comprised 45.7% of the source of spending, with household out-of-pocket payments still high at 44.7% (the balance is attributed to voluntary payment schemes). In 2020, government and contributory financing schemes overtook household out-of-pocket payments for the first time.[445]

HIV context: The Philippines has the highest incidence of HIV in the Western Pacific Region, with an increase in daily incidence of 418% between 2010 to 2023.[446] Cases are also predicted to increase 200% by 2030[447]. Vulnerable populations are disproportionately affected (92% of those with HIV represent vulnerable populations) with men who have sex with men (MSM) aged between 25-34 the most affected. Since 2020, incidence has risen and late presentations are a major concern, with almost a third of confirmed cases having advanced HIV in January 2023[448]. The overall prevalence is low with estimates indicating about 160,000 people living with HIV in 2022. Coverage of anti-retroviral therapy (ART) is relatively low at 41%.[449]

TB context: The Philippines is ranked fourth globally for TB incidence, accounting for 11% of cases worldwide[450]. Incidence in 2022 was estimated at 737,000, with 2.3% with MDR-TB. Treatment coverage is estimated to be 59%[451]. The Philippines is far off reaching 90—90 targets, with only 43% of new TB cases notified in 2021 (having dropped in 2020-2022), and the treatment success rate at 76%.[452] Nearly 10 million people reside in urban slums[453] and social determinants are major drivers of TB endemicity. Filipinos aged 0–24 years comprise a substantial proportion of the Filipino population with TB (27·3%). This age group have also been shown to be more likely to discontinue TB treatment, compared with those older than 24 years.[454]

Malaria context: Malaria has greatly decreased in the Philippines over the last two decades with incidence dropping from 1.8 per 1,000 population at risk to 0.2 in 2021[455]. Malaria is now restricted to one province in the Philippines (Palawan) and targets are in place with the aim of achieving elimination by 2030. There is not however a consistent downward trend in incidence, with cases in Palawan having risen in recent years, especially since the onset of COVID-19. There were an estimated 10,609 malaria cases in 2021, 3,600 for 2022 and a rise to 4,300 cases reported at the time of study (January-September) in 2023.[456] The recent rise is largely attributed in-country to post COVID-19 mobility increases and shifts in weather patterns, though shifts in data collection and validity could also be factors, such as the strengthening in community health workers (CHW) data recording efforts.

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[444] Philippine Statistics Authority, 2020

[445] Capuno J.J., Kraft A.D., O'Donnell O. Filling potholes on the road to universal health coverage in the Philippines. Health Syst. Reform. 2022

[446] https://www.unaids.org/en/regionscountries/countries/philippines

[447] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10224495/

[448] Gangcuangco LMA, Eustaquio PC. The State of the HIV Epidemic in the Philippines: Progress and Challenges in 2023. Trop Med Infect Dis. 2023 Apr 30;8(5):258.

[449] https://www.unaids.org/en/regionscountries/countries/philippines

[450] Calderon JS, Perry KE, Thi SS, Stevens LL. Innovating tuberculosis prevention to achieve universal health coverage in the Philippines. Lancet Reg Health West Pac. 2022 Oct 6;29:100609

[451] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&iso2=%22PH%22&lan=%22EN%22

[452] DNA Factbook Philippines, slide 56.

[453] Department of Health, 2019 Philippines TB joint program review. Department of Health, Manila

[454] Snow K et al. Tuberculosis among children, adolescents and young adults in the Philippines: a surveillance report. Western Pac Surveill Response J. 2018; 9: 16-20

[455] https://data.worldbank.org/indicator/SH.MLR.INCD.P3?locations=PH

[456] Global Fund (2023). Philippines DNA Factbook

10.1.2. Summary of Global Fund support

The Philippines is categorised as a High Impact Country under Global Fund classification. For 2017-2022, there were three grant recipients: Save the Children (GC5 only, HIV only)[457], Pilipinas Shell Foundation, Inc. (PSFI, malaria and HIV) and Philippine Business for Social Progress (PBSP, TB). For GC6, PSFI was Principal Recipient (PR) for all HIV/AIDS and malaria investments, and PBSP for TB. The signed amount of funding for GC5 was US$ 141.2 million, increasing 45% to US$ 204.2 million for GC6. This includes US$ 11.4million for C19RM in GC5 and US$ 45million for GC6. TB has been the dominant focus for disease investment across GC5 and GC6. Breakdowns per disease and grant cycle are provided in Table 10.1 below.

Table 10.1: Balance of signed investments for GC5 and GC6 (inclusive of C19RM)[458]

	GC5	GC6
HIV/AIDS	US$ 11.6m (8%)	US$ 24.7m (12%)
TB	US$ 118.1m (84%)	US$ 171.7m (84%)
Malaria	US$ 11.5m (8%)	US$ 7.9m (4%)
RSSH	US$ 7.1m	US$ 12.4m[459]
TOTAL	*US$ 114.2m*	*US$ 204.2m*

Catalytic investments: Two Matching Funds (MFs) were funded for GC5 (US$ 11million) and three for GC6 (US$ 12million). HIV Human Rights and TB Missing People were priority MFs for GC5, with TB Missing People continuing into GC6, and HIV Key Populations and RSSH Human Rights also added. Philippines was eligible for 9 SIs in GC6[460]: Differentiated HIV Service Delivery, TB Missing Cases, CRG, HR, STE, CCM Evolution, SDI 1 South-South strategic support and learning, SDI 2 Community Led Monitoring, SDI 5 Strategic Private Sector Approaches. Philippines was part of one multi-country grant (MC) focussed on HIV through GC5 and GC6, namely the Sustainability of HIV Services for Key Populations in Southeast Asia Program (SKPA). The PR for the multi-country grant in the region was the Australian Federation of AIDS Organisations (AFAO) and the local recipient was LoveYourself.

10.2. KEY FINDINGS

10.2.1. Relevance of Global Fund investments

There was broad consensus that the Global Fund's investments are well aligned with DOH strategic plans and priorities and demonstrate good complementarity with other donors. In-country stakeholders generally considered the scope of the Global Fund's investments through GC5 and GC6 to be guided by, and in line with, national health priorities and needs, as well as informed by broad consultation across partnership groups. For TB, for example, the Global Fund strategy was underpinned by the National TB Control Program. For HIV, investment is well aligned with the Philippine Health Sector HIV Strategic Plan 2020–2022, and the scope of the Global Fund's investment has evolved and grown as incidence has risen across the strategy period. In particular, this includes an enhanced focus on addressing key gap areas identified and better understood through GC6, such as relating to gender and human rights. The National Strategic Plan for the Control and Elimination of Malaria in the Philippines 2020-2022[461] is focused on achieving elimination, which is aligned with the Global Fund's focus. There are concerns however as to whether there is sufficient Global Fund investment, flexibility in approach and medium-term view to effectively reach the elimination end-goal, which is focused on case reduction in one remaining province.

The Global Fund's investment has aimed to respond to and keep pace with evolving DOH priorities, including the transition to a more horizontal, UHC focus, and devolution processes, though uncertainty remains on how

[457] The PR for HIV changed from Save the Children to PBSP in 2020.

[458] These numbers are from DNA factbook, slide 21, signed amounts.

[459] Global Fund (2023). Philippines DNA Factbook (slide 24). These figures were subsumed in TB grants, not a standalone grant.

[460] Global Fund (2023). Spreadsheet on GC6 SI Eligibility for focus countries. Prepared by CID team.

[461] https://www.apmen.org/sites/default/files/all_resources/Philippines_National%20Strategic%20Plan_2020-2022.pdf

this will be managed in future cycles. The Global Fund has engaged proactively with the DOH around the scope of its investment in line with overall DOH restructuring and appears to be committed to finding solutions to maintain alignment with DOH investment priorities. The Global Fund's investment has remained three-disease focused through this strategy period, despite the disbanding of the disease programs by the DOH. For now, there remains disease focal people who act as key contact people for the Global Fund, though it is unclear how static these posts are and how this will shift going forward as the UHC and 'life course' approach is further entrenched and operationalised. How the Global Fund will maintain effective engagement and technical support to integrated departments and processes remains to be determined. Achievement of disease specific targets will also increasingly rely on integrated processes within the DOH and the overall strength and resilience of the service delivery system. How the Global Fund will fund wider systems strengthening is still to be clarified. Multiple in-country stakeholders have however commended the flexibility of the Global Fund in shaping and adjusting investments across grant cycles. Reprogramming has largely been done on a quarterly basis, with the aim of maintaining a high absorption of funds.

RSSH has not been a significant focus and there is a general perception that this has been under-considered. RSSH is also seen as increasingly important given the over-riding shifts in country towards UHC and devolution, and the enhanced heath security focus of the Global Fund. RSSH investments were limited through the strategy review period, though were increased from GC5 to GC6. RSSH allocations are fully incorporated into the TB grant. There was some consensus among stakeholders that while progress is being made under each of the disease grants, there are common health system challenges which are impeding (and will continue to impede) further progress in relation to three diseases unless they are targeted for more support and investment. These include low logistical supply chain capacity; ineffective procurement systems; variable data quality and timeliness; ineffective planning and review and data-based decision-making; and quality of care, including through integrated services. That there is no separate and focused RSSH allocation is seen as a limitation in the context of shifts towards UHC and PHC, integration of services, and devolution of management capacity to LGUs. In addition, climate related events and disasters remain a constant threat in Philippines, as one of the most disaster-prone countries in the world[462] and health system resilience is high on the agenda of the DOH (and other government departments). The Global Fund's enhanced focus on pandemic preparedness in the 2023-2028 Strategy[463] is seen as an opportunity to both boost and protect progress in relation to the three diseases, as well as to enable more effective preparedness in the case of future health emergencies – these are seen as complementary and mutually-reinforcing aims.

10.2.2. Progress and results achieved

This section provides an overview of the results achieved over 2017-2022. **Progress has been seen in relation to all three diseases across the strategy period, which is in large part attributed to the Global Fund given the scale of its investment.** Overall, a 41% increase in funding was seen between GC5 and GC6, to address gaps in, and scale, HIV/AIDS and TB efforts. Success in part was perceived to be focused on 'volume', for example Global Fund prioritising provinces with higher known HIV/AIDS burdens and investing in higher output-based programs which aimed to achieve higher and faster outcomes across the target population. Investment in malaria, on the other hand, decreased through the strategy period, based on the streamlined focus on achieving malaria elimination through targeted efforts in one province. While COVID-19 impacted and delayed implementation in the early phase of GC6, programs appeared to have regained momentum by the end of the grant cycle with benefits of the COVID-19 investments now being seen in relation to the core Global Fund investment. For example, procurement of GeneXperts to help diagnose COVID-19 are enabling further strengthening of TB diagnosis and are expected to boost diagnostic support to other infectious diseases in the future.

Grant ratings for the Philippines varied considerably across the strategy period, with HIV/AIDS ranging A2 - C2, TB ranging A2 – C5, and malaria A1 – B3. Grant ratings were fairly consistent and high (B1 - A1) for all diseases in the 2018 - 2019 period but all saw a drop in ratings during 2020, likely owing to COVID-19[464] (Table 10.2). The Philippines has seen high absorption of funds with 99% of funds absorbed across the GC5 and GC6 cycles. As indicated above, future and sustained progress will also be dependent on the extent to which the Global Fund's investments can be

[462] https://openknowledge.worldbank.org/entities/publication/d75af5f3-d370-540f-a00d-0868df722ac6

[463] Global Fund. Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028)

[464] Global Fund (2023). Philippines DNA Factbook. (A1 >100%, A2 90%-100%, B1 60-89%, B2 30%-59%)

harmonised with DOH efforts towards the strengthening of LGU capacity and the integration of services, as well as the linkage of various agents/activities with the uptake of LGU responsibilities.

Table 10.2 Grant performance evolution since 2019[32]

	2018		2019		2020		2021
	June	December	June	December	June	December	June
HIV PSFI	-	-	-	-	-	-	B1
HIV SC	B2	A2	A2	A2	B2	B2	
Malaria PSFI	B1	A2	A1	A1	B1	A2	A2
TB PBSP	B1	A2	B1	A2	B1	B2	B1

HIV

The scope and size of the Global Fund's HIV investment has increased considerably across the strategy period, to enable the testing of approaches targeting key populations. While progress is being made, the situation remains complex and GC7 will be key for applying learnings at a larger scale. While the Philippines is considered to have a low prevalence of HIV, the incidence of infection is growing, particularly among MSM and other key affected populations who tend to have late case presentation, as noted above. While cases have risen, underreporting of cases remains a significant challenge. In December 2018, the Philippine HIV and AIDS Policy Act of 2018 was passed, which repealed the Philippine AIDS Prevention and Control Act of 1998[465] and made HIV/AIDS services more accessible to Filipinos, opening up new opportunities for intervention[466]. The Global Fund has responded by increasing its HIV/AIDS investment by 4% of overall grant allocation from GC5 to GC6 (more than doubling the HIV investment in monetary terms). Across cycles, prevention has been the predominant focus of the Global Fund, with the DOH supporting treatment focused services. However, the Global Fund has provided support across the cascade including prevention, differentiated HIV testing, treatment care and support, TB/HIV and human rights, as well as COVID-19 focused investments in GC6. This increase across GC5 to GC6 is seen to have enabled an expansion of efforts focused across high-risk groups, such as MSM and transgender populations, and provided opportunity to address specific barriers across the treatment cascade – stakeholders have described a shift towards "*a whole of systems response*". Increases in funding have also supported the expansion of HIV services (across the cascade) from 9 to 50 provinces. There are also reports of an "*increasingly consultative, flexible investment approach"* which has enabled the 'testing' of various approaches. GC6 was seen as the "*sandbox cycle*" with learnings to be applied alongside the scaling up of a range of interventions in GC7. The Differentiated HIV Service Delivery Strategic Initiative provided a good opportunity to test specific initiatives relating to both HIV and C19RM in GC6 and is a good example of this approach[467].

The expansion of the investment has not been without challenges. Community-based organisations (CBOs) deliver many of the services and activities. While progress is clearly been made, there are concerns among some stakeholders that both outcomes and impact of their work is not sufficiently understood, and measurement, reporting and communication of results needs to be improved, both at localised levels (i.e. LGUs) and at aggregate levels through the PR. There have been efforts to address this, such as through quality spot checks during GC6 by the LFA, though the LFA's capacity to conduct these assessments is not well aligned with the expertise or understanding of program implementation. There has also been suggestion of the need to accelerate progress as relating to human

[465] Republic of the Philippines (2018). Republic Act No. 11166

[466] Ranada, Pia (9 January 2019). "Duterte signs law strengthening HIV, AIDS health services".

[467] FHI360 (2022). Review of Differentiated Service Delivery and Other Service Delivery Approaches for HIV Testing and Treatment in the Philippines.

rights and gender, and reports of some activity coordination and synchronisation issues across implementing partners.

The Government has progressively funded HIV/AIDS commodity procurement over the strategy period but stockouts remain a challenge. Across the review period, HIV/AIDS related commodities have experienced periodic stockouts. The Government agreed to progressively lead and fund ARV treatment and condom procurement across GC5 and GC6, alongside a progressive withdrawal of Global Fund support for these commodities, though the Global Fund continues to support procurement of pre-exposure prophylaxis (PrEP). It is noted that PEPFAR does also not support direct procurement of health products. While this transition is welcomed by stakeholders and seen as an important aim towards sustainability, periodic stockouts have compromised the realisation of this planned handover as the Global Fund has needed to step in to address the supply issues. While the Global Fund's responsiveness is appreciated, it was recognised that this is a key area which requires focused support going forward.

TB

In 2017, the Philippines launched the 2017–2022 Philippine Strategic TB Elimination Plan[468], with goals to reduce the TB burden by:

- Decreasing the number of TB deaths by 15% from 26,000 to 22,000;
- Decreasing the TB incidence rate by 12% from 554 to 488 per 100,000;
- Reducing catastrophic cost incurred by TB-affected households from 35% to 0%; and
- Enabling at least 90% of patients to be satisfied with TB services.[469]

Investment in TB has dominated the Global Fund's investment in the Philippines over recent grant cycles, including throughout this strategy period, with priority given to case finding. With key support of the Global Fund, 93% of the Philippines' National TB Program case notification targets have been achieved. Active case funding has been a key priority, with three approaches having been adopted as part of a complementary package: active case finding (mass screening in communities), enhanced case finding (deployment of CHWs to undertake specific, targeted sample collection and screening) and intensified case finding (potential cases receiving an XRay voucher).

Focus has also been given to private sector case notification, which whilst expensive, has reaped benefits. Case reporting from the private sector was previously very low, with reporting mechanisms also onerous and low incentives to report. However, with government shifts towards mandatory reporting for TB cases, the Global Fund has funded agents to support private sector providers in reporting of cases to generate a fuller picture of TB case detection and to encourage case reporting as regular practice within the private sector. While this approach has overall been effective and further scale up of efforts are planned for GC7, sustainability has been questioned given the effort remains parallel to the health system and consumes a large proportion of activity funds.

Treatment targets have also been improved, enabled in large part by the shift to shorter regimen treatments. There has also been a progressive transition to government procurement of all medication for sensitive TB, though the Global Fund continues to support MDR treatment. Laboratory capacity has also been strengthened with Global Fund investment, with a notable boost in the number of GeneXpert machines with now over 1,000 available in-country (alongside an additional 40 True Nat). The government has also committed to progressively covering costs of GeneXpert cartridge provision.

Despite increasing government spending on TB, a 40% funding gap for TB remains, which according to in-country stakeholders, impacts efforts across the cascade of interventions and reduces potential for case finding by 200,000 per year. It is also suggested that preventive efforts remain a particular gap. Despite the case finding successes, the near-stagnant incidence of TB in the Philippines highlights the complexity of this diseas[470]. To address the funding gap, the PR is focusing on efficiency to maximise impact and reach of interventions where possible, but the complexity of the TB challenge will require a sustained funding and engagement effort for some time to come.

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[468] Department of Health (2020). Updated Philippine Strategic TB Elimination Plan. Phase 1: 2020 – 2023.

[469] Department of Health (2020). Updated Philippine Strategic TB Elimination Plan. Phase 1: 2020 – 2023.

[470] Department of Health (2020). Updated Philippine Strategic TB Elimination Plan. Phase 1: 2020 – 2023.

Malaria

Malaria control efforts have progressed towards elimination across the strategy period, though concern remains as to whether Global Fund investment projections will adequately support elimination needs. Malaria incidence has reduced dramatically over the strategy period with elimination efforts focused in eight provinces in GC5 to five in GC6, and only one in GC7. The Global Fund has contributed notably towards the elimination of malaria across the strategy period and while aspirations remain for 2030 elimination targets, rising cases over the last year in particular have raised concern over the feasibility in reaching these targets. However, in line with the targets, the Global Fund is shifting to a transition strategy for malaria, with the phasing out of investment as seen across GC5 to GC6. Multiple stakeholders have expressed concern that current and future investments may not be flexible or sufficient to adapt to the fluctuation in cases and intensive, sustained effort required to reach elimination. Specific control approaches in the face of persistent malaria such as mass drug administration (MDA) options are currently being considered though the associated high costs are not aligned with planned investment phase out. There is increasing awareness in-country that elimination is no 'quick win' and there may be need for continued Global Fund investment to respond to specific challenges over more years than is currently anticipated.

RSSH

The RSSH investment is small, though saw some growth from GC5 to GC6, and is subsumed into the TB grant. That there is no separate allocation is seen as a limitation, especially given the UHC shift, as is discussed further in the Relevance section above. Data on specific effectiveness of the RSSH component is limited and stakeholders had little insight into the investment here, though largely felt RSSH was a key area in which to boost allocation in future cycles in alignment with macro shifts in country, discussed above.

10.2.3. Funding model and business processes

Overall, the funding model appears to be functioning well in the Philippines context, with a relatively effective country coordination mechanism (PCCM), solid consultation processes and country dialogues, flexibility for reprogramming and a responsive and highly regarded Country Team (CT) at the Secretariat. Coordination and breadth of stakeholder engagement in the PCCM and country dialogues across all disease areas was largely seen as representative and effective, with good inclusion of non-state actors. The challenge of enabling inclusivity of all CSOs and implementing partners across the HIV and TB space was noted, however. Flexibility of Global Fund funding to evolving needs in country was widely recognised and the trusted and consultative relationship between the CT and in-country stakeholders appears to be key in enabling this. It is apparent that the Global Fund is also actively engaged in exploring how it can evolve the shape and focus of its investments going forward as the country adjusts to orientation around UHC, integration and enhanced decentralisation.

Private sector PRs are seen as a strength in driving activity and high absorption, as well as enabling funds accountability, though concerns remain about their limited technical capacity and level of autonomy. While formal approaches to PR selection were well recognised and the two primary PRs for GC6 have been long standing in the Philippines, some stakeholders expressed concern that the PRs had too much autonomy, owing to the fact they are not housed within government. While the PRs bring solid operational capacity and reportedly coordinate well with the DOH, PCCM and other in-country partners, some questions were raised around the limitations in their technical capacity and the potential flow-through to quality in delivery.

Over time the Philippines has engaged fewer sub-recipients (SR), with a preference for output-based contractors, potentially posing challenges for future sustainability of investments. The lower number of SRs in-country is attributed to the higher costs involved in supporting their organisational capacity and Secretariat-driven shifts towards boosting 'payment for results' leading to a rise in output-based contracts across a range of implementing partners. While this is seen to have supported efficient implementation on some level, that a wider range of organisations in country are not being strengthened organisationally could pose challenges for long term sustainability of Global Fund (and other) investments. It is also envisaged that LGUs will contract and absorb the human resource and implementation costs of many of these contractors over time (including i.e. agents supporting private sector TB case finding, peer navigators for HIV), and the legal and policy framework is in place for this to occur, though the appetite among LGUs to take these on needs to be better determined.

The role of the LFA in relation to program monitoring processes may need further clarity. . The LFA is longstanding in the Philippines, led by PWC Philippines with support from PWC Geneva and independent consultants with technical expertise in the three diseases and monitoring and evaluation. The LFA's role has been enhanced to include more of a focus on performance management and ongoing quality monitoring, for example, the LFA conducted spot checks during COVID-19. As noted above however, there are mixed views on how insightful these may be given the LFA is not a technical expert agency. PRs and other stakeholders did not apparently find the reports useful from a technical standpoint and several indicated that they did not adequately capture the nuance and context of the implementation and may have also misinterpreted implementation dynamics.

Few PCCM risk mitigation strategies have been in place, though this has been strengthened for GC7. CCM Evolution processes contributed to an assessment conducted by a consultant on risk management within the PCCM. The Philippines CCM performed poorly and has prioritised strengthening risk assessment and management for GC7. No risk management guidelines or processes were in place for the PCCM through GC5 and GC6. Consultants have supported identifying where this could be strengthened and the PCCM oversight committee is introducing steps in funding request (FR) processes to assess risks and mitigating actions. In addition, it is suggested that financial monitoring by the PCCM could be strengthened to support more open and transparent decision making around reprogramming. Examples were highlighted whereby reprogramming processes and SR changes did not always reflect open and collaborative processes. Whether and how the in-country investment will require and tolerate LGU disbursement in the future also needs to be determined.

Sustainability

Domestic financing has progressively increased across the review period with Global Fund resources being surpassed by government contributions, though there is scope to push this further. The government has progressively increased spending across the three diseases, including the progressive uptake of HIV and TB commodities. However, many stakeholders suggested that this could be pushed further as resources were potentially available, including at local levels, to foster greater financing commitment from government. The devolution process poses an opportunity for this though advocacy to LGUs will be needed to ensure continued prioritisation of the three diseases. To note, procurement for the three diseases will remain a responsibility of the DOH, at least during the period of the current DOH Devolution Transition Plan 2022-24[471]. In line with the UHC Act, PhilHealth also presents an opportunity as it progressively adapts and expands its benefit package, including as relating to the three diseases.

UHC and devolution processes provide strong frameworks with which to guide and align Global Fund investments and approaches. The UHC Act and devolution processes are steering Global Fund investments to consider more horizontal, health systems-focused support. The legislative and policy frameworks provide a platform with which future Global Fund investments could be strategically aligned. However, such approaches will likely challenge the existing Global Fund funding model and three disease focus. This shift will require stronger political, strategic and technical thinking by the Global Fund, PRs and the PCCM to ensure Global Fund contributions are supporting these changes in line with their processes and funding model. This presents an opportunity for the Global Fund to develop a 'learning lab' to capture and share learning from the Philippines UHC transition with the aim of informing other portfolios adapting to evolving UHC-focused contexts, as well as transitions from disease specific to health system strengthening and horizontal ways of working, whilst managing clear risks. As LGUs and Regional Health Offices take up greater responsibilities and leadership in health service planning, coordination and delivery, risks will increase as standardisation in approaches decreases.

There was broad consensus across stakeholders that so far, 'sustainability' of Global Fund investments has not been considered too proactively or long term, beyond re co-financing thresholds. It was noted by some that the 'cycle by cycle' aspect of the model is challenging in this regard, and that there is a need for more evidence-based advocacy to further leverage Global Fund investments, specifically to emphasise their value for money and to elaborate on scenarios if domestic financing does not fill the gaps. While it is not the case that stakeholders are willing to trade-off the surge/scale that is needed to fight HIV/TB to focus more on sustainability, there is a sense that

[471] Joint Devolution Transition Plan (DTP) of the Department of Health (DOH) – National Nutrition Council (NNC) as Reviewed and Approved by the DPM (2022)

transition efforts could be strengthened through more proactive tailored documentation, communication and engagement efforts. As one stakeholder stated, *"sustainability itself needs to be seen more as a direct investment.*"

M&E

Global Fund investment M&E targets are well-aligned with country targets, and data collection, collation and reporting processes are now habitual though they remain demanding for in-country stakeholders. M&E targets are reportedly well-aligned with country targets, with specific programmatic targets flexing dependent on the budget available. The performance framework is "*overall clear and reasonable"* with key stakeholders being well familiar and accustomed to its use and application, aside from minor suggestions on indicator adaptation. However, there remains concern among some that Global Fund data needs, driven by the Secretariat, have grown over time, without clarity of value in their application across the board. It was also suggested that routinely reported Global Fund M&E data may not be capturing the "*real story*" of investment progress in-country given "*there is no space for the contextual stuff and often that is hard to report – the real insight comes from visits and reviews".* There also remains some confusion around the pulse checks introduced during COVID-19, which enabled twice year 'snap shots' focused on both programmatic and financial progress, with suggestion that they are no longer needed, even though their frequency has now been reduced.

There have been recent shifts to strengthen data management and boost digitisation across diseases, though this will take time to consolidate and data quality challenges remain. Under the recent restructuring of the DOH, the Epidemiology Bureau has taken on increasing responsibility in the management of health system data overall and across the three diseases, in particular relating to HIV/AIDS and TB data. There have been efforts to boost aggregation and analytics, enable more clarity on intervention coverage against targets, and to create national repositories, digitalised where possible, to strengthen overall quality and boost efficiencies in processes. Particular progress has been made in relation to HIV/AIDS, facilitated by progress prior to the enhanced role of the Epidemiology Bureau, with the development of one overall information system and HIV registry, with data cleaned and compiled from across sources. More challenges have been seen with regards to TB data, with limited human resource capacity available to support TB data management in recent years, and various data management concerns in terms of duplication, validity, ineffective tracking of cases across the system and a lack of data from the private sector (though there have been some recent and encouraging efforts to address these issues, particularly though catalytic funding). The handover of the management of malaria data from the Department of the Prevention and Control of Diseases (DPCD) is still in transition. Overall, these shifts in responsibility and strengthening efforts by the Epidemiology Bureau in collaboration with others will take time to consolidate. There are also immediate plans to make data cleaning more efficient, improve access to data via dashboards, and to better triangulate inventory (stock) and disease data so as to improve the analysis of ongoing supply needs. Data quality and timeliness of submission also continues to be hampered by a lack of staff assigned to M&E at facility and sub-national levels, and this will become more important as the devolution process picks up pace. It is also recognised that any data management system will require some flexibility to reflect the variance in internet connection, so full transition to digitisation may take some time.

Concerns also remain about the extent to which the data driven approach to design and guide implementation of Global Fund's investment is optimised by the availability of relevant and quality data as well as analysis. In-country stakeholders have raised the challenge in enabling a more data-driven implementation approach, given data quality, timeliness and access issues. For example, HIV data, despite being considered relatively strong, is not reportedly disaggregated effectively for different KAPs, inhibiting efforts to review and guide tailored approaches. For TB, challenges in tracking data across the system have inhibited efforts to find lost to follow up cases. The restructuring of the DOH has also apparently limited "*ownership of the data to inform action*", compared with the previous scenario whereby the disease programs led the review and application of data, bringing detailed insight into context and implementation/ service delivery progress. This emphasises the need to boost data analytics and management as part of an overall RSSH investment which many claim will further boost outcomes and sustainability of the disease grants.

10.2.4. C19RM

C19RM was highly regarded by stakeholders for providing valuable country support in mitigating the negative impact of COVID-19 on HIV/AIDS TB and malaria, and in boosting initiation of country focus on health security. There was broad consensus that the C19RM grant was of benefit to the Philippines and aligned with evolving health

security priorities in-country, as reflected in the National Action Plan for Health Security (NAPHS). Stakeholders also praised the valuable strategic dialogue with the Global Fund to inform on priorities, and the collaborative approach the Global Fund took to mutual learning. C19RM investment was focused on:

- Procurement of health products/ commodities (including medical oxygen and COVID-19 medication), and testing equipment for laboratories (this was done by WAMBO so faster than if via local procurement);
- Support to Epidemiology Bureau staffing and efforts to strengthening health security surveillance (syndromic and event-based), data analytics, and planning and management capacity of the Bureau;
- Complementary technical assistance and training.

That the investment was also combined and coordinated with funding from other partners was also seen to extend the reach of Global Fund funding. For example, USAID supported two consultants to assist in the development of the NAPHS, and CDC has recently conducted evaluations on surveillance efforts to inform on priority efforts going forward. WHO has also been engaged in this space and there are plans underway to collaborate towards the conduct of a Joint External Assessment (JEE) next year. Overall, the Global Fund's investment was seen as useful in contributing to the initiation of investing in health security in the Philippines. In part with support from the Global Fund, the Epidemiology Bureau are emerging as the focal point for International Health Regulations (IHR) and cross-sectoral surveillance in country and have ambitions to collaborate further with the animal and wildlife sectors to strengthen overall efforts. The Interagency for the Philippines Committee on Zoonosis (PhilCZ) is the One Health country mechanism tasked with strengthening the coordination between the animal-human health and environment sectors in preventing and controlling zoonotic diseases at the national and local levels, and is constituted of the DOH, Department of Agriculture (DA) and Department of Environment and Natural Resources (DENR). While PhilCZ was formed in 2011[472], it has not been active in recent years, though with the onset of COVID-19 was strengthened with the release of Joint Department Administrative Order 2020-02 that provided guidelines to further operationalise it[473]. The Epidemiology Bureau has taken on the role of Secretariat and is looking to boost and generate activity in alignment with the enhanced health security focus of the government. There was some feedback that further integration of C19RM grants into the regular grant making process may have been helpful, but overall, *"the Global Fund was good at responding – in general, a bit messy, but that's understandable. It was good."*

It is however recognised that the Global Fund is new to this space, and there is a need to establish parameters for its focus. Stakeholders raised that the Global Fund has neither the solid technical capacity nor experience of investing in health security, nor is the funding model shaped based on the demands of investing in pandemic preparedness and response, which may present differing challenges and opportunities. Specifically raised was a potential need to consider more flexibility for investments in health security given the nature of fast evolving priorities and the need for harmonisation with other partner investments, which will also shift with the evolving landscape. Not specific to the Global Fund necessarily, there is a need for more strategic thinking around how any health security investment blends with and supports the in-country shift to the UHC agenda. It was also suggested by multiple stakeholders that the Global Fund needs to more deeply consider the extent to which it will prioritise investing in health system resilience and how this will be linked to the HIV, TB and malaria agenda and its RSSH investments. This will also require the Global Fund to collaborate with the other development partners in this space and generate relationships and organisational understandings with new partners (or new partner departments) that it is not accustomed to collaborating with.

10.2.5. Catalytic investments

Several MFs, one MC and several SIs were implemented across the review period. **Overall, CIs were seen to add value, though not necessarily catalytic in design or impact.** Three MFs funded for the 2020-22 funding allocation period were all seen to be successful. **The TB Missing People MF, which aims to boost the reporting of TB from**

[472] Bureau of Animal Industry (May 2023). BAI Updates National Strategic Plan on Zoonoses. Available at: https://www.bai.gov.ph/blog-detail?b=BAI%20Updates%20National%20Strategic%20Plan%20on%20Zoonoses

[473] Bureau of Animal Industry (May 2023). BAI Updates National Strategic Plan on Zoonoses. Available at: https://www.bai.gov.ph/blog-detail?b=BAI%20Updates%20National%20Strategic%20Plan%20on%20Zoonoses

the private sector, was seen as a valuable component of the TB program and has led to an overall and significant rise in TB reporting levels. The grant was allocated US$10m for both GC5 and GC6 and projected US$4m in GC7, of which US$8m is allocated to the project from the country allocation, raising the total investment to US$12m. The investment is thought to have contributed to efforts to improve reporting including the passing of a TB Mandatory Notification Law which applies to public and private sectors. The project has evolved over the grant cycles and is extending to support reporting across the cascade of care indicators, focused at linking private sector patients to public services such as GeneXpert testing and treatment plans. There are incentive schemes provided to support notifications and follow ups, though they are not well utilised with a level of distrust in the online payment systems by private physicians cited as one of the challenges. Sustainability has been highlighted as one ongoing challenge of the scheme, as it directly supports over 200 TB notification officers and financial incentives may not work well in the long term. There are plans for LGUs to take up the scheme through GC7 though financing and long-term sustainability here is also unclear. However, the increasing allocation from the country grant in GC7 indicates that there is opportunity for this to transition to country grant/domestic financing over future cycles. In addition, the grant also aims to boost private sector compliance with the TB Law, based on the assumption that sustainability of compliance will also be improved once providers are in the habit of reporting.

There were mixed views on the MC focussed on HIV on its alignment with the country grant, though changes have been made to strengthen harmonisation in subsequent cycles. Some reported that the MC had progressed well across GC6 whereas others felt it was not well aligned with the broader grant program and HIV efforts, with perspectives varied based on the stakeholder and their role. Plans are in place to strengthen PCCM stakeholder involvement in design and engagement with the MC in GC7 to strengthen how it is aligned with broader HIV efforts.

Overall, CIs were perceived to raise awareness of key priorities and provided flexibility to provide new approaches that have contributed to learning and progress in both HIV/AIDS and TB. However, several respondents noted that while the CIs were supportive and contributed to HIV and TB programs, there was limited strategic thinking into how CIs could be best used to complement disease efforts and which areas may drive maximum benefit, nor did the process for CI design usefully encourage this. This was raised in general terms for all CI modalities, though it is noted that only a few stakeholders spoke to this area with specific insight. In addition, several respondents were not able to distinguish between specific CIs and country grants which perhaps demonstrates alignment, though was also interpreted by some that CIs were mostly useful for 'topping up' areas in the country grant. There was also some confusion around how CIs differed from co-financing and unfunded quality demand (UQD).

10.2.6. Partnerships

Overall, there was a perception that the Global Fund has good collaboration with key partners and country forums, though there are opportunities for strengthening engagement mechanisms. The Global Fund was seen to coordinate and collaborate well with UNAIDS, WHO and USAID/PEPFAR and others, with each actively participating in the PCCM. The partner landscape in the Philippines is generally seen to bring solid localised insight, with a few key active players and overall, good relationships. Over the strategy period, cohesion and coordination has been somewhat disrupted by the dissolving of technical working groups (TWGs) for the three diseases, linked to the shifts in leadership and restructuring of the DOH, though they are in the process of being reformed. There was also broad agreement that higher levels of the DOH need to be actively engaged in the PCCM for it to have more technical, strategic and managerial clout. Further clarity must also be made around engagement points as relating to the three diseases within the new DOH structure, as has been discussed above. The PCCM governance manual is currently being revised and there is opportunity to redefine governance processes and engagement. It was also suggested that representation from both the private sector and from UHC/RSSH focused stakeholders could also be strengthened, dependent also on shifts in focus of the future investment. How localised implementation efforts coordinate with and report through LGU processes will also require further consideration.

For HIV specifically, there was general consensus that KPs are well represented in the PCCM and country dialogue processes, though transparency and representation could be further strengthened. While progress has been made in establishing a KP committee linked to the PCCM, some partners expressed that KP representation could be expanded to include more community-based groups and those outside the national capital region (NCR). It was also noted that while dialogue does engage KP groups, those represented can often be more organisation rather than sector focussed, comprising their representation effort. Stakeholders reported that HIV overall was less well

coordinated across partners at both national and local levels, which likely speaks to the comparative breadth of the grant, both technically and geographically. Specifically, there were reports of some duplication of efforts and resultant challenges of double counting and in attribution of impact.

10.2.7. Gender, human rights, equity & communities

Notable progress has been made in relation to gender, human rights, equity and communities, driven by wider inclusion of KPs in PCCM processes and programming, and priority efforts required as highlighted by a range of assessments. The engagement and cohesion of the KP community has reportedly grown considerably through GC5 and GC6 with support and commitments from the Global Fund and other partners (i.e. UNAID and USAID, DFAT and ADB), and also enabled by the recently formed PCCM KP Committee. Various assessments over the last three years have highlighted key aspects to address in HIV programming in particular, and the need for more tailored approaches, including the targeting of specific KPs. This strategy period has seen significant expanding of HIV programs to include transgender populations and MSM. This overall has led to the testing of approaches and various active programmatic learning, which is being utilised in GC7 as various initiatives are being taken to scale. Stakeholders also discussed the recent formation of an Ethics Committee within the PCCM, a Global Fund corporate initiative e which encourages safeguards against sexual harassment and other ethical considerations, and which is still being effectively operationalised. The Philippines National AIDS Council (PNAC) Human Rights Roadmap has also been adopted though further support to implement needed.

However, with various applications of learning come operational and coordination challenges, and questions have been raised as to whether enough is known about the quality of implementation, whether demand generation within communities has been enough of a focus, how capacity gaps within KP organisations can effectively be addressed, and how localised efforts can be effectively coordinated under the leadership of LGUs going forward. With TB specifically, it was raised that maintaining the involvement of TB champions is problematic given they disengage from community advocacy efforts when their treatment is complete, in comparison with HIV champions who are often committed for life. The extent to which gender-sensitive approaches are considered across diseases was also highlighted as a gap. Overall, stakeholders agreed that there is a need to think carefully about which key populations will be left behind as we approach 2030 and to target focus there.

10.3. Conclusion and suggestions for possible improvements

The Philippines has made a clear commitment towards achieving UHC over the next five years and high-level leadership for devolution of power, including through commitment of resources to decentralised levels. Despite a shift towards more horizontal health programs in line with the 'life-course' approach, direct focus has remained for HIV/AIDS, TB and malaria across the strategy period which has enabled key and notable areas of progress. However, HIV/AIDS and TB remain major concerns with incidence continuing to rise and major gaps remaining in achieving national targets. The Philippines is making solid strides towards malaria elimination, yet this progress could be compromised by reducing investments through the pressure to transition funding to domestic sources. The UHC and devolution processes are seen as opportunities to tackle key localised HIV/AIDS, TB and malaria issues and priorities, though the Global Fund will be challenged over coming grant cycles to adapt its processes, focus and business processes to align with these shifts. There is hope in country that the Global Fund can shape its machinery effectively to adapt so as to maintain progress with the three diseases, whilst useful expanding complementary investments in RSSH and health security to enable needed boosts to the resilience of the overall health system. Given the Philippines' high grant absorption, effective and established partners landscape, alignment of its investments with DOH plans and policies, and well-performing grant processes, there is opportunity for the Global Fund to trial and innovate their approach. Challenges will lie in the stronger dependency between the Global Fund investments with overall DOH performance, and effectiveness and pace in the transfer of responsibility to the LGUs.

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A.21. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 20 stakeholders from the following entities:

Stakeholder Group	Entity
CCM	CCM
Global Fund Secretariat	Global Fund Country Team
Ministry of Health	HIV/AIDS Representative
	TB disease program
	Epidemiology Bureau
PRs	Pilipinas Shell Foundation Inc
	Philippine Business for Social Progress
Technical Partners	WHO
	UNAIDS
	USAID/PEPFAR
Community and civil society organisations	AHF
Local Fund Agent	PWC
SRs	Philippine Coalition Against Tuberculosis (PhilCAT)
	LoveYourself

11. SIERRA LEONE CASE STUDY REPORT

11.1. INTRODUCTION

11.1.1. Key country characteristics and HTM context

Sierra Leone is a low-income country in Western Africa, with a population of less than 9 million. With more than 50% of its population living under the poverty line, Sierra Leone is ranked 163 out of 173 countries in terms of GDP and 181 out of 195 countries in the UNDP's Human Development Index. The country's national health system operates at 16 district levels, each with a health management team, an average of 50 peripheral health units, and more than 100 technical staff.

Following the Ebola outbreak which devastated its already weak health system, Sierra Leone was classified as a Challenging Operating Environment (COE) by the Global Fund in 2015. The crisis threatened the implementation of activities related to HIV, Tuberculosis and malaria as well as health systems strengthening and while the outbreak ended in 2015, the health system remains fragile. Weaknesses in the health system include insufficient donor coordination by national entities to invest effectively in priority areas, ineffective functioning of the health system at the district level, weak health product management (quantification, procurement, distribution, etc.), and suboptimal capacity and management of the health workforce.[474]

The Sierra Leone health system is guided by: the 2010 Free Health Care initiative[475], the Health Sector Recovery Plan 2015-2020[476], the National Health Sector Strategic Plan 2017-2021, the Sierra Leone Basic Package of Essential Health Services 2015-2020, and disease specific National Strategic Plans for HIV/AIDS, TB, and malaria (2021-25). A National Health Policy and UHC Roadmap were developed for 2021-2030.[477]

Sierra Leone has a high disease burden across HIV, TB and malaria. It has a mixed concentrated and generalised HIV epidemic- with a prevalence of 1.7% among the general population and higher prevalences among KPs (11.8% among SWs, 3.2% among MSM, 4.2% among the transgender population, 4.2% among PWIDs, and 3.7% among prisoners).[478] Sierra Leone is also considered one of the 30 high-TB burden countries, although it is also one of the six countries which achieved the 2020 milestone for TB mortality reduction. [479] Finally, Sierra Leone is the 26th largest contributor to global malaria cases, and ranks 20th for malaria- related deaths globally. [480]

11.1.2. Summary of Global Fund support

Sierra Leone has been classified as a Core country by the Global Fund. During GC5, the Ministry of Health and Sanitation (MoHS) was a multi-grant PR for TB and malaria, the National HIV/AIDS Secretariat (NAS) was the PR for the HIV grant, and Catholic Relief Services (CRS) was a PR for malaria. During GC6, NAS was replaced as HIV PR following an OIG audit report in 2020 (see discussion in the risk section), and CRS and MoHS became PRs for a multi-component grant each of which included funding for HIV/AIDS, TB, malaria and RSSH.

Details on levels of funding and trends over 2017-2022 by disease area are provided in Table 11.1. There has been an increase in the allocation across all three disease areas from US$ 92 million in GC5 to US$ 155 million (an increase of 69% which includes C19RM funding).

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[474] GC6 Funding Request and Global Fund internal documents (confidential)

[475] Provides free primary care to lactating mothers, pregnant women and under-five children with the goal of reducing the burden of user fees among the most vulnerable population.

[476] Developed after the Ebola epidemic.

[477] GC6 Funding Request and Global Fund internal documents (confidential)

[478] UNAIDS, 2022

[479] Global Fund (2023). OIG Audit Report, Sierra Leone

[480] Global Fund (2023). OIG Audit Report, Sierra Leone

Table 11.1: Overview of Global Fund investment across allocation periods

Disease area[481]	Allocation GC5 and GC6	Main investment areas (GC6)
HIV/ AIDS	US$23.9M GC5 US$37.2M GC6	Treatment, care and support (62%), prevention for KP and vulnerable populations (19%), and differentiated HIV Testing services (9%)
TB	US$7.4M GC5 US$12.4M GC6	TB care and prevention (64%), MDR-TB (33%), TB/ HIV integration (2%)
Malaria	US$23.3M GC5 US$43.4M GC6	Vector control (58%), Case management (31%), specific prevention interventions (11%)
RSSH	US$28.9M GC5 US$18.8M GC6	HRH (28%), Health Products Management Systems (24%), HMIS and M&E (14%)[482]

Other key features of the country portfolio include:

- **C19RM:** Funding awarded for COVID-19 totalled $US28.7M (with an additional US$2M awarded during GC5).
- **Catalytic investments:** During GC5, Sierra Leone was the recipient of the following Matching Funds: Human Rights as part of the Breaking-Down Barrier initiative (US$1.8M for HIV) and US$2.9M for RSSH Human Resources in Health and RSSH Data Science (US$2.0M). During GC6, Sierra Leone received US$1.5M for Human Rights.

11.2. KEY FINDINGS

11.2.1. Relevance of Global Fund investments

Global Fund supported interventions are aligned with country needs and priorities are based on quality National Strategy Plans (NSPs) and take account of conducted mid-term reviews. There was a strong view from country stakeholders that the Global Fund supported interventions were well aligned with the three respective NSPs which set out key country priorities for TB, malaria, and HIV. There was a strong view from country stakeholders that the Global Fund supported interventions were well aligned with the three respective NSPs and as result key country priorities for TB, malaria and HIV. Stakeholders considered the NSPs to be of high quality that have been developed in partnership between government stakeholders and technical partners. For GC7, mid-term reviews have also been conducted across the three diseases which were used during the funding dialogue stage.[483,484,485] As such, the selection of interventions and the underlying Global Fund process of selecting interventions were considered to work well. Stakeholders also considered that the interventions offer value-for-money but did highlight that further stratification and focus of interventions could improve cost-effectiveness (e.g., stratification of malaria interventions by geographic burden and resistance profile or an increased use of index testing for HIV).

[481] Global Fund (2023). DnA Factbook, Sierra Leone, slide 21. Excludes COVID-19, RSSH, program management modules, and payment for results.

[482] GC6 Funding Request and Global Fund internal documents (confidential)

[483] National AIDS Secretariat (2023). Mid-Term Review Report of Sierra Leone National HIV & AIDS Strategic Plan 2021-2025

[484] MOHS (2023). Mid-term performance review of the national malaria elimination Strategic Plan 2021-2025

[485] MOHS (2023). Mid-term review of the TB National Strategic Plan 2021-2025

The focus on commodities in the portfolio and the type of products supported through the Global Fund were also considered to be adequate to the context in Sierra Leone. With regard to innovation, the Global Fund was seen to support scale-up of innovations once there has been strong evidence of the value-add of the interventions (ideally shown through small-scale pilots supported by partners in the country or the region). For example, Sierra Leone successfully conducted a large-scale round of mass campaigns using PBO nets during the GC5 cycle as a response to the rise in pyrethroid resistance. For TB, the switch to shorter oral regimens for MDR-TB treatment was also seen as working smoothly once global guidelines were updated.

The majority of stakeholders considered the allocation across diseases as well as RSSH as adequate. However, there were a few minority views that highlighted that the provided RSSH allocations (within the HTM allocation) was insufficient to address many of the key health system challenges. Additionally, a minority expressed concerns that the RSSH space was fragmented by spreading the investment too thinly across a wide range of health system areas. Nevertheless, the majority viewed that the current allocation was adequate (given the need for necessary trade-offs within a limited portfolio) and considered that RSSH challenges were more related to the implementation and coordination arrangement rather than the allocation across interventions.

11.2.2. Progress and results achieved

There has been limited progress across the three diseases in GC6 primarily due to a range of implementation challenges that have led to low absorption of Global Fund funding. While there have also been challenges in the implementation within GC5 (in which Sierra Leone already required a no-cost extension), these became more pronounced in GC6 with both grants receiving the worst possible financial rating reflecting the very low absorption rate of the grant (see Figure 11.1 below).

Figure 11.1: Sierra Leone Grant performance evolution since 2017 [486]

		Overall Grant Rating					Grant Performance		
		2019		2020		2021	2021	2022	
		Jun	Dec	Jun	Dec	Jun	December	June	December
Sierra Leone	SLE-H-NAS	B1	B1	B1	B1	B1			
	SLE-M-CRS	A1	A1	B1	B1	B1			
	SLE-Z-CRS						D 5	D 5	C 5
	SLE-Z-MOHS	B1	B1	B1	B2	B1	C 5	C 5	C 5

Before December 2021		Since December 2021			
Overall Grant Rating		**Programmatic Rating**		**Financial Rating**	
A1	>100%	A	>=100%	1	>=95%
A2	90% - 100%	B	90% - 99%	2	85% - 94%
B1	60% - 89%	C	60% - 89%	3	75% - 84%
B2	30% - 59%	D	30% - 59%	4	65% - 74%
C	< 30%	E	< 30%	5	< 65%

The rest of the section describes the results across the three diseases and RSSH outlining key progress and disease-specific drivers and barriers. The overarching implementation challenges which are cross-cutting are discussed in the implementation section further below.

HIV progress

There have been improvements in ART coverage but only limited progress or reversal in other key areas including KP prevention services, PMTCT and testing. HIV/AIDS remains a major public health problem in Sierra Leone. The HIV prevalence among adult population (aged 15 – 49) was 1.7% in 2022; only 61% of people living with HIV knew their status, of which 89% were on treatment, and 45% of those on treatment were virally suppressed compared to 27% in 2019.[487] ART coverage has steadily improved over the years and the Global Fund target was

[486] Global Fund (2023). DnA Factbook, Sierra Leone. Data as of July 2023.

[487] National AIDS Secretariat (2023). Mid-Term Review Report of Sierra Leone National HIV & AIDS Strategic Plan 2021-2025

met in 2021.[488] The Global Fund funding is used to purchases ART commodity across the full country (including PEPFAR supported facilities) and this arrangement was largely considered to work well. However, there remain gaps in the pediatric ART coverage which the overall coverage (all ages) dropping to 72% compared to 89% for ages 15-49. However, stakeholders pointed particularly to challenges regarding testing when looking at the HIV 95-95-95 targets. While there were some improvements in PLHIV knowing their status, there remains a large gap and stakeholders called for more target index testing to further improve in this area. Similarly, there remain challenges to test for VL with stakeholders pointing to the lack of demand creation for VL testing as well as limitations of the laboratory system in the country.

Vertical transmission rate remains high Sierra Leone and only changed marginally from 17.8% in 2019 to 15.9% in 2022. A number of supply, demand and quality factors were seen as contributing to this challenge, with many of them related to weak integration in RMNCAH services. Stakeholders pointed in particular towards the geographical access constraints for EID (only offered in 146 sites out of 826 offering PMTCT services), low quality of RMNCAH services, stock outs of HIV test kits and demand side barriers including stigma and discrimination.

There has been a large drop-off in prevention services for KPs supported through Global Fund funding since 2021. This is reflected in the drop in results for key prevention indicators for MSM (60% achievement against target in 2021) and female sex workers (35% achievement against target in 2021).[489] Stakeholders emphasised that this poor performance is predominately due to a range of implementation challenges. In particular, stakeholders pointed to the switching of the PR from the National AIDS Secretariat (NAS), and the subsequent separation of the KP component of the HIV grant across both the MoH and the Catholic Relief Services (the switch was reportedly a response to the OIG reports finding ineligible spending further discussed in the risk management section). The switching of the PRs without a transition period and use of PRs without extensive experience working directly with HIV KPs led to severe delays in contracting and implementation.[490]

TB progress

TB progress dipped briefly during the COVID-19 pandemic but rebounded for case notification, however large gaps remain especially for MDR-TB and pediatric TB. There has generally been a narrowing of the TB notification gap which stakeholders credited particularly to the scale-up of Directly Observed Therapy (DOT) sites that were seen as working well. In 2020, there was a large dip in case notification due to the COVID-19 pandemic similar to other countries, but results rebounded in 2021. Nevertheless, stakeholders emphasized remaining challenges in TB with around 5000 TB cases still going undetected, pointing to the limited funding for the disease and the need to further scale-up DOT services. Besides wider implementation challenges faced across all diseases, stakeholders also stated the challenges with the new CHWs approach in GC6. In particular, stakeholders pointed to design challenges in that fewer CHWs were placed in urban areas with high TB burden (instead covering more remote areas relevant for other diseases such as malaria) as well as implementation challenges including the delay in training (discussed further below). This has reportedly led to drop of community case findings from 20.5% in 2019 to below 1.1% in 2022.[491] Another gap also relates to pediatric care which reportedly has not recovered since the dip following the COVID-19 pandemic. Similarly, stakeholders pointed to the limited progress on MDR-TB treatment particularly to challenges around testing and also questioned whether the underlying burden estimates are accurate. In contrast, they positively reflected on the switch to the short MDR-TB treatment over the time period including the updating of the national guidelines.

HIV/TB integration has worked very well, with the target of PLHIV on TB preventative treatment being achieved by 96% in 2021. Stakeholders credited this to the approach of having one-shop stops with health facilities providing both HIV and TB services. However, prevention services outside of HIV have been extremely limited with very low

[488] Global Fund (2023). Sierre Leone DnA Factbook

[489] Global Fund (2023). Sierre Leone DnA Factbook

[490] The separation of the KP program implementation was required as the Catholic Relief Services were not seen in the best place to take forward some of the prevention components including condom distributions

[491] MOHS (2023). Mid-term review of the TB National Strategic Plan 2021-2025

household tracing and TB preventative service provision. Stakeholders questioned whether community engagement and household tracing could be done effectively under the updated and integrated CHWs set-up.

Malaria progress

There has been a reduction regarding malaria incidence rate in contrast to some other countries in Western and Central Africa. Malaria incidence has dropped from 303/1000 per population at risk to 222/1000 per population at risk in 2022. Overall, there has been a decline in cases and deaths since 2018 by 4% and 7% respectively. According to stakeholders, contributing factors included the use of CHWs (in GC5), the use of PBO nets (in GC5) combined with high net usage, and the introduction of IPTi (PMC) with good partner coordination across the two PRs as well as wider partners such as PMI and RBM. As outlined in the relevance section, the support of the Global Fund was considered evidence based and seen as supporting the right type of interventions, including a comparatively early use of PBO nets. The progress on malaria is also reflected across the Global Fund targets which were all above 90% for testing, malaria cases treated and IPTi although stakeholders did report challenges regarding commodity stockouts in certain areas.

RSSH progress

Sierra Leone has a weak health system and only limited progress has been achieved across the different RSSH components due to a range of implementation challenges. Challenges related to implementation arrangements across the disease areas were reportedly exacerbated for RSSH given the lack of strong and coherent coordination across the different components and the involvement of many different partners. While stakeholders pointed out the high need across many of the RSSH components reflecting Sierra Leone's overall weak health system, a few stakeholders questioned whether spreading the investments thinly across many areas contributed further to implementation challenges.[492] The following challenges were highlighted across the different RSSH components:

- *Updated approach to CHWs to integrate and increase criteria / level of education has not been effective to-date due to implementation challenges*. While the majority of stakeholders agreed in principle to have a more integrated approach to CHWs, they pointed to the many implementation challenges in particular the delay in training of over year as well as delayed payments to CHWs. This was seen as severely limiting the effectiveness of the program and leading directly to challenges in delivery for the three diseases. Moreover, a number of stakeholders also pointed to larger challenges in the current set-up including: (i) no clear arrangement of how CHWs will be taken over by the government; (ii) a very large number of services to be provided compared to low remuneration for CHWs reportedly impacting on motivation; (iii) issues around geographic deployment (e.g., no urban areas for TB services) or insufficient number of women CHWs in some remote areas.
- *Supply chain and distribution capacity remains low with key activities such as the warehouse construction not progressing as planned.* Stakeholders repeatedly pointed to stock-outs of key commodities in the country and the disruption that has caused to the disease programs. Since GC4, there have been plans to construct a warehouse to store HTM commodities but so far only the road leading up the construction site were finalised due to a number of reasons including the lack of promised co-financing from the government as well as challenges around the project management. Additionally, stakeholders pointed to the challenges in distributing commodities across the country with a key barrier being the accurate forecasting and quantification of used commodities. There have been first promising steps in this area with the introduction of the M-supply software which would provide commodity data, but its needs to be scaled-up to be used effectively.
- *The laboratory systems including both existing equipment as well as sample transport remains weak and creates an impediment for TB and HIV testing in particular.* While there has been reportedly some progress on GeneXpert expansion during GC5, there was little progress in GC6 especially due to challenges in the

[492] As result, many welcomed the selection of Siera Leone as a priority country for RSSH under GC7 which increased matching funds for RSSH as well as the reprogramming under the C19RM funding which all contributed to ensuring a larger amount of funding for RSSH aspects.

procurement of new equipment as well as procurement of technical experts to provide trainings (however, reportedly an agreement with Roche on new equipment has been negotiated jointly with PEPFAR).

- *There have been some improvements in the data systems of the country with regard to digitalisation and improvements in data completeness.* Nevertheless, gaps remain with regard to data quality, timeliness, and use. This includes a gap in moving HMIS from paper-based to fully electronic-based at the facility level. The HMIS system is further discussed in the M&E section.
- *Stakeholders reported that progress has been made on community level monitoring and community strengthening.* However, stakeholders pointed out that the challenges related to CHWs delayed results as have challenges integrating CLM reporting into the DHIS2.

11.2.3. Funding model and business processes

Funding model and CCM

The Global Fund funding dialogue works well with good engagement and inclusion of KPs and CBOs in the process although reporting back to wider KP groupings could be further strengthened. As outlined in the relevance section, stakeholders considered that the Global Fund funding model allows for the right selection of interventions. The technical guidelines provided by the Global Fund are considered to be helpful and very comprehensive and the communication with the current Global Fund Country Team was also seen as helpful. There were a few minority views considering the Global Fund processes as very rigid. The requirements within the funding request stages to engage with KPs and CBO/CSOs were also welcomed and considered to largely work well in particular through engagement with CARKAP which is a consortium of CBOs and KP groups. However, stakeholders mentioned that the reporting back to wider KP groupings could be strengthened by providing specific support for these activities.

While the selection of interventions works well, the funding model is considered to be very heavy on stakeholders which has contributed to some challenges in implementation. As further discussed below, the key challenge in Sierra Leone has been program implementation and a few stakeholders mentioned that the funding request process in its current state can further hamper implementation. The heavy and complex process (e.g., funding request stages, several rounds of C19RM funding) was seen to divert attention away from implementation oversight given capacity of the key stakeholders such as the PR, CCM and CCM Secretariat. In the case of Sierra Leone, the extensive funding request process has reportedly also contributed to the decision to postpone the PR selection until after the funding request has been submitted in order to have additional time for this vital aspect of the process. However, not having the PR selection as part of the funding request comes with key drawbacks including a minimised transition period for any new PRs and risks of starting a new implementation period with a delay (as observed in GC6).

The CCM Secretariat oversight capacity should continue to be strengthened and the CCM composition should be further improved bringing stronger technical expertise. The implementation challenges within Sierra Leone could be addressed by more pro-active oversight and stronger coordination and accountability mechanism (see section below). Stakeholders felt that in this regard the capacity of the CCM Secretariat and CCM should be further strengthened. The CCM Secretariat benefited from the CCM Evolution Strategic Initiative which also included payment for an oversight officer. This was considered as very useful, and stakeholders stressed that this should be maintained after the end of the Strategic Initiative. The CCM composition should be improved by bringing in stronger technical expertise across the three diseases and RSSH that can provide the necessary guidance and oversight – this was considered increasingly important given the complexities of the Global Fund portfolio. Additionally, some stakeholders also suggested that the technical expertise should be complemented by bringing in a few high-level decision makers (including from the Ministry of Finance) that could quickly escalate any implementation roadblocks.

Program implementation

The very low absorption rates are driven by challenges in the implementation set-up in Sierra Leone and the lack of strong coordination and collaboration especially with regard to Integrated Health Project Administration Unit (IHPAU). The Project Management Unit (PMU) is managed under IHPAU which is a country initiative to optimise financial management and administration for all key donors (including World Bank, Global Fund,

Islamic Development Bank, CDC, and Gavi). In theory, this model was expected to improve donor collaboration and mitigate risks of overlapping donor activities but in practice has led to many implementation challenges which has also been well documented in the OIG reports (OIG report 2018, 2020 and 2023). In particular, in-country stakeholders emphasised the disconnect between the financial and programmatic aspects and that this disconnect has led to continuous frustrations on all sides. While there have been some improvements in GC6 such as strengthening grant management and programmatic understanding at IHPAU, there is still a lack of proactive coordination and collaboration. A key challenge within this has been the lack of strong monitoring / tracking processes and work plans limiting the ability of IHPAU to monitor implementation. While some tools have been developed, such as the procurement work plan, it is not effectively used due to inaccurate data, inadequately tracked advance payments to Sub-Recipients, and no mechanism to evaluate supplier performance (OIG report 2023). These challenges are compounded by a lack of sufficient technical capacity compared to an increase in complexity of the implementation arrangements (e.g., increase in funding amount, number of SRs and C19RM).

Weaknesses in the implementation arrangement have been compounded by not actively managing and addressing other challenges including (i) rapid increase in inflation / changes in exchange rate; (ii) procurement and supply chain; and (iii) coordination across RSSH and disease areas. In particular, the following has been highlighted:

- *Inflation and exchange rate depreciation have increased attrition and further challenged program implementation***.** Sierra Leone had a rapid increase in inflation of 27% in 2022 and a depreciation in the exchange rate value of nearly 60% in 2022.[493] This impacted on implementation in a number of ways including on the need to reassess budgets and costs leading to delays. Additionally, in many cases staff remuneration also had a ripple effect on attrition with staff looking for other opportunities. This is compounded by the fact that other donors pay staff remuneration based on the latest exchange rates at the end of the month leading to comparatively higher salaries. This reportedly also impacted on motivation with staff working on World Bank and Gavi projects earning considerably more. The Global Fund has recently tried to mitigate this by allowing an annual inflation adjustment to staff remuneration in 2023.

- *Challenges due to national procurement law and customs clearance. The* Global Fund follows the national procurement law in Sierra Leone in contrast to other donors such as World Bank that apply their own procurement guidance. This has led to considerable delays – in particular, stakeholders explained that the inflation increase has meant that more elaborated and lengthy procurement processes are now triggered once procurement volume are above threshold of around US$ 4,000. The more elaborate process reportedly can take a minimum of 12 weeks leading to many delays in grant implementation across all disease areas (with delays in procurement being cited as a challenge by each implementing partner). Stakeholders emphasised that these challenges could be plainly seen but were not escalated to advocate for an adjustment. A similar challenge emerged when a local law was changed with regard to commodity clearance in the local ports, which led to Global Fund containers being held in the port for over 12 months in some cases. The situation was only very recently resolved due to the Global Fund Country Team intervention and discussion with the Vice Presidency eventually leading to an exception for Global Fund commodities so that they can be "delivered at place". However, stakeholders emphasised that the lack of accountability and tracking and no pro-active mitigation measures meant that the situation was only escalated after it severely impacted on commodity availability in-country.

- *There is no strong programmatic coordination across the many different RSSH components as well as disease components which then leads to implementation challenges including with regard to the interaction with IHPAU.* Stakeholders emphasised that the current RSSH coordinator lacks the necessary high-level clout to bring together the different health system departments. Similarly, some stakeholders mentioned that having a Disease Control and Prevention Department Head that combines HIV, TB and malaria could help coordination across the diseases.

[493] https://www.worldbank.org/en/country/sierraleone/overview

- *Challenges related to implementation arrangements also got compounded by additional requirements around fiduciary risk and the response to OIG reports* which is discussed in the risk section below.

Recently some of the challenges outlined above have been partly addressed or mitigated including through the GC7 funding request stage and the following lessons learned / solutions were identified:

- *Deliberate and intentional communication from the Global Fund Secretariat on highlighting the key challenges and also pointing to the consequences of in-action*. This was considered by informed stakeholders as helpful in order to elevate the key challenges to senior decision-makers in order to move things forward. Reportedly, it has helped to clearly point out key consequences of the status quo such as low absorption leading to the return of funding or continued challenges in procurement maybe leading to the potential use of alternative procurement arrangements (e.g., through international organisations). Additionally, direct engagement with high-level government officials including the vice-presidency in particular was considered key to obtain the needed waivers on the clearance in the port and to move to a "delivery at point" exception.

- *Strengthening of technical capacity including on programmatic and financial management either by directly involving other actors or providing stronger TA / embedded staff to government.* Stakeholders pointed to the need to further improve the core technical capacity around program implementation, but there were different views on whether this should take place through embedded staff, increased provision of TA or even direct involvement of other organisations in the delivery. While there is a trade-off with regard to sustainability of implementing some of these changes (e.g., embedded staff or direct involvement of other organisations), it was considered that the poor implementation performance warranted this approach. Most stakeholders agreed that UN organisations can play an important part with regard to technical assistance which hasn't been fully leveraged to-date. However, a few stakeholders cautioned that an increased use of UN organisation for programme management would have higher cost implications.

- *Strengthening of oversight, accountability and performance measures*. This was identified as a key gap by stakeholders though they did note that there has been some recent discussion and progress on this. For example, most stakeholders agreed that a clear dashboard presented to the CCM on the progress against each area would be helpful to improve on oversight and react proactively to manage emerging challenges. Additionally, stakeholders suggested to introduce and improve performance measures used for programmatic and financial management (e.g., tracking length taken to process procurement, documents and payments). The OIG previously recommended to develop a clear work plan for key activities as well as a procurement plan and whilst these tools have been developed, they are not used effectively to monitor progress and mitigate risk.[494]

Risk management

The OIG audit in 2018 as well as follow-up investigations found non-compliant expenditures and rightly put the spotlight on gaps in the program management and fiduciary risk management processes. However, the mitigation response to manage especially the fiduciary risks has had some unintended consequences on program implementation which were not proactively managed. The OIG audit in 2018 and in particular the subsequent investigation reports in 2020 and 2022 found ineligible spending with regard to training, catering and some commodity distributions mainly at the SR level during GC5.[495] Additionally, the reports pointed to a range of challenges with regard to program and fiduciary risk management and provided a range of mitigation measures. While stakeholders acknowledged these challenges and agreed that an improvement in processes were necessary, they pointed to a range of unintended consequences on program results which were not proactively managed and compounded the already weak implementation arrangement:

- *Swapping of NAS as PR without a transition period had negative consequences for the KP program.* While many of the SRs for which there was found non-compliant expenditures were managed by NAS as PR in

[494] OIG (2023). OIG Audit - Follow-up Audit of Global Fund Grants to the Republic of Sierra Leone

[495] OIG (2019, 2020 and 2022)

GC5, many stakeholders felt that completely removing NAS from the Global Fund implementation process without a transition period had large negative consequences on KP programming (as discussed in the results). There was agreement that in such circumstances a clear transition plan should have been put into place, with a minority of stakeholders going further and arguing that maintaining NAS as PR (under changed leadership) would have led to better outcomes programmatically. Reportedly, there were made attempts for transition arrangements, but these were ultimately not implemented as planned.

- *The cashless policy in the form of mobile payment for trainings has led to many frustrations at program level and has reportedly led to delays and impacted on quality.* A specific mitigation measure that has led to frustrations by program implementers is use of mobile payments for training sessions and to not provide catering directly at events. The vast majority of stakeholders reported that this meant many participants would come back late or not at all after lunch severely impacting on training quality. Additionally, while generally stakeholders acknowledged the advantages of mobile money payments especially with regard to risk mitigation, they pointed to the fact that the current format of collecting stakeholders' details during events and then passing them on for payments to IHPAU has led to severe payment delays reportedly eroding trust from KP participants in some instances.

- *Some stakeholders perceived there to be a "chilling effect" in response to the OIG report and felt that an overemphasis on demonstrating compliance to fiduciary risks has developed.* For example, stakeholders reported that the priority for IHPAU has become to demonstrate compliance with programmatic and fiduciary risk processes (e.g., around procurement laws and regulation) even if that leads to further programmatic delays. Specifically, they criticised that there was not more active planning on how this impacted on programs – for example, having much earlier attempts to flag and change the procurement laws thresholds which were seen as too low to be fit for purpose.

- *Lastly, some stakeholders noted that there is no exit strategy in place to move away from the additional mitigation measures to address fraud and corruption and asked for a stronger focus on capacity building.* While agreeing with the use of the additional mitigation measures currently, some stakeholders noted that it would be good to put in place clear exit requirements and to also strengthen capacity building in financial and programmatic management. In particular, the current Fiscal Agent is seen as providing oversight rather than developing capacity.

Sustainability, Transition and Co-financing

The co-financing requirements were considered to be overly ambitious and without sufficient visibility and buy-in from high-level decision-makers. Sierra Leone has recently been granted permission to "de-link" its co-financing payments meaning that its HTM and related RSSH domestic payments do not need to be in addition to HTM spending in the previous cycle. Despite this improvement, an analysis of the co-financing has shown that only 4 out of 10 commitments in GC6 are expected to be partially met.[496] Stakeholders also commented that many of the specific programmatic commitments made were ambitious and lacked visibility and buy-in from senior decision-makers, including regular reporting on the progress. This has been improved during the grant-making for GC7 with more high-level engagement of key decision-makers, including MoF. A key challenge in the past has also been with regard to the co-financing for the supply warehouse which was not provided during GC5. Stakeholders commented that an improved approach to co-financing would be to set fewer but realistic and clear requirements, which then require sign off and regular reporting to senior decision-makers. Additionally, verification should be ensured, including if needed through the use of counter-part financing for key investments (e.g., upfront payment into a separate bank account for aspects such as the warehouse construction).

There is a need for stronger capacity building as part of the sustainability planning including on programmatic and financial management. Stakeholders perceived sustainability aspects to be de-prioritised especially when at odds with fiduciary risk aspects. This includes for example the swapping out of the PR (explained above) but also a (perceived) focus on fiduciary control through the Fiscal Agent and the wider GF processes rather than an investment

[496] Letter to CCM Sierra Leone: Co-financing Monitoring of the Government of Sierra Leone Commitments

in improving capacity of PRs and SRs with regard to programmatic and financial management. Specifically, stakeholders considered that additional investment in in-service and pre-service training on programmatic and financial management aspects would be helpful. Additionally, this should be coupled with a more overarching HR strategy to attract as well as retain qualified and trained health professionals especially in programmatic and financial management roles (though it was acknowledged that this goes beyond the scope of the Global Fund).

Monitoring and Evaluation

There have been some improvements in the use of the national DHIS2 for the three diseases, however gaps remain especially with regard to community, paediatric and commodity consumption data as well as data use. Key gaps remain however with regard to community data, with the data from CHWs not being successfully integrated into DHIS2 to-date (the Community Health Information System (CHIS) deployment is currently in progress with the aim to integrate this into DHSI2). Additionally, stakeholders pointed to challenges related to commodity consumption data although this is reportedly starting to change with the introduction of M-Supply. Within the diseases, stakeholders flagged the limited data quality for paediatric health outcomes as well as challenges on MDR-TB and KP population estimates (further discussed below). Lastly, while data availability has been improved, there is a continuous need to also improve data use across both national and sub-national levels.

Reporting requirements by the Global Fund are largely aligned with country reporting, and the target setting process was considered adequate albeit suffering from poor quality of MDR-TB and KP population estimates. Overall, stakeholders considered the health outcomes and impact indicators of the Global Fund to be well aligned with national reporting requirements (though some stakeholders pointed to the introduction under GC7 of gender disaggregated data and new RSSH indicators that could increase reporting burden). The target setting process was considered to be adequate and the level of ambition of the targets was largely considered as fair. Key aspects in the process that were considered to work well include the involvement of the disease programs and, where possible, use of programmatic results trends from the past. Stakeholders flagged the challenge of the underlying data quality for some indicators especially for MDR-TB and KP population estimates, which meant that in these areas it was considered much harder to set targets at the right level.

11.2.4. C19RM

While the COVID-19 pandemic negatively impacted on the three diseases, most notably TB, stakeholders did not identify it as the primary reason for the limited progress in GC6. Stakeholders emphasised that the COVID-19 pandemic had a negative impact on program implementation (e.g., adding further delays on contracting etc.) and the supply chain. The disease with largest negative impact was the TB program with TB notification experiencing a considerable drop in 2020, and while this rebounded for adults, it did not recover for paediatric notifications. However, despite the additional challenges added by COVID-19 pandemic, most stakeholders pointed out that many of the root causes with regard to program implementation are irrespective of COVID-19 (see implementation section above).

There has been a range of challenges in implementing the received C19RM funding similar to the challenges also experienced with the wider portfolio. The C19RM funding was considered to face many of the same challenges with regard to procurement and program implementation as the full portfolio, with some stakeholders noting that the situation for C19RM was even more complex given the larger number of (new) partners in the space. As such, the overall absorption rate of the C19RM was also relatively low at 39% by June 2023. Reportedly, the use of technical partners to support on procurement has helped to move forward on some aspects. Overall, stakeholders considered that there has been good progress on oxygen (e.g., installation of three oxygen plants), placement of non-health products (e.g., vehicles and motor bikes) and on infection prevention and control (e.g., improvements in hand hygiene). Stakeholders stated that the progress with oxygen was largely due to the decision to outsource the project to UNICEF who reportedly managed the work well. The recent round of reprogramming of C19RM funding for RSSH was welcomed and, reportedly, freed up space within the GC7 allocation process. However, a minority pointed towards the heavy application process for C19RM funding which required resources from the PR and CCM at a time when the country already struggled to implement the core portfolio.

11.2.5. Catalytic investments

The Matching Funds for Breaking-Down-Barriers has been helpful and catalytic in GC5 but hasn't been used extensively in GC6 due to implementation challenges. Stakeholders have been positive about the matching funds initiative for huma rights and considered the investment catalytic. It was seen as improving the approach to HR in the country with funding also being used to the develop the Human Rights Strategy. In GC6 implementation challenges augmented by the swapping of NAS as PR (which has been and continues to lead on human rights barriers) has meant that the majority of the matching funds have not been used to-date. This also had an impact on progress made in the space with no direct impact attributed to the BDB initiative in GC6.[497] However, stakeholders have credited progress from partners such as the recently joint initiative from NAS and PEPFAR on outreach to the judiciary as building on the work under GC5.

Matching Funds for RSSH on data systems and human resources were also considered helpful in GC5 although there have also been implementation challenges similar to other RSSH interventions (see discussion above). Many stakeholders also welcomed the increased focused support through matching funds under RSSH in GC7 as helpful given the many health system challenges in the country. The higher amount of funding for RSSH in that regard was seen as positive allowing coverage of multiple areas without spreading the investment too thin. One stakeholder familiar with the processes suggested that additional flexibility with regard to the matching funds could be helpful – e.g., allowing the Global Fund CT to set conditions and focus areas based on country contexts rather than setting these centrally across all country portfolios.

11.2.6. Partnerships

There have been improvements in partner coordination across the grant cycles, but there is further room for improvement especially within RSSH and to leverage more strongly on the technical capacity of UN organisations. Stakeholders commented that donor coordination has improved across the cycles for HTM, commenting specifically on perceived strong alignment between Global Fund and PEFPAR as well as a strong working relationship with PMI and RBM. The also has been donor coordination through the Health Development Partners (HDP) Forum which was seen as helpful. However, several stakeholders commented that there is an opportunity to move beyond a "needs based" approach with partners such as the World Bank and FCDO, and include more strategic coordination and, potentially, joint investment or close coordination on overlapping topics (e.g., supply chain). A prerequisite for this would be a stronger understanding of the investments across donors in the RSSH space, and an RSSH donor mapping is reportedly currently ongoing.

Technical partners provide valuable technical assistance, but many stakeholders felt that the capacity of UN organisations in-country could be more strongly leveraged. There has been valuable technical assistance provided by the UN organisations particularly WHO and UNAIDS, and stakeholders have credited them with strong contributions and guidance on the National Strategic Plans, Mid-term assessments and the funding requests (this was partly funded through the Global Fund's Strategic Initiatives). However, many stakeholders from a range of different stakeholder constituencies emphasised that the technical capacity of the UN could be leveraged more with regard to key challenges of the government including on procurement and program management. There were however, diverging views on what this engagement should look like, with some arguing for an increase of technical assistance from UN organisations to the government and others arguing for a more direct involvement in program implementation of the UN.

11.2.7. Gender, human rights, equity and communities

Progress has been made on human rights in HIV partly due to the support of the Breaking-Down-Barrier initiative and the increased focus on human rights from the Global Fund, but progress in TB has been more limited. As outlined in the CI Section above, the BDB matching funds in GC5 were credited as a successful catalyst in the area of human rights that has also been leveraged by partners (especially in the absence of implementation of BDB in GC6). This has also been reflected in an assessment of the BDB initiative which showed strong progress at the mid-term assessment in 2021, but more limited progress in HIV has been made since then (and achieved progress

[497] Kananelo Consulting (2023). Breaking Down Barriers Initiative 2023 Progress Assessment for Sierra Leone

is credited to partner interventions rather than BDB initiatives directly).[498] In contrast, there has been very limited progress in TB both at the mid-term as well as until 2023. Beyond BDB, stakeholders positively commented that the Global Fund has really put human rights on the agenda for HIV.

Gender has received less attention in the past strategy period, but stakeholders welcome the increased focus on gender within the GC7 application process. Stakeholders commented that stronger gender and equity related lens would be helpful highlighting that women's access to care is still a challenge especially in some of the remoter rural areas. They also welcomed the increased focus on sex disaggregated data in Global Fund indicators which has been a gap in the past. However, they also cautioned that this requirement should be combined with additional support to strengthen data systems and data use given the additional reporting burden that comes with this change.

11.3. CONCLUSION AND SUGGESTIONS FOR POSSIBLE IMPROVEMENTS

The Sierra Leone country case study highlighted the risk of limited progress within the three diseases and RSSH related areas due to weaknesses in the implementation arrangement and the lack of proactive monitoring and mitigation of additional challenges which further exacerbate difficulties related to program implementation. There are a number of possible improvements to address learnings from this country case studies, with some of these suggestions already being taken forward as part of the GC7 funding request process:

1. **Strengthen oversight and accountability with regard to Global Fund program implantation, including with regard to CCM and CCM Secretariat capacity.** Stakeholders identified the need for a more proactive approach to identify and mitigate challenges, starting with stronger oversight and monitoring by the CCM. This can include aspects around (i) strengthening technical expertise in the CCM; (ii) maintaining the CCM Secretariat oversight officer and (iii) ensuring the effective use of tracking tools including a clear progress dashboard used at CCM meetings.
2. **Deliberate and intentional communication by the GF Secretariat to highlight key challenges and point to consequences of inaction.** The more deliberate communication of the Global Fund CT during the GC7 process was seen as helpful in escalating some of the observed challenges, and bringing in more senior decision-makers to resolve some of the key bottlenecks.
3. **Ensure a balanced approach between fiduciary risks and programmatic results,** including proactively planning for potential unintended consequences of introduced measures (e.g., have a clear transition period when swapping out a PR) and planning for subsequent exit of introduced mitigation measures.
4. **Simplify Global Fund funding request and country dialogue processes and/or adjust capacity in order to ensure implementation.** Stakeholders noted that while leading to the right selection of interventions, the Global Fund processes around the funding request and country dialogue can in some instances be very heavy especially compared to available staff capacity, consequently diverting away attention from implementation and risking delays.
5. **Leverage technical expertise of international organisations and other in-country partners**, including on programmatic and financial management. Though this should be balanced against the higher cost implications of such an approach.
6. **Co-financing requirements should be set at realistic levels, be signed-off and receive input at senior level and regularly reported on.** The approach of "de-linking" HTM funding requirements as well as an increased engagement with the MOF within GC7 has been welcomed in this regard. For specific large-scale projects, the Global Fund should consider clear counterpart financing (e.g., upfront payment for large scale projects such as the warehouse construction).

[498] Kananelo Consulting (2023). Breaking Down Barriers Initiative 2023 Progress Assessment for Sierra Leone

A.22. References

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A.23. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 55 stakeholders from the following entities:

Stakeholder group	Entity
Global Fund Secretariat	Global Fund Country Team
CCM	CCM
Principal Recipient 1: Ministry of Health representatives and GF-related program implementation units	National Malaria Control Program
	National AIDS Control Program and National AIDS Secretariat
	National Leprosy and Tuberculosis Control Program
	RSSH/ NMSA
	HSS
	IHPAU
	DPPI
Principal Recipient 2	Catholic Relief Services
Donors and Technical partners	WHO
	UNAIDS
	UNICEF
	CHAI
	PEPFAR
	World Bank
	FCDO
COVID-19 stakeholders	C19RM Coordinating Unit/ IHPAU
	Laboratory Services
	Directorate of Health Security and Emergencies
LFA and Fiscal Agent	Pricewatersscooper
	DT-Global
Sub-national government representatives	District Medical Officers
Other Government representatives	Ministry of Finance representatives
	Ministry of Gender and Children's Affairs
National CSOs, CBOs	CARKAP

12. SOUTH AFRICA CASE STUDY REPORT

12.1. INTRODUCTION

12.1.1. Key country characteristics and HTM context

South Africa is a multi-ethnic, constitutional democracy which comprises a parliamentary republic and consists of nine provinces. Socio-economically, South Africa is an upper middle-income nation, endowed with an abundance of natural resources (gold, platinum, and diamonds) and a well-established manufacturing sector. During the last 10 years however there has been a steady stagnation of growth in the economy. This stagnation has been driven largely by the crumbling transport infrastructure and the rolling scheduled power cuts (locally referred to as load-shedding) necessitated by lack of generation capacity. According to the latest South African Reserve Bank estimates, load shedding had a negative impact of 2.1% on quarterly GDP in the third quarter of 2022, with agriculture, forestry, and fishing the most impacted.[499] In healthcare, some hospital and healthcare groups reported a 3.5 fold increase in cost of running power generators vs electricity.[500] The nation also grapples with persistently high rates of unemployment, poverty, and income inequality. Based on Gini coefficients of consumption (or income) per capita, South Africa, the largest country in Southern African Customs Union, is the most unequal country in the world, ranking first among 164 countries in the World Bank's global poverty database.[501] According to the United Nations Development Programme's Human Development Index for 2021, South Africa ranks 109 out of 191 countries, reflecting a moderate level of human development.[502]

Politically, South Africa operates as a constitutional democracy with a three-tier system of government that includes national, provincial, and local tiers. The country has made significant strides since the end of its infamous apartheid era in 1994, a period characterized by institutionalized racial segregation. South Africa has been on a path towards reconciliation and equality, but it continues to face lingering political and social challenges. One of the more pressing issues the nation faces is with regards to security. Major cities like Johannesburg, Durban and Cape Town are grappling with high crime rates, posing ongoing challenges to law enforcement and civil society. Moreover, the nation also contends with episodes of social unrest and strikes in various sectors, adding a layer of complexity to its security landscape.[503] South Africa's challenges extend into environmental concerns as well, most notably in the context of climate change. The country is experiencing water scarcity, a problem exacerbated by shifting climate patterns.

Healthcare in South Africa is administered by the National Department of Health (NDOH) and consists of a public and private sector. The National Department of Health is responsible for developing national health policies, setting national standards and monitoring the performance of the health service across the 9 provinces. The National Department of Health is not responsible for delivering health services. Provincial Departments of Health are responsible for the management of the health budget in the respective provinces and implementation of all provincial health services. They are also allowed to adapt national policy to the local needs of that province. Provinces run health facilities and employ staff. The public sector is state-funded and caters to the majority of the population The private sector is largely funded through contributions to medical aid schemes or health insurance and serves around 16% of the population providing direct and quick access to health services at a higher cost to those who can afford them.[504]

South Africa has made strides in managing HIV, TB and STIs, but these diseases remain significant public health concerns. The COVID-19 pandemic exacerbated existing inequalities, intensifying pressure on the overburdened

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[499] South African Reserve Bank. Quarterly GDP Estimates
[500] Investec. [Online] [Cited: 25 October 2023.] https://www.investec.com/en_za/focus/economy/sa-s-load-shedding-how-the-sectors-are-being-affected.html
[501] Sulla, Victor; Zikhali,Precious; Cuevas,Pablo Facundo. *Inequality in Southern Africa : An Assessment of the Southern African Customs Union (English).* Washington, D.C. : World Bank Group.
http://documents.worldbank.org/curated/en/099125303072236903/P1649270c02a1f06b0a3ae02e57eadd7a82
[502] UNDP Human Development Reports. 2021.
[503] U.S. Department of State, Bureau of Diplomatic Security. 2022. [Online] [Cited: 21 October 2023.] https://www.osac.gov/Content/Report/66ce23b4-8681-4cb7-825f-1c598469bc7a
[504] National Department of Health, Republic of South Africa. South African Government. [Online] [Cited: 4 October 2023.] https://www.gov.za/about-sa/health.

health system. Despite having the world's largest HIV-treatment programmes, South Africa fell short of the globally agreed target of a 75% reduction in new HIV infections by 2020. Women, particularly adolescent girls and young women (AGYW) are at a disproportionately high risk of HIV. In 2022, HIV prevalence was highest amongst AGYW aged 15-24 years (8.8% compared to 3.7% among male peers). Girls aged 16 years are 10 times more likely to acquire HIV than their male peers (as reported based on the Thembisa model 4.6). The treatment approach adopted in 2016, where all people who are diagnosed HIV-positive are offered HIV treatment as soon as possible after the diagnosis, has resulted in over five million people being on Antiretroviral therapy (ART), yet challenges persist due to resource shortages and the impact of the COVID-19 pandemic. TB also continues to cause significant illness and death, with 172,200 people diagnosed in 2021, 4% of whom had multidrug-resistant TB. High HIV-TB coinfection rates (53%) are also a concern. There has been no substantial decrease in cases of STIs such as gonorrhoea and chlamydia for the past 30 years, with approximately 4.5 million and 5.8 million diagnoses respectively in 2017.[505]

12.1.2. Summary of Global Fund support

South Africa has been part of the Global Fund partnership since 2002.[506] During this time, significant progress has been made in the fight against HIV and TB (the risk of malaria in South Africa is low and is limited to three provinces bordering Mozambique and Swaziland. As such, the Global Fund has no current malaria investment in the country).[507] The Global Fund currently has four core grants active in South Africa. The South Africa Country Coordinating Mechanism (CCM) sits within the South Africa National AIDS Council (SANAC) structure, which is responsible for coordinating the multi-sectoral response to HIV.

There are 4 PRs in South Africa, namely AFSA, NACOSA, Beyond Zero and the National Department of Health. AFSA, NACOSA and Beyond Zero have a focus on Adolescents and Young People, as well as the Community Systems Strengthening Program. Furthermore, AFSA focuses on the Sex workers Program, while NACOSA focuses on People who Use Drugs (PWUD) and the Transgender (TG) program is implemented by Beyond Zero. All four PRs are involved in the Human Rights and Advocacy Program. The National Department of Health (NDOH) is responsible for the TB program, including the community component.

South Africa has mobilised and managed an enormous flow of domestic resources over the last decade[508] and contributes around 75% of HIV and TB spending. According to the most recent National HIV/AIDS Spending Assessment (NASA), the national HIV response in SA is funded primarily by the South African Government (69%, USD $1.7B) through domestic public revenue, with additional funding from external development partners (donors) such as PEPFAR SA (24%), the Global Fund (2%), as well as the private sector.[509]

Global Fund grants to South Africa are referred to as gap filling and are designed to leverage opportunities within the country to further strengthen partnerships to deliver quality health services to all. The significant Global Fund investment aims to consolidate hard-won gains against HIV and TB and supports efforts to continue to bend the curve of new infections and deaths for both diseases. As of September 2023, South Africa was approximately halfway (1.5 years) through the Grant Cycle (GC) 6 implementation. Grants over 2017-2022 are as follows:

- GC5 was active from April 2019 to March 2022. The total funding allocated for this grant was US$369 million across four PRs as follows: Networking HIV and AIDS Community of Southern Africa (NACOSA) (20%), AIDS Foundation South Africa (AFSA) (16%), Beyond Zero (BZ) (14%), and the largest portion (50%) to the National Department of Health (NDOH).[510]

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[505] SANAC, South African National AIDS Council. National Strategic Plan for HIV, TB and STIs 2023-2028.
[506] The Global Fund. The Global Fund Seventh Replenishment Preparatory Meeting South Africa. [Online] [Cited: 29 September 2023.] https://www.theglobalfund.org/en/seventh-replenishment/preparatory-meeting/south-africa/.
[507] Malaria. National Department of Health. [Online] [Cited: 1 October 2023.] www.health.gov.za/malaria/.
[508] The Global Fund. The Gobal Fund Data Explorer. [Online] [Cited: 27 September 2023.] https://data.theglobalfund.org/location/ZAF/overview.
[509] South African National Aids Council (SANAC). National AIDS Spending Assessment plus (NASA+) HIV and TB Spending in South Africa: 2017/18 – 2019/20
[510] South African National Aids Council (SANAC). NSO and PIP Realignment. 2022.

- GC6 spans the period from April 2022 to March 2025, with a substantial allocation of US$547 million (a 48% increase from GC5). A breakdown of the allocations for the principal recipients of this grant is as follows: NACOSA (15%), AFSA (20%), Beyond Zero (18%), and NDOH has the largest allocation at 47%.[511] This grant targets activities across 31 distinct implementation districts across the country.
- C19RM funding spans from 1 April 2019 to 31 December 2025. The total C19RM award (including C19RM 2020 awards) is USD 213,192,855 (C19RM Total Award).[512]

The aforementioned increase in the GC6 Global Fund allocation supports expansion of services, with GC6 catering to 31 districts in comparison to 27 in GC5. The allocation dynamics among principal recipients also experienced shifts; notably, NACOSA's allocation declined from 20% in GC5 to 15% in GC6, while both AFSA and Beyond Zero observed increased percentages. Furthermore, the amplified financial allocation in GC6 (nearly 50% from the previous cycle)[513] suggests both heightened donor confidence and an acknowledgment of the escalating resource requirements in South Africa.[514]

Global Fund supports programs aimed at reducing the impact of HIV and TB among key and vulnerable populations. These programs include strengthening the legal and policy environment for key populations such as men who have sex with men, sex workers, transgender people, and people who use drugs.

12.2. KEY FINDINGS

12.2.1. Relevance of Global Fund investments

In South Africa, Global Fund's investments are viewed as very relevant to the needs of the country, filling gaps in national funding. The Global Fund-supported interventions are also informed and aligned to the country's National Strategic Plans (NSPs) for HIV, TB and STIs, and work with and through key government departments. Global Fund investments in South Africa are perceived to be vital and a needed supplement to South Africa's domestic funding for health from the national treasury. All stakeholders (government, donors, civic society, private sector, secretariat, etc), agreed that the Global Fund's investments have been well aligned with South Africa's health needs, filling significant gaps, especially in areas such as Pre-Exposure Prophylaxis (PrEP), eHealth platforms, commodity supply chain, and technical assistance where there is some limitations in domestic funding. These investments are also reported to be well-crafted and carefully selected based on available epidemiological and programmatic insights, aligned to existing government, development partners and Global Fund regional interventions to ensure complementarity. Opinions vary however concerning the portfolio on procurement (which accounted for approximately 25% of the GC6 budget)[515], as compared to investments in Technical Assistance and local capacity building. Stakeholders consider that Global Fund support has also allowed South Africa to introduce innovations that would otherwise have been unfunded. Noteworthy contributions include e-health platforms, mobile TB X-ray tests, and digital healthcare solutions. RSSH investments were also perceived as highly relevant over Grant Cycles 5 and 6: these cover all core HSS components (plus support for buffer stock to supplement the government's efforts on commodity supply and security), as well as strengthening of CSOs, some of which have since become Global Fund SRs.

Global Fund investments are considered crucial to addressing the needs of underserved and marginalised communities in the country, who are often overlooked and have limited access to health services. There are however still gaps in effectively engaging these communities. The Global Fund is viewed as being the only large funder focusing on removing Human Rights barriers in the sector. Global Fund's investments in HIV and TB are reported to target key and vulnerable populations especially the youth and other high-risk groups (including

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[511] South African National Aids Council (SANAC). *NSO and PIP Realignment.* 2022.
[512] The Global Fund. (2021). COVID-19 Response Mechanism Additional Funding for South Africa. Retrieved November 9, 2023, from https://sanac.org.za/wp-content/uploads/2021/10/C19RM2021_Award-Letter_South-Africa_signed.pdf
[513] The Global Fund. The Gobal Fund Data Explorer. [Online] [Cited: 27 September 2023.] https://data.theglobalfund.org/location/ZAF/overview.
[514] South African National Aids Council (SANAC). *NSO and PIP Realignment.* 2022.
[515] DnA Factbook South Africa August 2023

sex workers, MSM, LGBTI+, PWUD, AYP) and their communities. Across the two grants (GC5 and GC6), there is an evolution in strategic focus, including the transition from Adolescent Girls and Young Women (AGYW) to Adolescents and Young People (AYP) in GC6 indicative of broader inclusivity and recognition of diverse needs to include boys and young men. Stakeholders also report that the investments have had a strong focus on communities and rights, emphasising the fact that Global Fund is one of the few funders that focuses on Human Rights in the health sector. The persistent emphasis on human rights-related barriers across both grants, reaffirms the Global Fund's commitment to ensuring equity in healthcare access.[516] However, more work needs to be done for locally situated programs going forward as some interventions do not resonate well with local community perceptions. For example, stakeholders report that the needle exchange program was viewed by local communities in the townships as enabling drug use in the youth. This misconception could be avoided by improving communication with local communities. The Community Systems Strengthening (CSS) program is viewed as unique in its bottom-up design approach which involves Key Populations (KPs) in program design, and is widely welcomed and encouraged by the majority of stakeholders. While there is acknowledgment of Global Fund's contribution to CSS by a majority of stakeholders, they however report gaps in actively involving target groups in decision-making during implementation. There is also an evident desire for more strategic recognition and investment, especially in community-based organizations (CBOs) who have capacity gaps.

12.2.2. Progress and results achieved

HIV Progress

Despite the stabilization of HIV prevalence at 13.2% over three years, the absolute number of individuals living with HIV continues to rise due to population growth, with distinct trends in prevalence based on age, gender, race, and key populations.[517] Data from South Africa's trusted modelling tool for HIV surveillance (the Thembisa Model version 4.6), covering both private and public healthcare facilities, indicates that the prevalence of HIV remained at 13.2% in 2022 (same as the past 3 years). This equates to approximately 8 million South Africans living with HIV. Despite the stabilization in prevalence, the absolute number of individuals with HIV continues to rise annually due to population growth. There is a trend in HIV prevalence based on age - starting from the age of 15, the prevalence increases, peaking in the 40-45 age bracket for both genders. This trend mirrors changes in risk behaviours and the overall risk of infection over time. The gender disparity in HIV prevalence is concerning, with women being more affected than men. This disparity is more pronounced among female adolescents and young women aged 15-24, who are three times more likely to contract HIV compared to their male peers. There are also racial disparities in HIV prevalence in South Africa, intersecting with other factors like education, income, and healthcare access. Data from the 2012 South African National HIV, Prevalence, Incidence, Behaviour and Communication Survey (SABSSM VI) revealed that the brunt of the epidemic is shouldered by Black Africans at 19.8%, while only 1.3% of White and Asian South Africans are HIV-positive. The Thembisa Model Version (TMV) 4.6 indicates that there was a marginal reduction in HIV prevalence among expecting mothers, from 26.9% in 2016 to 23.5% in 2022. Although, a 2017 antenatal care (ANC) survey among pregnant women accessing public healthcare facilities found a slightly elevated prevalence of 30.7%. Regarding key populations, South Africa's largest groups are men who have sex with men (MSM) and sex workers. According to TMV 4.6, the 2022 HIV prevalence rates stood at 29.9% for MSM (a decrease from 32.8% in 2017) and 58.8% for female sex workers (down from 66% in 2017).

South Africa has made significant progress in the fight against HIV/AIDS from 2010 to 2020, with substantial reductions in AIDS-related mortality, new cases, and an increase in access to antiretroviral treatment, particularly noteworthy is the impressive decline in annual AIDS-related deaths by 50%. From 2010 to 2020, there was a marked decline in AIDS-related mortality. The annual number of AIDS-related deaths plummeted by a staggering 50%, reducing the toll from 164,000 individuals in 2010 to 83,000 by the end of 2020. This substantial decrease signifies the effectiveness of interventions and treatment modalities implemented during this period.[518] In terms of new cases, the TMV 4.6 estimated that there were 261,458 new cases in 2016, which fell to 175,645 by 2021

[516] South African National Aids Council (SANAC). *NSO and PIP Realignment.* 2022.
[517] South African National Aids Council (SANAC). Annual Report 21/22. 2022
[518] The Global Fund**.** The Global Fund Seventh Replenishment Preparatory Meeting South Africa. [Online] [Cited: 29 September 2023.] https://www.theglobalfund.org/en/seventh-replenishment/preparatory-meeting/south

– a reduction of 32.8%. This downward trend in HIV incidence was observable across all age groups and genders. AIDS mortality is on a downward trend. In 2018, there were 58,742 AIDS-related deaths, down from 67,941 deaths in 2016 (a 13.5% decline), according to the Thembisa Model, version 4.4. Parallel to the decline in mortality, there was a commendable surge in the number of HIV-positive individuals accessing antiretroviral (ARV) treatment, rising from 20.53% of people living with HIV on ART in 2010 to 73.2% in 2022. The tripling of ARV coverage is a testament to the combined efforts of policymakers, healthcare professionals, and community advocates. In addition, over the ten-year period, coverage of PMTCT rose from 71% in 2010 to 95% in 2020,[519] emphasizing the prioritization of safeguarding future generations. Overall, the HIV treatment cascade in March 2022, revealed that South Africa was doing very well with the first 95 of the 95-95-95 targets and almost achieved the third 95 which needs to be interpreted with caution since it is dependent on the second 95 where South Africa is generally struggling.[520] Linkage to and retention on treatment has been a great challenge for the country mainly due to cultural, social and economic reasons mainly affecting younger age groups 18 to 35 years.

TB Progress

Tuberculosis (TB) notifications in South Africa have declined steadily, but the treatment success for drug-susceptible TB (DS-TB) has been below the 90% target. Treatment outcomes for multi-drug resistant TB (MDR-TB) however, have significantly improved over time. The South African National Strategy for HIV, AIDS, TB, and STI (2017 to 2022), set ambitious objectives of: screening 90% of individuals for TB, initiating TB treatment for 90% of those eligible, and ensuring 90% of those with DS-TB and 75% of those with drug-resistant TB complete their treatment successfully. The overarching goals were multifaceted: interrupting the transmission cycle, achieving the global 90-90-90 goal in every district, addressing the epidemic's structural and societal catalysts (such as poverty, overcrowding and occupational exposure with higher TB incidences reported in the mining sector), and guaranteeing universal inclusion. Complementing this, the National TB Program's 2017-2021 strategic blueprint targeted a 43% reduction in TB mortality and a 26% drop in incidence by 2021 compared to 2015 figures, aligning with the WHO's 'End TB' objectives and Strategic Development Goals. From 2017 to 2021 results show that TB notifications were on a steady decline (250,354 to 181,864). In 2022, there were reports of 224,621 TB diagnoses. Of this number, 214,295 were new or relapse cases, as well as 6,781 patients who tested positive for rifampicin resistance. This was a reduction from 250,354 notifications documented in 2016. However, DS-TB treatment success has not achieved its 90% target. There was a decline in treatment success from 81.1% in the 2016 patient group to 78.5% in the 2020 group. Factors like patients lost to follow-up and patient mortality have adversely influenced the success rate. For multi-drug resistant TB (MDR-TB), treatment outcomes have shown marked improvement rising from 40% in 2010 to 62% in 2020.[521] From 2016 to 2022, there has been a continuing decline in the number of people developing DR-TB in South Africa (from 19,000 to 11,000). The number of individuals on treatment decreased as well, which correlates with the 31% decline in incidence from 10,135 to 6,940.[522]

While progress has been made in addressing HIV/AIDS and TB co-infections in South Africa over the past decade, recent data shows a concerning decline in the co-management of TB and HIV, emphasizing the ongoing importance of integrated care approaches in healthcare service delivery. Data from the District Health Information System (DHIS), maintained by the National Department of Health reports in 2020, 5.6% of PLHIV had active tuberculosis, a marked improvement from 11.7% in 2015. Out of 383,403 individuals on ART in 2020 who were candidates for tuberculosis preventive therapy (TPT), 356,872 (93%) commenced TPT. The percentage of HIV patients co-infected with TB and receiving ARVs increased from 54% in 2010 and reached 85% by 2019, reinforcing the importance of holistic care and integration in healthcare service delivery.[523] According to UNAIDS (AIDSinfo) the co-management of TB and HIV in South Africa is on the decline. Coverage has fallen from 49% in 2017 to 42% by

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[519] The Global Fund. The Global Fund Seventh Replenishment Preparatory Meeting South Africa. [Online] [Cited: 29 September 2023.] https://www.theglobalfund.org/en/seventh-replenishment/preparatory-meeting/south
[520] South African National Aids Council (SANAC). Annual Report 21/22. 2022
[521] The Global Fund. The Global Fund Seventh Replenishment Preparatory Meeting South Africa. [Online] [Cited: 29 September 2023.] https://www.theglobalfund.org/en/seventh-replenishment/preparatory-meeting/south
[522] Stop TB Partnership. South Africa TB Dashboard. Retrieved November 9, 2023, from: https://www.stoptb.org/static_pages/ZAF_Dashboard.html
[523] The Global Fund. The Global Fund Seventh Replenishment Preparatory Meeting South Africa. [Online] [Cited: 29 September 2023.] https://www.theglobalfund.org/en/seventh-replenishment/preparatory-meeting/south

2019. In tandem, the District Health Barometer 2019/2020 highlighted a dip in the percentage of the TB/HIV co-infected population receiving ART, dropping from 91% in 2015 to 87% in 2018.[524]

RSSH Progress

In South Africa, Global Fund investments for RSSH include Human Resources for Health, Community Systems Strengthening, Health Management Information Systems, Health Products Management Systems, Integrated Service Delivery, National Health Strategy and Financial Management Systems.

South Africa's landscape of Information Management and Health Management Information Systems (HMIS) is marked by disparate systems and isolated programs, which limit a comprehensive view of nationwide health data. The country has several data systems with limited alignment or system interoperability. Stakeholders report grappling with the task of selecting and reporting indicators, primarily due to constraints in data availability especially due to the level of fragmentation of the information systems. Stakeholders describe the already fragmented HMIS landscape as compounded by a significant deficit in essential Health Informatics and IT skills in the public sector. There have been recent efforts by government and donors to improve interoperability of various M&E and data systems. For instance, the recent Presidential Health Summit Compact paved the way for the National Digital Health Strategy 2019-2024.[525] Aligned with this strategy, the NDOH is in the process of establishing an integrated, efficient information system to support decision-making and provide robust ICT infrastructure to public health institutions. The Health Patient Registration System was also developed and has been scaled up to 3,111 public health facilities.[526] The migration from the offline DHIS 1.4 to the Web-based DHIS2 has been another progress milestone.[527] There is however a need to sustain investments toward the integration of these data systems. These improvements are expected to generate accurate data to inform improvements in healthcare programs, optimize resource allocation, and bridge research gaps, towards enhancing health outcomes.

South Africa's healthcare system has shown resilience and adaptability, with consistent progress in commodity availability, notably HIV and TB drugs, with some sub-national disparities. Stakeholders report that throughout the review period, there has largely been consistent commodity availability throughout the supply chain up to the last mile (fixed Primary Health Care (PHC) and community health centres). They emphasize high availability rates for first-line HIV and TB drugs. The country has also instituted key supportive policies and structures to guide and sustain its procurement and supply chain systems. These include: the National Supply Chain Medicine Availability Surveillance Center[528] which provides real-time stock visibility across provinces; the new Supply Chain Management Policy and Procurement Procedure Manual released in March 2021[529], which is indicative of a more proactive approach toward improving supply chain processes. Despite these successes, there have also been sub-national disparities, especially the North-West province where there has been a decline in commodity availability and where the buffer stock provided through Global Fund's investments, importantly supplements the government's commodity security efforts.

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[524] South African National Aids Council (SANAC). *Annual Report 21/22.* 2022.
[525] National Digital Health Strategy for South Africa 2019-2024 accessible at https://knowledgehub.health.gov.za/system/files/elibdownloads/2023-04/national-digital-strategy-for-south-africa-2019-2024-b.pdf
[526] 2021/2022 National Department of Health Annual Report
[527] 2021/2022 National Department of Health Annual Report
[528] Falco, Marco & Meyer, Johanna & Putter, Susan & Underwood, Richard & Nabayiga, Hellen & Opanga, Sylvia & Miljkovic, Nenad & Nyathi, Ephodia & Godman, Brian. (2023). Perceptions of and Practical Experience with the National Surveillance Centre in Managing Medicines Availability Amongst Users within Public Healthcare Facilities in South Africa: Findings and Implications. Healthcare. 11. 1838. 10.3390/healthcare11131838.
[529] Released by The National Supply Chain Medicine Availability Surveillance Center

The National Health Laboratory Service (NHLS) continues to be a comprehensive and robust system that covers the majority of the country, and provides diagnostic and monitoring services, including for HIV to TB. It is a critical component in the country's healthcare ecosystem and has experienced significant improvements during the review period. The National Health Laboratory Service (NHLS) offers diagnostic testing services to more than 80% of the countries' public sector population.[530] Its large network of laboratories include centralized facilities, and decentralized services at community level through outreaches and mobile hubs. Service provision ranges from Early Infant Diagnosis HIV-PCR diagnostics, CD4-count diagnostic services, Xpert MTB/RIF Ultra tests and smear-microscopy. It also has specialized laboratories that handle liquid-based TB culture and drug-susceptibility testing for both first- and second-line anti-TB treatment agents. Stakeholders report recent improvements, such as the Data Command Centre (DCC) that enables real-time monitoring.[531]

Civil Society Organisations have benefitted from capacity strengthening efforts under the auspices of Global Fund, with increased program implementation capacity and a diversification of their resource base. Global Fund community systems strengthening (CSS) efforts are well aligned with the country's National Strategic Plan for HIV, TB and STIs. Stakeholders report that these efforts have supported hundreds of CSOs, with many of them attracting/leveraging other funding mechanisms/social contracting towards increasing their financial sustainability. Some have even become Global Fund implementers.[532] These CSOs have also demonstrated improved capacity to reach key and vulnerable populations. Also, networks representing key populations have been empowered to better engage their communities, including conducting focus group discussions to document both successes and challenges, that inform improvement in programmes, through working closely with PRs.

12.2.3. Funding model and business processes

CCM Constitution, Secretariat and Implementers

The CCM demonstrates adequate inclusivity, bringing together various sectors, including the government, civil society (including key populations), private sector, and development partners, with diverse representation, leadership, and technical expertise. South Africa's Country Coordination Mechanism (CCM) serves as a foundational structure in addressing the challenges of HIV/AIDS and TB. Comprising 21 primary members and 19 alternates, it represents various sectors, including the Government, Civil Society, Private Sector, Development Partners, and Provincial Councils on AIDS. The CCM's leadership consists of a chairperson, who also serves as the Chief Executive Officer of SANAC, and a Co-Chairperson elected from the Civil Society Forum. Civil Society's representation is diverse, including seats for youth, People Living with HIV, the LGBTQI community, Sex Workers, TB advocates, and People Who Use Drugs. Public Sector departments such as Health, Social Development, Treasury, and Education have designated seats, as do Provincial Councils on AIDS, Development Partners, and the Private Sector. SANAC provides professional secretariat and corporate governance services to the CCM, with the assistance of a coordinator and an administrator. The CCM benefits from technical experts who inform its decision-making in areas such as risk management, audit functions, and program monitoring and evaluation. Observers, like the LFA, may attend CCM meetings by invitation with the CCM Chairs' consent, though they do not have voting rights and do not contribute to meeting quorum, and their inclusion is reviewed and approved in fully constituted CCM meetings.[533] Majority of stakeholders felt that the CCM was well constituted and representative of South Africa's HIV/TB and healthcare sector. Attendance at meetings was considered to be optimal and that there was great participation from those attending. It was recognised that having Key Populations (KPs) sit at the table was very progressive and allowed them to contribute to the design, implementation and overall governance of the programs and interventions.

There were a significant number of stakeholders that thought the powers of oversight and governance of the CCM could be further strengthened. Majority of stakeholders felt that the powers of oversight and governance of the CCM could be further strengthened. Some of the areas of improvement were related to slow implementation of decisions made by the CCM. Stakeholders also reported a need for increased clarity/transparency on in-country communication and coordination so as to avoid misalignment and leaving others behind. Overall they called for better

[530] 2019/2020 National Health Laboratory Service Annual Report
[531] 2020/2021 National Health Laboratory Service Annual Report
[532] CSS Presentation at PR Consultation 29-30 March 2021
[533] South Africa CCM Secretariat. 2023.

communication and alignment between the Country Team based in Geneva, Principal Recipients (PRs), Government, LFAs and CCM especially during implementation. In regards to CCM composition, while not unusual for state and non-state implementers to also be CCM members, stakeholders noted the heightened importance of SANAC managing conflicts of interest given its role as CCM chair/coordinator and also being funded as an implementer.

PRs personnel report feeling sidelined at times in strategic discussions, with a seeming heavy reliance on external consultants who provide TA. These consultants sometimes do not meet PRs program implementation needs. There is a general sentiment amongst stakeholders of an overreliance on external consultants, with PR personnel feeling sidelined. They encounter challenges they attribute to the theoretical approaches some external consultants attempt to introduce through their technical assistance, which are somewhat impracticable. Stakeholders suggest increasing focus on capacitating PRs personnel, and a more integrated approach in selecting consultants not hired directly by PRs, emphasizing the need for better communication and inclusion of PRs in the introductory process, especially those working on different SIs, as well as active engagement in co-creating solutions.

Funding Requests Design and Processes

The Global Fund's model ensures alignment with national health strategies, however, there is a growing demand for greater flexibility, especially related to longer grant cycles, and better visibility of funding allocation decision-making processes. The Global Fund's operational model is designed to be adaptable, allowing countries to craft proposals suited to the country's unique health conditions. This approach ensures that support aligns with national health strategies, key being the National Strategic Plan for HIV, TB and STIs. Stakeholders value the Global Fund's support but also stress the need to increase flexibility to adapt programs based on changing needs and on-the-ground realities. The Global Fund provides this flexibility in principle, allowing countries to lead their FR processes and reprogram activities, however in practise, the Global Fund's grant cycle length has been pointed out as a potential disruptor of this flexibility. Shorter grant cycles are said to not allow for comprehensive assessments, adaptation, and fine-tuning of programs. A majority of respondents were of the view that longer grant cycles would allow for continuity and sustained impact, with room for reflection and evaluation of performance in a way that informs the next cycle. Another reason for the preference for longer implementation cycles is that there is a mismatch between the Global Fund's grant end-date and the country's National Strategic Plan which is said to be an imminent challenge. This mismatch affects continuity of programs and interventions, putting a lot of pressure on PRs during implementation.

Some KP stakeholders indicated there is a need for engagement to be more holistic with more visibility around funding decision making processes. Although these stakeholders are involved in design conversations, they report not understanding how final decisions are made especially as these sometimes vary from what was agreed during country consultations.

Implementation Processes, Policies and Challenges

Implementers have experienced significant operational delays, especially during the phases of contracting and the early stages of grant implementation, **mostly due to working through government systems.** Several stakeholders indicated challenges with their contracts, late funding disbursements, and bureaucratic red tape, leading to confusion and sometimes frustration. For GC6 (NMF3), many stakeholders noted that some of the local implementers had not begun work because they were still waiting for memorandums to be signed within their operating districts or jurisdictions with the government. Ambiguous communication concerning processes and timelines has been cited as a source of inefficiency, leading to potential wastage of resources. Furthermore, stakeholders requested South Africa's broader transformation objectives, focusing on empowering small local entities, to be considered when implementing projects locally.

There are robust national M&E structures in place, however, a consistent challenge has been ensuring the accuracy of data. This is further compounded by concerns about the frequent updates to Global Fund guidelines and tools being disruptive. South Africa is mainly reliant on the District Health Information System (DHIS) for its public health data. There are challenges with gaps and accuracy of the data particularly as it is aggregated from lower levels of the health system to national level. In general, stakeholders have a positive view of the Global Fund's M&E systems for their coherence with the country's established data collection frameworks. The M&E mechanisms resonate well with the indicators and data already in circulation within the country. This seamless

alignment is evident when observing the close fit between the M&E practices, including indicators and the rigorous target setting procedures in line with the National Strategic Plan (NSP). There is however less support for GF HRG indicators which stakeholders felt could align more with the Human Rights Commission strategy.

Stakeholders also pointed out the frequent updates to guidelines, tools, and templates, which disrupt ongoing processes and introduce confusion among the implementers. The adoption and then subsequent alteration of reporting tools have been a recurrent concern, and the frequent change in guidelines is considered challenging. Stakeholders emphasize the need for stability in these tools and express there is an absence of training when these tools are introduced.

Sustainability

Global Fund investments are well integrated into national health systems, a key precursor towards sustainability, with South Africa's health budget predominantly domestically funded. There are however concerns that the additional funding portfolio may not be easily taken over by the government in the future due to fiscal changes and budget cuts experienced in the health sector recently. Stakeholders agree that the sustainability of Global Fund programs is underscored by their effective integration into the national health system, with many initiatives seamlessly becoming part of the government's ongoing efforts, such as drug procurement, aligning them with national priorities and promoting long-term viability, indicating a positive progression towards self-sustainability. However, although Global Funds investments are only a small proportion of available health funding in the country, stakeholders expressed concerns about the ability of the government to financially take over or sustain this additional portfolio in the future. They described recent fiscal challenges and budget cuts already affecting the quality assurance processes, medical equipment, operational support for Human Resources, Information Technology (including the electronic health management system), and legal services. These cuts are viewed as a substantial threat to the effectiveness and longevity of programs.

Global Fund investments in RSSH have supported significant HRH recruitments, and these have been aligned with the country's salary scales towards ensuring staff continuity during resource transitions. Many stakeholders viewed the alignment of the Human Resources costs of Global Fund investments with South Africa's approved salary scales as an astute move. Such alignment increases the likelihood of staff continuity by making it feasible for these professionals to transition seamlessly between GF funding and Government payroll. Nevertheless, South Africa's prevailing fiscal constraints and budget reductions earlier described also pose substantial risks and obstacles to this transition process. The government has also set aside ZAR 7.5 billion in 2022/23 to employ community healthcare workers which the GF has supported.

The development of a tailored sustainability framework by SANAC is positive for the health sector, however the Global Fund sustainability framework, as it exists now, may not be fully representative of the country's health landscape. Stakeholders point to the development of a sustainability framework by South Africa's National AIDS Council (SANAC) as an important initiative towards sustainability of donor investments. The framework was developed in order to detail how significant external funders' activities would be sustained if funds become limited. Stakeholders report that the Global Fund sustainability framework was, in some ways, not wholly representative of South Africa's unique health landscape. In regard to the Global Fund's approach to financial sustainability and role in this regard, stakeholders consider that external oversight and feedback from entities like the Global Fund is invaluable in terms of providing unbiased assessments, evaluations, and overall accountability that further strengthens the health system and promotes improvements to foster sustainability.

Risk Management

The Global Fund's approach to risk management is said to be comprehensive and proactive, however the roles and responsibilities of Global Fund entities in this regard (particularly the CCM, LFA, and the Country Team) are not uniformly understood across country stakeholders. Respondents acknowledged Global Fund's comprehensive risk management framework, which signifies the organization's proactive approach to navigating potential pitfalls. They described the resulting risk considerations as adequate, covering both planning and implementation phases of GF investments. There is however a perception of ambiguity in the roles and responsibilities of the various country-facing entities, with stakeholders reporting misalignment between the CCM, LFA, and Country Team. This is however more an indication of limited clarity in country stakeholder understanding of the roles of these

stakeholders than it is about their roles being unclear. For instance, in the context where there are gaps in understanding risks to implementation, some stakeholders described the LFA as having been inadvertently drawn into day to day operational and compliance assessments, rather than its higher-level risk management oversight role, due to lack of capacity of some implementers. This, however, is indicative of the tailoring of LFAs response to the risk levels of different organisations.

Monitoring and Evaluation

The Global Fund's Monitoring and Evaluation (M&E) requirements are well aligned and coherent with the national M&E systems, especially its established data collection frameworks. The frequent changes to GF monitoring tools however disrupts existing workflows and adds complexity. South African stakeholders repeatedly lauded the Global Fund's M&E systems for their coherence with the country's established data collection frameworks. The M&E mechanisms resonate well with the country's established indicators and data models. This seamless alignment is evident when observing the rigorous target setting procedures with most indicators well aligned to national strategies and plans. There is however a dominant concern among stakeholders, revolving around the frequent amendments to Global Fund's tools and frameworks, even amidst ongoing grant cycles. Such shifts not only disrupt well-established workflows but also introduce an array of complexities into the system. There is a palpable sentiment among stakeholders that the Global Fund, once it decides upon monitoring tools and avails training for the same, should prioritize consistency in their application.

12.2.4. C19RM

Global Fund's initial C19RM funding based on budget flexibilities was viewed as effectively implemented and timely by stakeholders, especially for the rapid response and positive impact on TB and HIV programs. The Global Fund's financing was considered instrumental during the initial stages of the pandemic, primarily due to its capability for rapid deployment. This speed was essential, as it circumvented the bureaucratic challenges often associated with the mobilization of government resources. The immediate allocation of funds supported procurement of critical resources such as Personal Protective Equipment (PPE), though important to note that South Africa's initial response to the pandemic was considered delayed (as the experience in many countries).

C19RM funds had a significant impact on HIV and TB programs in the country. A notable success was the integrated screening for COVID-19, HIV, and TB, enhancing the breadth and depth of healthcare delivery and overall, the pandemic highlighted the need to integrate various healthcare screenings, as seen in the combined approach for COVID-19, HIV, and TB. Additionally, C19RM investments made a significant difference in patient education, with a focus on addressing vaccine hesitancy among the populace.

The outlook on C19RM investments however changed during 2021, with a lack of clarity on the focus of the funding, as well as potential inefficiencies and wastage due to procurements of commodities that were no longer critical. Stakeholders reported that by 2021, there was a decline in the effectiveness of the C19RM, particularly stemming from a lack of clarity in focus and perceived inefficiencies and the alleged waste of resources. C19RM also faced criticism from stakeholders due to perceived ambiguities on what would be funded in this phase and led to some proposed interventions/projects being rejected. Furthermore, the challenges were exacerbated by short turnaround times for the second C19RM funding request. The absence of a post-implementation assessment for the initial response also contributed to the clarity issues. A Global Fund audit reported that during implementation, many procurement-related activities materially exceeded their budgets, while key non-procurement activities have not been implemented. The audit notes there was non-compliance with commodity procurement and supply chain controls, contributing to occasional inefficiencies and limited visibility of whether commodities were reaching their intended beneficiaries. Gaps in the performance management of the third-party logistics service provider were also noted, making it difficult to measure service quality.[534] In 2023, the C19RM guidelines have however been significantly updated and better reflect the strategic shift from addressing a pandemic emergency towards longer-term investments that strengthen health systems and support pandemic preparedness. This includes the introduction of a C19RM-specific Performance Framework.

[534] The Global Fund. South Africa Audit Report 2022

The COVID-19 pandemic and the need for traditional HTM focused organizations to implement C19RM investments revealed gaps in implementer capacity to respond to broader pandemic responses. Stakeholders raised the challenges pertaining to capacity, particularly among Principal Recipients (PRs) for implementing C19 responses. Some PRs have shown expertise in dealing with specific health challenges, namely HIV and TB, but seemed less prepared to respond to an emerging pandemic such as COVID-19. The experience with C19RM however raises the issue of whether there should be dedicated funds or mechanisms specifically designed for pandemic preparedness and response, allowing for swifter and more effective reactions.

12.2.5. Catalytic Investments

There appears to be limited general knowledge about Catalytic Investments (CIs). Many stakeholders were unable to clearly identify or discern which were Matching Funds, Strategic Initiatives and Multi-Country Grants. However, overall feedback on these investments was positive. Initiatives executed through the catalytic investments portfolio generally received positive feedback. However, these funds were not typically perceived as having a catalytic impact, or at least case study respondents were unable to identify concrete, empirical evidence to suggest such an effect. However Matching Funds (MF) were understood to augment the available resources to enhance existing interventions. Stakeholders also report that the MFs have bolstered the TB program, critically aiding in the reduction of individuals missing from TB care. MFs have also been used for the Human Rights Program which many stakeholders felt was unique as no other funder, apart from Global Fund, was specifically investing in this area in health. They also described a technical leadership role played by South Africa with respect to Multi-Country grants (MCG), and marginal benefits from the grants towards elimination of malaria in border communities with Mozambique and eSwatini (Swaziland).

12.2.6. Partnerships

Collaboration across partners has been effective, facilitated by implementation of Global Fund investments through existing country structures (NDOH as PR) which has created linkages with other donor investments. There are, however, still reports of coordination challenges, especially in the National TB program. Stakeholders report positive collaboration efforts through intentional collaboration between the Global Fund and entities like PEPFAR, with good alignment and limited duplication of initiatives. Platforms such as the CCM and Development Partners' Forum are recognised as facilitators for alignment. The integration of Global Fund investments into NDOH structures and systems has increased government autonomy around the investment and streamlined execution, with services seen as government services not a separate donor-funded activity. This has enabled functional relationships with major partners and donors in the country that may not traditionally work hand in hand with the Global Fund. Stakeholders also report some coordination issues, primarily within the National TB program, due to siloed thinking and segmented approaches, leading to fragmented programs and potential resource duplications across donors.

There is less confidence in the effectiveness of technical assistance support from partner organizations, with recipients' TA needs seemingly unmet. Stakeholders seem to appreciate the rationale behind the technical assistance provided by the Global Fund and partners like WHO, PEPFAR, USAID, and UNAIDS. They are however dissatisfied with the appropriateness of the TA services and the level of implementation, with some stakeholders reporting that it is not tailored to their specific needs, and sometimes more academic than practical. This challenge is also exacerbated by the concentration of technical support at the national level, leaving sub-national tiers underserved.

12.2.7. Gender, human rights, equity & communities

The Global Fund has made significant strides in promoting human rights, gender equality, and health equity in SA, however, there are internal (programmatic and political) and external (cultural and legal) challenges that affect its overall impact. In contrast to the challenging global landscape for human rights, South Africa's robust protection of human rights stands out positively, above others globally. Stakeholders described the challenging global landscape for human rights, with notable rollbacks, especially for marginalized communities like LGBTQI as evidenced by the introductions of restrictive legislation in Uganda and more recently, India's top court’s rejection of the appeal on legalizing same sex marriages. They report that, although South Africa has made significant strides, there is still a gap in policy intent and the complicated legislative environment in the country and insist that addressing

these challenges requires a multi-faceted approach that considers the cultural, political, and legislative landscape. Key persistent and contentious issues include the criminalization of sex work, where the government has attempted to provide supportive services including developing identification mechanisms for sex workers, however the legislative environment complicates these efforts, revealing a contradiction between policy intent and legislative enforcement.

The Global Fund is recognized for investing in addressing human rights violations and championing justice; and being the only health donor investing in this area in South Africa. There is however a need for closer alignment between Global Funds investments and South Africa's national agenda. A key theme from stakeholders was the necessity for the Human Rights (HR) agenda under Global Fund investments to be more intricately coordinated with the national agenda of the Human Rights Council. There is alignment in the content and focus, but there are currently no clear coordination efforts between these initiatives during implementation. Such alignment would create synergies for greater impact.

Funding levels for human rights initiatives is reported to be insufficient, and funding, especially for GBV interventions is said to have been hampered by the GBV program mainstreaming. Stakeholders indicate that the current funding level for these human rights initiatives in general is insufficient. Also, recent changes in Global Fund's approach to resource Gender-Based Violence programs through mainstreaming it across program areas has had the opposite effect, as the resources for GBV seem to have been diminished as the visibility of these interventions within programs is somewhat limited, potentially affecting their reach and impact. Stakeholder feedback was indicative of a certain level of fragmentation in the execution of GBV interventions. A holistic, cohesive approach, designed at the national level and executed uniformly, is recommended to enhance effectiveness and optimize resource use.

Global Fund-supported initiatives have benefited marginalized groups at community levels, however, there is also a need for more grassroots interventions to address ingrained sentiments against the LGBTQI community. Programs delivering community-based health services have yielded positive results for marginalized communities, providing crucial alternatives to conventional health facilities, especially for groups who might feel alienated from traditional health infrastructures. Nevertheless, more grassroots interventions are necessary, such as capacity building of civil society to be able to educate and reduce stigma/homophobia in local communities, to challenge and change ingrained sentiments, especially those driven by certain faith-based sectors against the LGBTQI community.

12.3. CONCLUSION AND SUGGESTIONS FOR POSSIBLE IMPROVEMENTS

In South Africa, the Global Fund's investments are highly regarded for their relevance, effectively filling critical gaps in national funding for healthcare. Investments are closely aligned with the country’s National Strategic Plans for tackling HIV, TB, and STIs, and work in conjunction with key government departments. The HIV prevalence in South Africa has stabilized, however, the number of individuals living with HIV is increasing due to population growth, with distinct prevalence trends based on age, gender, race, and key populations. More work needs to be done on retention in care. On the TB front, notifications are on a decline, but the country falls short of achieving its 90% treatment success rate target for drug-susceptible TB. Conversely, treatment outcomes for MDR-TB have shown significant improvements. The CCM has succeeded in achieving a high level of inclusivity by involving various sectors. However, there are concerns about the level of CCM oversight being inadequate, and a noticeable disconnect between the CCM and PRs and perceived ambiguities in the roles of CT, CCM and LFA. Operational effectiveness is also challenging as the alignment and integration of Global Fund's investments into government systems which increases ownership, is also the root of many operational delays due to government bureaucracies, particularly in the phases of contracting SRs and early grant implementation. Also, there is a perception of heavy reliance on external consultants instead of capacity strengthening of implementers and a growing demand for greater flexibility, especially related to longer grant cycles, and better visibility of funding allocation decision-making processes. Partnerships have largely been effective, with linkages created with other donor investments, and national M&E structures are aligned with GF requirements, but there are persistent data quality gaps that are further compounded by frequent and disruptive updates to GF guidelines and tools. The Global Fund has received praise for its rapid response, particularly the initial C19RM investments, which have had a positive impact on mitigating the impact of COVID-19 on TB and HIV programs, however the planning and implementation of subsequent C19RM funds was not as effective. Lastly,

Global Fund investments have made noteworthy progress in advancing human rights, gender equality, and health equity, although funding could be increased in order to be more effective.

The review of the Global Fund Strategy in South Africa makes the following suggestions for areas of strengthening to course correct and to build on the gains already achieved:

1. Orientation of country stakeholders on the roles and responsibilities of the key country-facing roles CT, CCM, LFA, within Global Fund's funding model, to clarify perceived ambiguities and set appropriate expectations for planning, implementation, monitoring, quality assurance and risk management.
2. Leverage technical assistance consultants to provide capacity building for the local teams (PRs, SRs and CSOs), co-designing the support to meet their needs.
3. Sustain Global Fund's efforts in empowering communities including Key Populations, as well as the Human Rights agenda. For example, monitoring systems need to be in place to ensure equal representation and active participation of all stakeholders, further consolidating the decision-making processes. In the domain of human rights, legislation reforms, especially concerning sex workers, were recommended by stakeholders.

In regard to the Funding Model and Global Fund business processes, key suggestions for possible improvements are:

4. To consider options for improving alignment between Global Fund 3-year cycle and the National Strategic Plan – which would not require financing commitments beyond 3-years
5. Plan for guidelines and tools updates with a frequency that minimises disruptions in implementation processes, along with providing support to socialise country partners when there are new tools/templates/guidance etc to facilitate their use.

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A.25. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 19 stakeholders from the following entities:

Stakeholder Group	Entity
CCM	CCM
Government	HIV / AIDS disease program
	Department of Basic Education
	Provincial Departments of Health- Western Cape Province
Private Sector Representatives	Chamber of Mines
PRs	NACOSA
	Beyond Zero
	AFSA
Technical Partners	USG
	PEPFAR
Community and civil society organisations	SWEAT
Local Fund Agent	KPMG

13. SOUTH SUDAN CASE STUDY REPORT

13.1. INTRODUCTION

13.1.1. Key country characteristics and HTM context

South Sudan is a country located in East Africa, with an estimated population of 10.75 million people (as of 2021). The country is home to the world's youngest population, with more than 70% of its population being under 30. South Sudan gained its independence just over a decade ago in 2011. The country has a very complex political and socio-economic environment, and has been highly impacted by the 4Cs (conflict, corruption, climate and most recently COVID-19), riddled with unpredictable and unstable security environment, high political instability, hyperinflation and economic decline, and climatic shocks. The country is classified by the World Bank as a low-income country, with the 2nd lowest GDP per capita in the world (US$ 327 in 2022) and a highly oil-dependent economy (60% of its GDP). In 2022, the country ranked 191 of 191 countries in the Human Development Index. Most recently, global economic shocks from the pandemic exacerbated an already precarious national economic situation, bringing the country's GDP down by -6.5% in 2020 as a result of sharp decline in oil prices.[535] This is further aggravated by the impact of climatic shocks that have led to historical floods strongly affecting both food and oil production.

The country faces acute humanitarian challenges including unprecedented levels of food insecurity (an estimated 6.17 million people are facing extreme food insecurity in the country) and high levels of internal displacement (1.9 million IDPs and ~297,000 refugees were reported in 2019).[536] Despite continued international assistance, ongoing conflicts continue to destroy livelihoods and infrastructures, increasing extreme poverty, deepening the food crisis, and further deteriorating an already weak health system. The resulting situation is an overstrained health system, highly dependent on donor support. The health sector is predominantly externally funded and domestic financing for health has been extremely low over the years, decreasing from 7% of the national budget in 2012 to 1% in 2016 and remaining in the range of 1-2% as of 2018/19.[537] The inadequate human resources for health capacity is compounded by ineffective governance, non-functional infrastructures, and ineffective supportive systems for health including health information, laboratory, supply chain and community systems.

This situation has taken its toll on the three diseases over the years and HIV, TB and Malaria continue to be high public health priorities in South Sudan. They were 2,953,582 estimated malaria cases in the country, 173,807 people living with HIV (PLHIV) and 24,400 TB cases in 2021.[538][539] Despite increasing funding and some progress made, HIV prevalence continues to be high (2.5% adult prevalence in 2020) with pockets of hyperendemicity in the southern part of the country (the Greater Equatoria region) and among Key Populations (KPs).[540] There is a critical lack of reliable data to accurately estimate HIV prevalence in the country, especially for KPs (Female Sex Workers (FSW), Men who Have Sex with Men (MSM), People who Inject Drugs (PWID)) for which access to services is constrained by legal barriers, high levels of stigma and discrimination. Similar challenges hinder accurate estimation of TB cases although current data report a high incidence (227 TB cases per 100,000 in 2021).[541] Due to limited funding for TB in South Sudan, TB interventions coverage is poor, living large swaths of the country not covered with TB services at all.[542] As for malaria, the disease is highly endemic in all parts of the country with the entire population at risk of

[535] Based on Global Fund internal documents (confidential)

[536] Global Fund (2019). South Sudan Country Portfolio Review

[537] Global Fund (2023). South Sudan Portfolio analysis

[538] Global Fund (2023). South Sudan DNA Factbook

[539] Based on Global Fund internal documents (confidential). In the national budget of US$1.3 billion for 2019, health received 1% of this funding. For GC7, the Secretariat noted that government health budget execution is very variable and that timely and reliable reporting of expenditures for health could not be assumed during GC7.

[540] UNAIDS (2020). Country progress report - South Sudan. Global AIDS Monitoring 2020

[541] WHO (2023). Country Disease Outlook. South Sudan

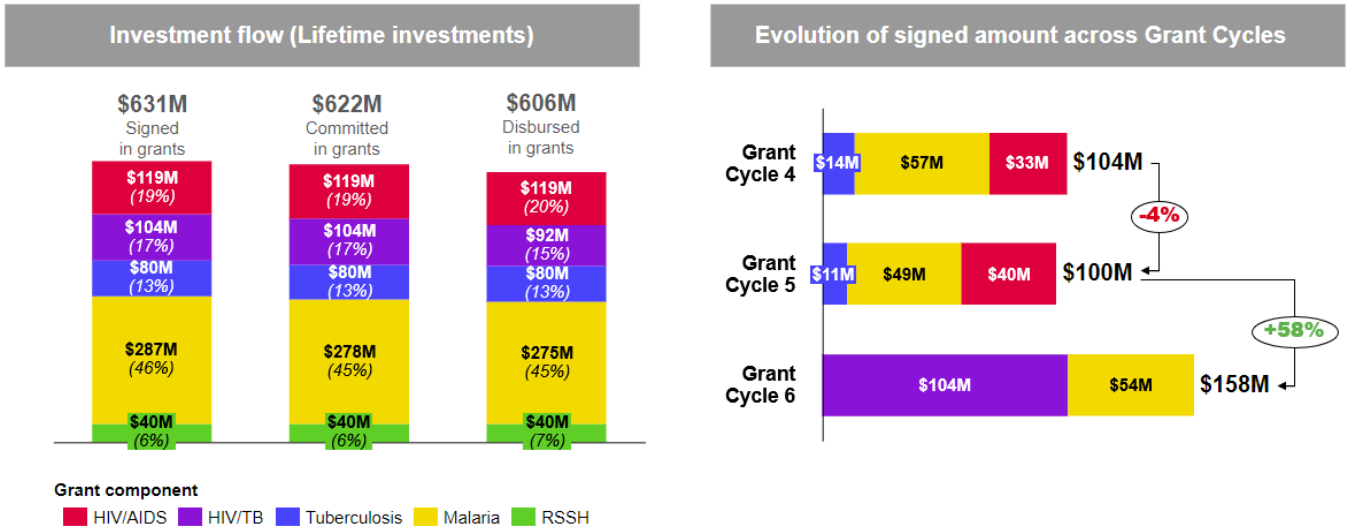
[542] Based on Global Fund internal documents (confidential)

infection.[543] In 2019, Malaria accounted for 30% to 50% of all visits to health facilities, over 40% of all hospital admissions and over 56% of all inpatient deaths.[544] Across the three diseases, current data are considered to be underestimates especially for HIV and TB for which there is no national consensus on the size estimation results due to poor information systems and fragmented M&E processes.[545]

13.1.2. Summary of Global Fund support

South Sudan has been classified as a Challenging Operating Environment by the Global Fund since 2016 and is managed under the Additional Safeguarding Policy (ASP) since 2005.[546] Global Fund lifetime investments in the country are estimated[547] to reach US$631 million with US$119 million allocated to HIV, US$80 million to TB, US$104 million to HIV/TB combined, US$287 million to malaria and US$40 million to RSSH overall as illustrated in Figure 13.1.

Figure 13.1: Overview of Global Fund investment in South Sudan[548]



Due to current ASP arrangements in place, UN agencies or International organizations have been acting as Primary Recipients (PRs) for South Sudan, with UNDP as PR for HIV and TB grants and UNICEF as PR for malaria grants from GC6 (taking over from PSI who was the malaria PR until end of GC5). The Ministry of Health and various iNGOs act as sub-recipients (SRCs), and local NGOs act as sub-sub recipients (SSRs).

Table 13.1 provides an overview of Global Fund allocation across the three diseases between GC5 and GC6.

Table 13.1: Global Fund allocation across the three diseases +RSSH in GC5 and GC6 ($US millions)

Disease areas	GC5	GC6
HIV	$40.6	$58.1
TB	$11.4	$9
Malaria	$51.1	$54.6
RSSH	$6.3	$9.2

[543] Republic of South Sudan, Ministry of Health: National Malaria Strategic Plan for 2021 – 2025

[544] Republic of South Sudan, Ministry of Health: National Malaria Strategic Plan for 2021 – 2025

[545] Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

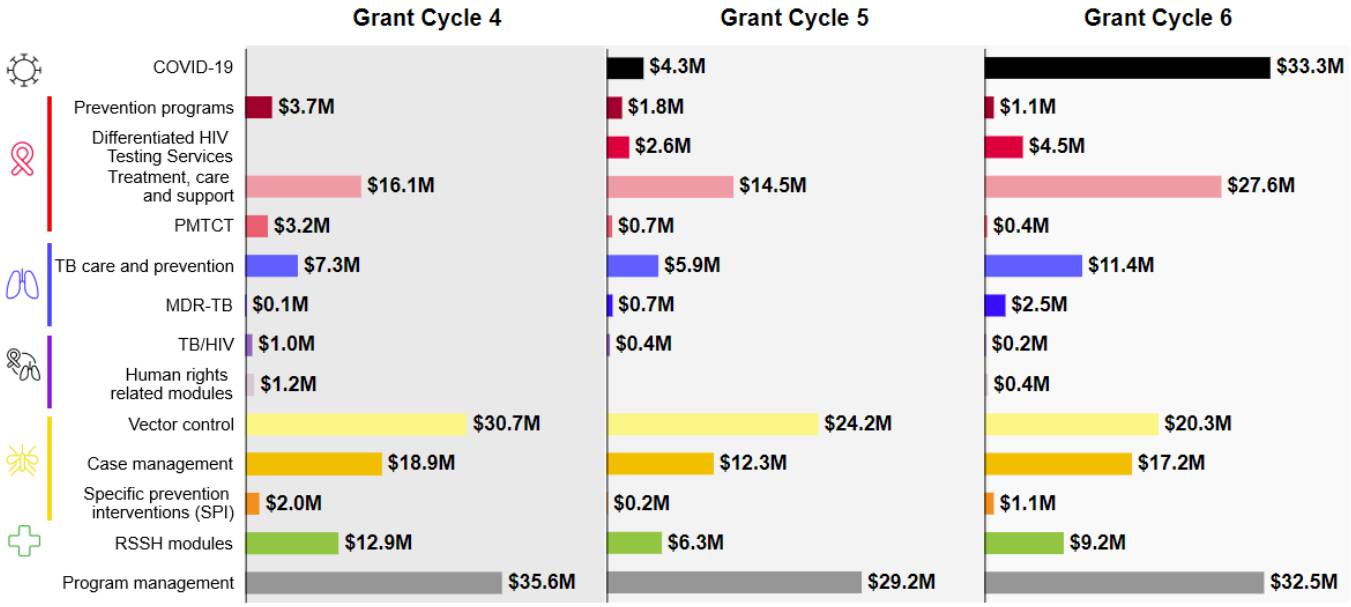
[546] Global Fund (2023). South Sudan Portfolio Analysis

[547] Global Fund (2023). South Sudan DnA Factbook

[548] Global Fund (2023). South Sudan DnA Factbook

In GC6, the long-lasting insecticidal nets (LLIN) Mass campaign received the highest allocation amongst malaria interventions ($20.1Mmillion), differentiated ART service delivery and HIV care was the highest investment for HIV ($25.5million) whilst TB treatment (care and prevention) was the biggest category for TB. Refer to Figure 13.2 for breakdown the Global Fund budget by modules.

Figure 13.2: Overview of Global Fund budget by modules the over the last 3 Grant Cycles



13.2. KEY FINDINGS

13.2.1. Relevance of Global Fund investments

Global Fund investments have been responding to acute needs on HIV, TB and Malaria in the country especially seeing the limited funding available, making all investments highly relevant. There is high consensus from stakeholders of the important role of the Global Fund as a major donor in the country and a key driver for HTM responses in South Sudan. Global Fund investments have been covering a critical gap in funding for the three diseases as Malaria remains the leading cause of morbidity and mortality in South Sudan, whilst the prevalence of HIV and TB also remains high, exacerbated by poor coverage of services as well as high level of stigma and discrimination further hindering access to treatment and care.[549]

Public financing for health in South Sudan continues to be extremely low, below 2% of the national budget, and the country is disproportionately dependant on donor funding assistance for health (at over 70% of its total health expenditure).[550] Funding to respond to HTM needs remains limited, increasing the relevance of Global Fund investment who is the only donor for TB, and one of the main donor for HIV (with PEFAR) and for Malaria (with the World Bank and a consortium of partners through the Health Pooled Fund).

In 2022, Global Fund allocation investments (US$21.4 million) and PEPFAR contributions (~$38 million) constituted almost 100% of total HIV program budget in the country, whilst the US$13.3 million TB grant from the Global Fund represented only one-third of South Sudan's needs, leaving a significant gap in funding for the disease.[551] On the

[549] Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

[550] WHO (2021). South Sudan Annual Report 2021

[551] Based on Global Fund internal documents (confidential)

Malaria side, the US$50 million grant provided by the Global Fund far exceeded other partner contributions of (US$19.3 million) for the NFM3 period[552] especially as the HPF has been scaling down its presence in the country.[553]

Global Fund investments have been well aligned with national priorities and responsive to country's evolving needs by prioritising key interventions to maximise impact, though aspects of HIV interventions and RSSH in particular, have been limited, and there is room to improve efficiency and value for money overall. Stakeholders feedback have highlighted the strong alignment of Global Fund interventions with the National Strategic Plans (NSPs), facilitated by an inclusive process for developing funding requests through the CCM which includes representation from government, CSOs and key stakeholders. In addition, stakeholders have confirmed that the Global Fund has been strategically targeting key evidence-based interventions across the three diseases, responsive to emerging diseases priorities (e.g., adapted interventions for Malaria in evidence of increasing Pyrethroid-PBO resistance), and promoting systematic analysis and use of the limited available data to inform interventions and maximise impact.

However, there are several key challenges and trade-offs implicated in the prioritization decisions required and reflective of constrained total donor funding, in particular the decision to fund 100% of HIV commodities was highlighted by a number of stakeholders, as it leaves little funding for other interventions including HIV prevention which has been deprioritised as a result. This could be mitigated to some degree by closer and more substantial coordination with PEFPAR (second major for HIV) to avoid unnecessary duplication and fragmented service delivery in this space. Poor integration of HIV and TB services into the health system also remains a critical issue and causes sub-optimal utilisation of resources that are already very limited.[554] Stakeholders have also flagged the low level of RSSH funding in general, though C19RM provided an opportunity to increase funding for health and community strengthening interventions.

Furthermore, stakeholders have flagged the relatively high program management costs to implement Global Fund interventions in South Sudan (e.g., 30% of all available funding in GC5 for HIV, 38% for TB grants and 26% for malaria[555]), mostly driven by the need to operate through non-Government PRs (as mandated by the ASP in effect). This has further reduced the funding available for service delivery and highlights the need to better balance risk management and value for money trade-offs in the decision making.

13.2.2. Progress and results achieved

The Global Fund reported a steady increase in performance against targets overall and across the three diseases though critical data gap hinders exact assessment of situation and consistent over-performance raises questions around the level of ambition of set performance targets. Whilst reported results against performance targets have been positive overall, often exceeding targets, performance against global targets remain extremely low[556], posing the question on whether performance targets, as currently set, enable optimal (ambitious yet realistic) assessment of progress against the three diseases. This is particularly critical as reported number of annual new infections has been increasing instead of going down and lost to follow up remains high (39% at 12 months in 2022)[557], elevating the need to identify new and lost cases more effectively, especially in the absence of large prevention interventions. In addition, stakeholders have flagged low coverage of GF interventions across the country and inequitable distribution of facilities leaving part of the population underserved especially in hard-to-reach areas and during rainy seasons.

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[552] Based on Global Fund internal documents (confidential)

[553] Global Fund (2023). South Sudan country risk profile

[554] Global Fund (2023). Funding Request and Global Fund internal documents (confidential)

[555] Global Fund (2023). South Sudan DnA Factbook

[556] Global Fund (2023). South Sudan DnA Factbook

[557] Based on Global Fund internal documents (confidential)

HIV progress

There has been positive improvement in the fight against HIV including a declining HIV related mortality, decrease in new infections and increase in people on Antiretroviral Therapy (ART), although the country is lagging far behind in reaching the 95-95-95 global targets due in part to inequitable access to services across the country, and poor information systems hindering an accurate estimation of PLHIV, especially KPs. AIDS-related deaths (all ages) have almost halved over the last decade, from 14,000 in 2014 to 7,900 in 2021, and new infections follow a similar downward trend, reaching 11,000 in 2021 from 19,000 in 2014.[558] Global Fund performance framework reports also show positive results with 47,541 estimated people currently on ART (99% of performance framework target) and HIV prevention programs for sexual workers reaching 136% of performance framework target in 2021.[559] However, the country is lagging far behind in reaching global targets with reported results at 39-32-27 against 95-95-95 targets (i.e., 39% of people living with HIV were aware of their HIV status, 32% of all PLHIV were on ARV and 27% had viral suppression in 2022). [560]

On average, 33% adults aged 15 years and above (34% of females and 32% of males) received ART. ART coverage among children is exceptionally low in the country with only 18% children currently on ART.[561] HIV services coverage has been unequal within the population including between gender (lower treatment coverage and viral suppression for males than females) and across age groups (Figure 13.3).[562] Although PMTCT coverage has been increasing (from 43% in 2019 to 52% in 2022[563]), it remains lower than expected, driven by low access and low utilization of ANC services and very low rates of institutional deliveries. In 2022, only 46% of pregnant women attended at least 1 ANC appointment and nearly 90% of all births occur outside a health facility.[564] Stakeholders have also highlighted that the lack of reliable data particularly affects the estimation of disease prevalence in Key Populations (FSW, MSM, PWID) for whom access to services remains limited due to legal barriers as well as high HIV and TB-related stigma and discrimination.[565]

[558] UNAIDS (2022) South Sudan Country Factsheet.

[559] Global Fund (2023). South Sudan DnA Factbook

[560] Based on Global Fund internal documents (confidential)

[561] SSAC and MGCSW (2023). Gender assessment report of the South Sudan national HIV epidemic and response

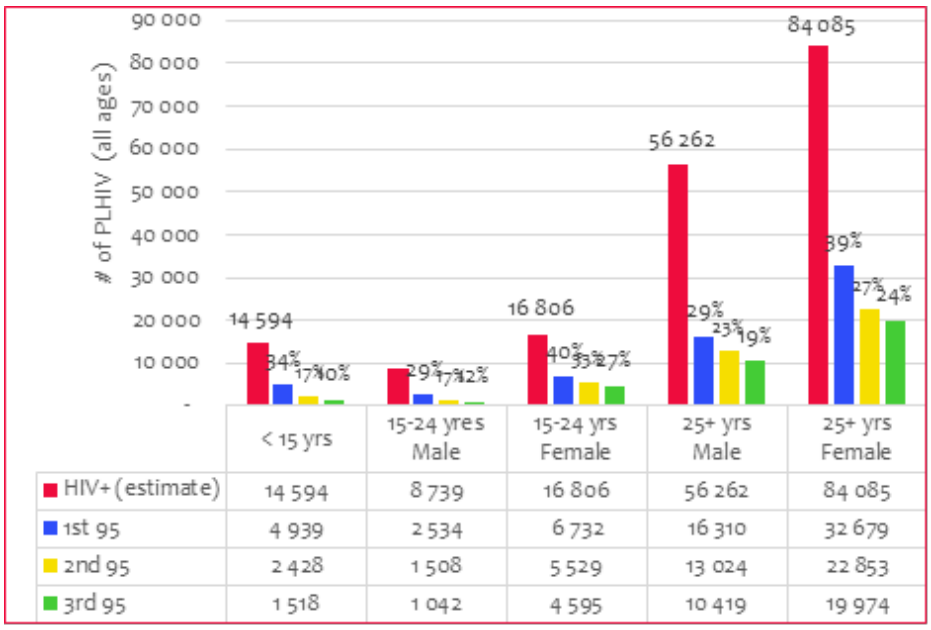
[562] Global Fund (2023). Funding Request and Global Fund internal documents (confidential)

[563] Ibid

[564] Ibid

[565] Ibid.

Figure 13.3: HIV cascade results for by age and sex (2021)[566]



	< 15 yrs	15-24 yres Male	15-24 yrs Female	25+ yrs Male	25+ yrs Female
HIV+ (estimate)	14 594	8 739	16 806	56 262	84 085
1st 95	4 939	2 534	6 732	16 310	32 679
2nd 95	2 428	1 508	5 529	13 024	22 853
3rd 95	1 518	1 042	4 595	10 419	19 974

In an effort to reach people still underserved by HIV services and better target pockets of hyperendemic groups and geographical areas, the Global Fund has been trying to improve its coverage across the country, increasing the number of ART sites from 82 in 2019 to 171 in 2022.[567] However, reported uptake of services in some sites has been poor (27 sites reported less than 25 PLHIV on ART, 20 reported less than 10; and 9 reported 0 PLHIV on ART).[568] Stakeholders have highlighted the need to consolidate and optimise ART services given the limited resources available, including through better coordination with PEPFAR who supports all high burden regions.

TB progress

The country is making solid progress against TB with treatment coverage and success increasing, contributing to a decline in TB related mortality over the last decade. However, outstanding challenges and gaps remain including poor service coverage across the country and poor integration of services into the overall health system. Tuberculosis treatment coverage has progressively increased with a treatment success rate reported at 82%. TB related mortality for all forms of TB (excluding HIV coinfection) has reduced since 2015, from 54 to 28 per 100,000 population in 2021, and the TB mortality rate among HIV-positive people has fallen from 13 to 8.5 in the same period.[569] Global Fund reported positive results for TB interventions including a steady increase in TB case notification rate over the last decade (Figure 13.4), reaching 17,424 out of estimated 22,637 cases as of 2021, and positive results for MDR-TB on second-line treatment (136% against set target) and HIV-positive TB patients on ART during TB treatment (107% against target).[570] This was the result of both passive case finding strategies (through facility-based screening) as well as enhanced community based active case finding by SRs (through Boma Health workers and home health promoters to increase screening and referral) and intensified screening of people with presumptive TB in HIV services or other health facility entry points.[571] Stakeholders also highlight Covid-19 indirect benefits as C19RM investments provided additional funding to decentralize diagnostic capacity for both for TB and MDR-TB, including for the decentralization of GeneXpert network. However, major data gap also hinders TB progress

[566] Global Fund (2023). Funding Request and Global Fund internal documents (confidential).

[567] Ibid.

[568] Ibid.

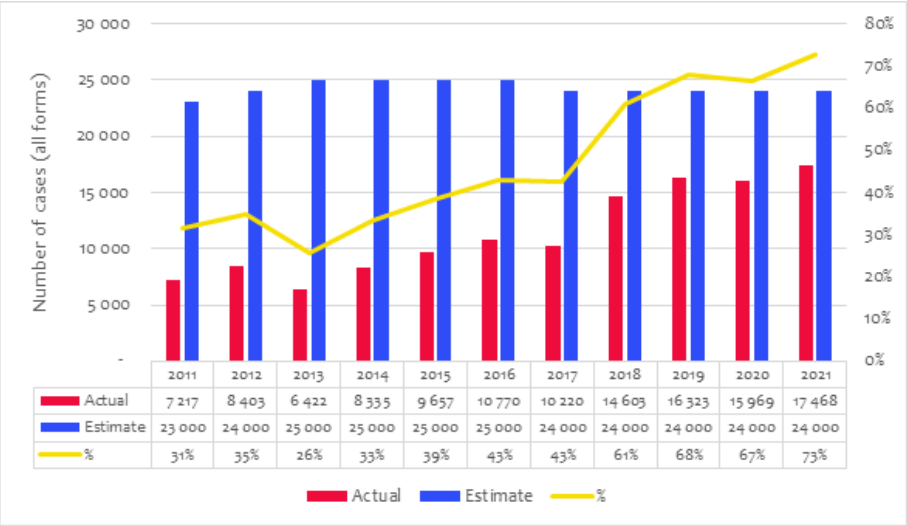
[569] WHO (2023). Country Disease Outlook. South Sudan

[570] Global Fund (2023). South Sudan DnA Factbook

[571] Based on Global Fund internal documents (confidential).

assessment, as stakeholders flag a potential underestimation of TB prevalence and inaccurate visibility on infection rate.

Figure 13.4: TB case notifications 2011-2021[572]



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Actual	7 217	8 403	6 422	8 335	9 657	10 770	10 220	14 603	16 323	15 969	17 468
Estimate	23 000	24 000	25 000	25 000	25 000	25 000	24 000	24 000	24 000	24 000	24 000
%	31%	35%	26%	33%	39%	43%	43%	61%	68%	67%	73%

In addition, stakeholders highlighted that, whilst integration of TB and HIV services into the overall health system has been initiated, interventions are still largely delivered though vertical programming with limited to no integration within larger health systems strengthening interventions. As of December 2022, TB services were provided in less than 20% of the 800 functional PHC health facilities across the country[573], leaving large parts of the country uncovered and emphasising the critical need to optimise TB existing interventions. In addition, the provision and uptake of some TB services remain low (e.g., TB preventative therapy (TPT) is not systematically implemented in South Sudan, there is a lack of isolation/emergency care facilities available for MDR-TB and injection-free treatment is not yet implemented).[574]

Malaria progress

Malaria incident and associated mortality has been decreasing and Global Fund reports overachieving results against set targets for its malaria interventions. However, stakeholders have flagged persisting challenges with low coverage of key interventions and significant underreporting hindering accurate estimation of malaria prevalence in the country. The midterm review of the national Malaria strategic plan reported a reduction in malaria incidence by 18.8%, (from 337 in 2019 to 274 cases per 1000 population in 2022) and reduction in associated deaths by 10.5% between 2019 and 2022 (38 to 27.5 deaths per 1000 population).[575] Global Fund performance reports have been positive with exceeding results against targets, including for suspected malaria cases that received a parasitological test (exceeding targets at 117% in 2021), cases of malaria treated (at 108% of set target), and pregnant women attending antenatal clinics who received intermittent preventive treatment for malaria (at 106% of set target).[576] The number of reported cases of malaria in South Sudan increased in 2021 by 74% compared to 2020 (3.1 million from about 1.8 million). The low number of cases reported in 2020 is suggested to be due to COVID-19 related disruptions and there are general concerns of underreporting, with an estimated discrepancy that could be three times higher than current estimation.[577]

[572] Global Fund (2023). Funding Request and Global Fund internal documents (confidential).

[573] Ibid.

[574] Ibid.

[575] South Sudan Ministry of Health National Malaria Program (2022). Mid Term Review of Malaria Strategic Plan

[576] Global Fund (2023). South Sudan DnA Factbook

[577] WHO (2022). World malaria report 2022

Vector control through distribution of insecticide treated bed nets (ITNs)/long-lasting insecticidal nets (LLINs) during mass campaigns and in routinely services (Antenatal Care (ANC) and Expanded Program for Immunization (EPI) services) has been the main strategy used to prevent malaria in the country and reach vulnerable populations especially women or under 5 children[578] (mass campaign funding accounted for ~60% of GC5 and 6 investments)[579] However, some stakeholders flag the limited reach of people through mass campaigns (given short window period for distribution especially during bad weather periods) and poor access to health services due to inadequate infrastructures, limiting to ITNs coverage. A recent Malaria Indicator Survey reported only 41.7% net utilization of ITNs by under-five and less than 50% of households own at least one ITN for every two people.[580]

In addition, whilst ANC coverage has been improving in South Sudan, coverage of intermittent preventive treatment of malaria during pregnancy (IPTp) remains low with IPTp1 coverage at 28% while IPTp3 coverage was 21% in 2022.[581] To address this gap, the Global Fund has been intensifying its focus on community-based services via IMCI and ICCM interventions through Boma Health Workers (BHW) as part of the Integrated Community Health Initiative to strengthen last mile delivery and increase prevention and case management.

It is also worth mentioning the change in PR for the malaria grant (from PSI in GC5 to UNICEF in GC6) which led to significant delay in the implementation of Global Fund malaria interventions (by almost a year) though stakeholders have shared that UNICEF was able to make up for initial delays with no reported impact on overall performance.

RSSH &CSS progress

The health system remains severely challenged in South Sudan with modest progress over the last funding cycles as critical issues remain including inadequate infrastructures, poor human resources capacity and weak financial and information systems. Overall, stakeholders have highlighted that progress and funding for RSSH have been very small especially considering the critical needs in the country. Human Resources for Health remain extremely low (1 physician per 65,574 population and 1 midwife per 39,088 population), infrastructures are highly inadequate (only 9% of the country has access to electricity and less than 1% has paved roads) and information systems are hampered by poor telecommunication, connectivity and transport infrastructure.[582] Global Fund investments in RSSH for South Sudan have remained low across GC5 and 6, accounting for only 6% of disbursed grants (6.3 million and $9.2 million respectively).[583] Although some components of community-based and community-led interventions were funded under the last funding cycles, recent briefing notes highlight that most interventions suggested by the constituencies were shifted to the PAAR component and left unfunded (as of end 2022).[584] Some stakeholders have also shared concerns around the very limited community-based interventions (especially for PLHIV) including mental health and psychological support.

RSSH and CSS interventions received an additional 7.8 million from C19RM (20% of its budget)[585] which stakeholders have flagged as highly beneficial at a time when RSSH was not getting enough traction. This enabled better support for systems strengthening (e.g., lab and surveillance), and more investment to strengthen community programming and monitoring (including through CSOs and the BOMA CHWs).[586]

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[578] Global Fund (2023). South Sudan Portfolio analysis.

[579] Global Fund (2023). South Sudan DnA Factbook

[580] Global Fund (2023). Malaria funding request.

[581] Global Fund (2023). Malaria funding request.

[582] Based on Global Fund internal documents (confidential).

[583] Global Fund (2023). South Sudan DnA Factbook

[584] Based on Global Fund internal documents (confidential).

[585] Global Fund (2023). South Sudan DnA Factbook

[586] Based on Global Fund internal documents (confidential).

Recent Global Fund reports also highlight a growing private health sector which aims to fill critical gaps in health services availability for HTM though oversight from the government will be essential to ensure effective regulation, good quality of services and complementarity with the public sector to avoid widening the equity gap.[587]

13.2.3. Funding model and business processes

Funding model

The CCM and CT have been instrumental in supporting inclusive and effective implementation of Global Fund investments in the country though capacity constraints at CCM secretariat level may have hampered optimal coordination. Stakeholders have reported that the CCM has provided a crucial space for engagement, both through its composition (e.g., good representation of Government and CSOs including in the executive committee and secretariat) and through wider cross-partner coordination mechanisms (e.g., participation of PEPFAR in funding requests development and Global Fund attendance in COP). Stakeholders have reported an inclusive and robust funding request process though some have flagged it can be a laborious and capacity intensive process. The CT support has also been highlighted as highly beneficial to enable effective implementation of Global Fund investments, including their efforts to support better contextualization of Global Fund processes in the country (e.g., supporting discussions on ASP flexibilities). However, some challenges have been raised regarding the limited capacity of the secretariat resulting in suboptimal coordination and admin, and a recent audit reports also flags potential challenges to CCM's independence as implementers contribute to financing CCM oversight activities.[588] The challenges experienced during the PR transition in GC6 also offers the opportunity to capture lessons learned, particularly regarding ways to optimise PR transition across cycles.

The COE Policy has largely worked well in South Sudan, though the use of grant flexibilities has been limited over the last funding cycles, highlighting opportunities to improve communication and understanding of the Global Fund policies across stakeholders to better exploit relevant available flexibilities. Although stakeholders report that general awareness of the COE has improved, they flag a persisting lack of understanding across stakeholders of what COE is and a potential negative connotation associated with the name of the policy. They have highlighted the need to improve stakeholders' awareness of the policy and the benefits it may offer. In particular, there is an opportunity to learn from the recent approved use of flexibilities in the country, such as those approved for the malaria grant in the last funding cycle. A recent audit of South Sudan[589] reported that the program was able to take full advantage of flexibilities (e.g., alternative reporting mechanism and outsourcing of bed net distribution to service providers including humanitarian agencies as opposed to SRs), although it highlighted key challenges including the absence of a clear risk appetite on key areas (e.g., loss of commodities/bed nets, accountability by the PR) leading to a cautious approach to the use of flexibilities which may have deterred implementers from exploring other flexibilities available under the COE policy. In addition, Stakeholder have mentioned the time it takes to apply for COE flexibilities (potentially linked to a lack of experience in the application process), with recommendation to initiate discussions on flexibilities as early as possible to provide enough time for planning and application.

Sustainability, Transition and Co-financing

South Sudan complex contextual challenges pose critical limitation to a full transition in the medium term, though strategic incremental changes can be made to promote better Government ownership with the vision of a transition in the longer term to ensure sustainability. South Sudan has been highlighted as the most challenging operating environments in the Global Fund portfolio, with critical concerns regarding the country governance capacity (e.g., reported Corruption Perception Index (CPI) was 180/180 in 2021) including weak accountability systems and on-going political divisions, compounded by a protracted humanitarian emergency crisis, which critically hampers the prospects of a stable development of national systems.[590] To mitigate these risks, Global Fund investments in South Sudan have been managed under the Additional Safeguarding Policy since 2005 including

[587] Based on Global Fund internal documents (confidential).

[588] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[589] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[590] Global Fund (2023). South Sudan Portfolio analysis

through the use of UN agencies as PRs (currently UNDP and UNICEF) and the implementation of additional risk management processes (e.g., a zero-cash policy, segregation of duties, regular financial audits etc.).[591]

Whilst the need for these arrangements has not been disputed, stakeholders have flagged the challenges they pose for efficiency and questioned the sustainability of such a model. The reported challenges of the current arrangement are many, including a lack of overall efficiency due to significant transactional and programmatic costs, added workload for administrative management on already overstretched PRs, as well as poor government ownership of HTM interventions and increased fragmentation of service delivery. Stakeholders have emphasised the need for better adaptation of Global Fund policies in South Sudan in light of its context and for identifying a way out of the ASP (as its currently applied) and zero-cash policy in the long term informed by a clear Capacity-Building and Transition Plan. Efforts have been ongoing (e.g., UNDP and MOH joint implementation of a three-year Capacity Development and Transition Plan (CDTP) to create a MOH/PMU[592]), with proposed progressive handover of some aspects of Global Fund interventions delivery to the government, to build its capacity across MoH directorates and relevant non-MoH entities and stop relying on international organisations over time.[593] Though some stakeholders also recognised that the ability to fully resolve current challenges lie beyond the scope of the Global Fund, highlighting the need to combine efforts by Global Fund with wider peace and state building initiatives from relevant partners.

South Sudan is likely to continue to face key challenges to mobilise domestic resource for health in the foreseeable future, emphasizing the need to support improved financial management whilst continuing to advocate for incremental investments in health. Domestic financing for health in South Sudan has been extremely low, with a health budget below 2% of National Budget[594] and an underdeveloped, fragmented health system, heavily reliant on donor funding. In addition, the country's high dependency on oil makes it vulnerable to volatile changes in oil prices and inflation.[595] Although the Government of South Sudan reportedly made some co-financing commitments over the last funding cycles (mostly expected to support facility operating costs, salaries for HRH)[596], it was not able to meet its NFM2 co-financing requirements, and a subsequent waiver of NFM3 requirements was granted in acknowledgement of many challenges faced by the country.[597] Going forward, stakeholders have shared anticipating little changes to the current situation as South Sudan is expected to remain heavily dependent on development assistance, including the Global Fund and other partners supporting the health sector, in the medium to long term.

Whilst a significant increase in domestic contributions to the health sector remains unlikely, stakeholders have flagged the importance of improving efficiencies to maximise the use of limited national resources and building public financing management systems to better track and monitor the use of funds. Key partners such as the World Bank, have been involved in providing technical assistance for health financing and building capacity of key government bodies (including MoH and MoF) to complement continued strategic advocacy for better resource management.

Risk management

Stringent risk management processes are in place in South Sudan to mitigate the high level of risks identified. However, stakeholders flagged critical challenges for balancing risk management tradeoffs and implementation efficiency especially in a limited funding context. The majority of identified risks for South Sudan are rated Very High and/or High by the Global Fund across the different risk dimensions (from program quality, in-country supply chain to in-country governance).[598] The risk management processes in place are mostly enacted through the ASP including the application of a zero cash-based policy and use of well-established PRs and SRs to manage fiduciary and programmatic risks. Additional risk management processes that have been documented

[591] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[592] Global Fund (2021). Funding Request and internal Global Fund documents (confidential)

[593] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[594] Global Fund (2023). South Sudan Portfolio analysis

[595] Global Fund (2023). South Sudan Portfolio analysis

[596] Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

[597] Based on internal Global Fund documents (confidential)

[598] Global Fund (2023). South Sudan Country risk profile

include procurement management through UN systems, development of an Integrated Risk Management module (tool) to track due dates of risk actions amongst other.[599]

Stakeholders shared that the process in place allow for adequate management of risks especially considering the context in which they operate, however, they have flagged the challenges posed by the current risk management processes under the ASP, especially the zero cash policy, highlighting that this has made implementation very challenging and complex (for the reasons mentioned previously). Overall, there has been unanimous recognition of a need to be a better balance of risk management priorities with programmatic needs to remove implementation bottlenecks and ensure the effectiveness of available funding especially in the context of restricted funding. Some stakeholders have already highlighted ongoing discussions to mitigate these challenges, highlighting it as a positive step in the right direction.

Monitoring and Evaluation

Despite continued investment to strengthen M&E processes, there are persisting gaps in the quality of data and information generated though the current health management information system (HMIS), further exacerbated by limited operational capacity for M&E and weak infrastructure in the country.

Inadequate design and poor operational capacity of M&E systems have been highlighted as a critical gap in South Sudan where national information systems continue to be extremely constrained by insecurity and a lack of infrastructure. Key national population surveys (e.g., national population census, demographic household survey, HIV/TB prevalence surveys) have not been conducted since 2011[600] leading to poor estimation of disease prevalence and hampering the ability of the Global Fund (and partners) to set ambitious targets and to clearly assess progress against the diseases. In addition, stakeholders flagged the existence of parallel reporting systems as data collection and reporting across implementing partners in the country is not systematically integrated in the national M&E system.[601]

To mitigate these challenges, the Global Fund has been investing in strengthening data management systems including through investments to strengthen the HMIS system and providing funding for M&E positions.[602] Funding was also made available to implement key surveys, periodic national program reviews and studies, as well as providing incentives for program monitoring and supervision etc.[603] In addition, the Global Fund had been promoting joint supervision and implementation of M&E activities and pushing for integration of data collection and data sharing across partners.[604] Despite these improvements, stakeholders flagged that funding and staffing remain largely inadequate and emphasised the need to increase investments to strengthen M&E systems including through accelerated digitalisation of processes and strengthening of M&E tools.[605]

13.2.4. C19RM

Stakeholders feedback highlighted the instrumental role of C19RM funding to support country C19 response and adaptation of HTM programs though the lack of flexibility in the use of funds caused poor absorption especially in the first part of the pandemic. A total of US$41 million was allocated to South Sudan through C19RM funding (US$0.8 million through grant flexibilities, US$3.7 million in 2020 and US$36.5 million through C19RM 2021 awards).[606] Of 2021 available funding, 61% was allocated to COVID-19 control and containment measures, 20% towards health and community systems and 1% on mitigating the impact of the disease. Reported in-country

[599] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[600] Global Fund (2023). South Sudan country risk profile

[601] Global Fund (2019). South Sudan country portfolio review

[602] Global Fund (2023). South Sudan country risk profile

[603] Global Fund (2023). South Sudan country risk profile

[604] Global Fund (2019). South Sudan country portfolio review

[605] Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

[606] Global Fund (2023). South Sudan DnA Factbook

absorption was low, with only 49% of funding that had been used[607], mainly due to a mismatch between scenario planning and actual evolution of the pandemic leading to an over-estimation of COVID-related needs according to stakeholders.[608] Some have raised a lack of flexibility to reprioritise the C19RM of funds, especially in 2020, as well as initial issues of coordination and information sharing amongst partners, and prescriptive, fragmented and administratively laborious processes further limiting access and utilisation of C19RM funding, though highlight some improvement in C19RM 2021.

Despite these challenges, there has been many document benefits of the C19RM to support Covid-19 responses and mitigate the impact on HTM in the country, including through an integration of C19 responses into existing health programs, decentralization of diagnostic capacity, investing in bidirectional screening capacity and in laboratory systems strengthening, and scaling up best practices interventions such as multi-month dispensing (MMD) which were already being implemented and scaled up through C19RM investments.[609] Most particularly, stakeholders have highlighted the additional funding to support expansion and strengthening of community services as "one of the most significant benefits of C19RM 2021 funding. This includes by resourcing Boma Health Workers to scale-up awareness raising, testing and referral activities, by conducting capacity assessment of CSOs to enhance strategic CSS interventions, and by supporting the roll-out of community-led monitoring (CLM).[610]

13.2.5. Catalytic investments

There was limited catalytic investments reported for South Sudan across GC5 and GC6 and a little awareness of catalytic funding in general across stakeholders. A marginal number of stakeholders were able to comment on the use and effectiveness of catalytic funding in South Sudan. They shared that the country had not received many CIs and that the very few provided have had mixed results. The lack of additional feedback and limited documented information available did not allow triangulation of the feedback received or gathering of additional information.

13.2.6. Partnerships

The partnership landscape in South Sudan is highly fragmented, with critical gaps in implementation arrangements across partners, further accentuated by inadequate coordination with the MOH. The health sector in South Sudan is highly reliant on international donors funding and implementation of HTM interventions is mostly led by independent implementing partners which stakeholders have flagged, reduces Government oversight and ownership of HTM programs. To make up for this shortfall, the Ministry of Health (MoH) had established various coordination bodies (including various Technical Working Groups (TWGs), Health Clusters, NGO Forums) to align partners strategies and consolidate Government oversight across the Health Sector.[611] However, a recent OIG audit reported sub-optimal coordination of these groups (including unclear ToRs, poor attendance and ad-hoc frequency of the meetings) as well as poor linkages with the CCM, leading to limited effectiveness of these groups in their oversight mandate.[612]

Other mechanisms to strengthen cross-partners collaboration include attendance and participation into each other planning session (e.g., COP and FR development) in addition to bilateral visits and joint missions though some stakeholders have shared that whilst these have been helpful for oversight, they have not necessarily led to better complementarity during program implementation. Poor partners collaboration and the existence of parallel reporting and data collection mechanisms[613], also contribute to widening the existing data gap as highlighted above.

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[607] As of July 2022. Global Fund (2023). South Sudan DnA Factbook

[608] Global Fund (2021). SSD_C19RM_FULL_Funding Request Form

[609] Global Fund (2021). SSD_C19RM_FULL_Funding Request Form

[610] Community-led monitoring was rolled out on a limited scale in 2022, with most activities taking place in 2023. Global Fund (2023). Funding Request and internal Global Fund documents (confidential)

[611] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[612] Global Fund (2019). Audit Report. Global Fund Grants in the Republic of South Sudan

[613] Global Fund (2019). South Sudan country portfolio review

Stakeholders flagged a challenging collaboration between the Global Fund and PEPFAR leading to a highly fragmented service delivery and poor coordination in facilities exacerbated by difference in paid incentives and staff contracting arrangements. HIV interventions are almost entirely funded by donors (PEPFAR and the Global Fund) and delivered by implementing partners and stakeholders have unanimously raised the significant gaps in coordination and high duplication. Although there is an agreement on geographical division between the two entities (PEPFAR supporting high burden areas and GF lower burden areas), mainly issues remain exacerbated by the vertical model of service delivery implemented, making the care pathway for patients very complex and inefficient, as they may need to go to through different processes and providers to receive their care in the same facility (e.g., such as in facilities delivering both Global Fund TB-led programs and PEPFAR HIV services). Other reported challenges include a difference in the quality of treatment between PEPFAR and GF led facilities as well as differences in the recruitment and retention processes of health workers, especially the discrepancy between paid incentives. The latter has been raised as a critical issue across stakeholders, as it often leads to less well-paid HIV providers refusing to contribute to the national HIV response or deliberately blocking access to some facilities or resources.

Effective delivery of Malaria programs through PHC services have also been limited by suboptimal coordination of Malaria donors though there have been reports of positive progress to strengthen alignment going forward. Since 2013, essential health service delivery in South Sudan has been financed by the Health Pool Fund (HPF), through a consortium of donors and administered by the UK FCDO, and the World Bank, covering two distinct geographical areas.[614] Whilst evidence suggests this has helped strengthen donor coordination for PHC and malaria services (e.g., streamlining package of services and harmonizing monitoring along with the HRH incentives), recent reports highlights some inefficiencies due to separate management structures between the two areas in the country[615], in addition, to poor Government's leadership and engagement to coordinate health service delivery has been limited which increases fragmentation and differences in service implementation. [616]

However, stakeholders have highlighted ongoing efforts to improve coordination across Malaria donors especially the prospective IDA multi-donor trust fund project (due to start in 2024) aiming at pooling all funding across donors to reduce fragmentation, improve integration and maximise efficient use of limited available resources.[617] They have also highlighted that the selection of UNICEF SRs (e.g., Crown Agents), who were also involved in the implementation of the Health Polled Fund supported primary healthcare program, contributed to improve complementarity and efficiency of service delivery across partners.[618]

13.2.7. Gender, human rights, equity and communities

Very complex gender and human rights situation in South Sudan with high GBV and HR issues due to a large extent by prevailing cultural norms, and exacerbated by poverty, conflict and an ongoing humanitarian crisis, that contributes to hinder equitable progress against the three diseases. Stakeholders have highlighted a very complex gender and human right situation in the country, where gender issues impact all aspects of society, including education (e.g., very low female literacy) and poorer access to health services for women. Highly patriarchal cultural norms, especially in rural areas, often prevent women from participating in decision-making and perpetuate harmful traditional practices, such as early marriage (45% of girls are married before the age the 18) and other harmful customs.[619] The country has been experiencing increasing levels of sexual and gender-based violence (a 17% increase of reported cases between 2019 and 2020), including sexual assault and harassment, domestic violence towards women and violence towards girls, exacerbated by the civil war, a culture of silence, stigma, and a lack access to legal recourse.[620]

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[614] World Bank. Co-financing concept note.

[615] World Bank. Co-financing concept note.

[616] South Sudan Ministry of Health National Malaria Program (2022). Mid Term Review of Malaria Strategic Plan

[617] World Bank. Co-financing concept note.

[618] Based on internal Global Fund documents (confidential)

[619] Care (2020). South Sudan Gender in Brief

[620] Global Fund (2021). SSD_C19RM_FULL_FundingRequestForm_En_2

Stakeholders flagged that the situation is most critical for KPs and other vulnerable populations, especially MSM but also including IDPs and refugees, sex workers, and people with disabilities for which instances of discrimination, stigma, violence and abuse are higher than other groups, with more constrained access to legal resources. A recent survey reported that more than half (52%) of IDPs and refugees in Juba do not have access to the police and only 13.8% had access to GBV health services, whilst sex workers reported significant increases in violence and abuse, including from the police.[621] These challenges, compounded by poor access to healthcare services, have resulted in a big gap in prevention, treatment and care coverage for KP and vulnerable populations across the three diseases, with a particularly dire situation for HIV.

There are high disparities in HIV prevalence and mortality between genders and KPs in part due to poor access to testing and treatment in institutional facilities, worsened by high levels of stigma and discrimination. There is gender disparity in the percentage of women and men living with HIV, with women and girls being most affected in part due to poor ART coverage for pregnant women as well as challenges in access to SRHR services for adolescents and youth (only 23% of adolescents who have sex use condoms).[622] The majority of PLHIV in South Sudan are women (64% among 15+) and HIV prevalence among adults 15-49 years is higher in women (2.5%) compared to men (1.4%).[623] HIV mortality is also higher in women (accounting for 58% of estimated HIV related deaths in 2022).[624] Stakeholders have raised how high levels of fear or stigma following disclosure of a positive HIV status, can lead to complete exclusion from communities, especially for women, which has led many to avoid getting screened. Stakeholders have also shared that, during Covid-19, the use of single community members to collect and distribute treatment to other HIV-positive people, has been welcomed by members of the community as it allowed them to remain anonymous. The high level of stigma and discrimination against KPs (FSW, MSM and transgender) including in health care facilities and in the broader community has also been raised as a key challenge for reaching PLHIV effectively. Persisting human rights violations especially against MSM and sex workers, a result in many not seeking HIV-related healthcare, leading to high rate of infections and underestimation of prevalence.[625]

Interventions to support KPs have been hard to implement due to the cultural challenges and legal barriers in the country emphasising the need for more advocacy and context sensitive interventions, including through CSOs and CBOs, to reach those left behind. Stakeholders report a high resistance to working with KPs especially MSM in the country, including from government stakeholders. Efforts are further hampered by the contextual and legal constraints as aspects of same sex sexual relations and sex work are criminalised under the Penal Code in South Sudan. Stakeholders have shared that CSOs and organisations working with KPs have often faced retaliations including threats or arbitrary arrests from law enforcers which have led them to stop their activities. This includes PEPFAR who previously had some interventions on KPs to support better access and reduce human right barriers but had to stop them due to a very hostile environment and recurrent critical challenges. Stakeholders also shared that there has been very limited funding overall on GHRE in general including from the Global Fund.

They nonetheless reported some marginal efforts, notably an assessment of bottlenecks and priorities to inform advocacy on legal environment and human rights led by the South Sudan AIDS commission in GC6. UNFPA (C19 SR) was also reported to have included monitoring on GBV and human rights in its interventions to address HR related barriers to accessing services. Stakeholders have unanimously highlighted the crucial role of community-based organisation and CSOs to scale up interventions to address stigma and discrimination against KPs and vulnerable populations, whilst increasing advocacy at state level to change the legal environment and allow implementation of services focused on KPs and other vulnerable populations going forward.

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[621] Global Fund (2021). SSD_C19RM_FULL_FundingRequestForm_En_2

[622] SSAC and MGCSW (2023). Gender assessment report of the South Sudan national HIV epidemic and response

[623] SSAC and MGCSW (2023). Gender assessment report of the South Sudan national HIV epidemic and response

[624] SSAC and MGCSW (2023). Gender assessment report of the South Sudan national HIV epidemic and response

[625] SSAC and MGCSW (2023). Gender assessment report of the South Sudan national HIV epidemic and response

13.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Overall, Global Fund investments in South Sudan are highly relevant and responsive to the critical needs in the country, especially in light of the complex contextual challenges and constrained funding environment. Despite reported progress against the three diseases, stakeholders have highlighted how far behind South Sudan remains to achieve global targets highlighting the need for better data to accurately judge progress and inform implementations. The health system in South Sudan remains highly fragmented, aggravated by acute security challenges, limited domestic financing for health and an over reliance on donor funding. The limited resources available are further constrained by high inefficiencies in implementations including high operational costs as well as suboptimal coordination and alignment across donors and partners. Finally, progress against RSSH and CSS have been found to be minimal due to consistent under-funding hindering the effectiveness of interventions to target the hardest to reach and most vulnerable communities including key populations. South Sudan also offers a good opportunity for learning about the Global Fund interventions in complex and challenging operating environments and identifying key challenging and best practices to better contextualise its approach for COEs.

Based on the evidence gathered and inputs collected across stakeholders through this case study, the reports highlight the following suggested areas for strengthening for the Global Fund in South Sudan:

1. **Strengthen partnership and program integration:** Consolidate engagement across partners (especially with PEPFAR) at both country level and at a highest level of leadership at global level, ensure adequate resourcing of the CCM as a key coordination platform and accelerate the integration of HIV and TB programs with cross-cutting health systems to reduce fragmentation, and increase impact of investments
2. **Invest in Government capacity building and gradually increase its ownership:** In coordination with key partners, increase investments in technical and financial capacity-building of Government entities (including the MoH and MoF), informed by a clear Capacity-Building and Transition Plan, and strengthen collaboration and oversight across Government entities, to promote sustainability in the long term
3. **Balance trade-offs between risk management and efficiency:** Define a clear roadmap for a way out of current ASP arrangements, especially the zero-cash policy, with adequate consideration of trade-offs between effective risk management and a need to maximise value for money of Global Fund investments
4. **Improve monitoring and evaluation systems:** Initiate a review of current HIV, TB and Malaria targets in the performance framework to ensure they reflect more ambitious targets and scale up interventions to strengthen M&E systems, especially the national information system (HMIS), as well as promoting data collection and reporting integration across partners to enable better progress oversight against global targets
5. **Increase investments towards RSSH and CSS interventions:** Accelerate investments and intervention to build health and community systems, including increasing the technical and fiduciary capacity of CSOs and CBOs, using the opportunity of available funding in the C19RM, as well as general grants and catalytic funding where appropriate, with a particular focus on key and vulnerable populations focused interventions.
6. **Raise awareness of Global Fund Flexibilities:** Increase communication and awareness of Global Fund policies across stakeholders especially on the COE policy to promote better use of flexibilities and enable better contextualisation of programs and operations in light of the complex and challenging environment

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A.27. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 23 stakeholders from the following entities:

Stakeholder group	Entity
Global Fund Secretariat	Global Fund Country Team
CCM	CCM
Government representatives	Preventive Health Services, Ministry of Health
	Ministry of Gender, Child and Social Welfare
Principal Recipients	UNICEF
	UNDP
Sub-recipients	Crown Agents
	UNFPA
	South Sudan AIDS Commission (SSAC)
	CORDAID
Donors and Technical partners	WHO
	UNAIDS
	PEPFAR
	World Bank
LFA	KMPG
COVID-19 stakeholders	Amref
National CSOs, CBOs	CHIEF (also Global Fund SSR)
	Health for action aid
	The Network of People Living HIV/AIDS (PLHIV Network)
	National Empowerment of Positive Women United, (NEPWU) JUBA South Sudan

14. ZAMBIA CASE STUDY REPORT

14.1. INTRODUCTION

14.1.1. Key country characteristics and HTM context

Zambia is a landlocked country located in Southern Africa with an estimated population of 19.6 million in 2022. The population is one of the world's youngest by median age and has a growth rate of 3.4% per year.[626] Zambia is categorised as a low-income country with a GDP per capita of US$1,487.9.[627] Recent estimates show 61.4% of all Zambians lived on less than US$2.1 a day in 2021.[628] The country's external debt levels rose from 34% of Gross National Income (GNI) in 2013 to 170% in 2020 while the tax revenue stagnated at 16% of GDP over the same period.[629,630] The weak economic conditions were exacerbated by adverse weather conditions and the advent of the Covid-19 pandemic.[631]

Zambia has made significant progress towards halting and reversing the HIV, Tuberculosis (TB) and Malaria epidemics over the two decades preceding 2000, with a 58% decline in HIV incidence and 56% decline in TB incidence over that period.[632] There are an estimated 1.1 million people living with HIV, with a prevalence of 11% (13.9% among women and 85 among men), and annual incidence among adults (aged 15+ years) of 0.3%.[633] The epidemic is exacerbated by harmful gender norms, cultural practices, and risky sexual behaviour.[634] Regarding TB, the disease incidence in the country has declined from 376/100,000 to 319/100,000 population between 2016 and 2021, the.[635] The DST TB treatment success rate was estimated to be 91% in 2021 with 59,752 estimated new TB cases.[636] Malaria remains a significant public health problem in Zambia, with an estimated 3,655,518 cases in 2021, with a high disease incidence and high mortality rate at 18,772 cases per 100,000 population and 45 per 100,000 population, respectively.[637]

The economic consequences of these three diseases include increased healthcare costs, lost productivity due to illness and disability, and a reduced workforce. The increased demand for medical facilities, healthcare workers, diagnostic tools, and medication overwhelms healthcare infrastructure.[638] The Ministry of Health (MOH) is responsible for all health functions in Zambia, including policy, management, coordination, and service delivery. The heath system is governed primarily by the Zambia National Health Strategic Plan (NHSP), which feeds into the countries National Development Plan (currently in its 8th iteration). Other relevant policies that feed from the NHSP include: the Zambia National Strategic Plan for Tuberculosis and Leprosy Prevention, Care, and Control, Zambia National HIV/AIDS Strategy and the Zambia National Malaria Elimination Strategic Plan. Despite reforms aimed at attaining financial sustainability, the health sector in Zambia remains under-financed, overly reliant on external financing amidst the increasing disease burden and consistently falling short of the 15% target set by the Abuja Declaration.[639] Over the last few years, the share of budget allocated to health within the total public budget previously declined from 9.3% in 2019, to 8.8% in 2020, 8.1% in 2021, and 8.0% in 2022, and a fiscal space analysis in 2022 showed that the government had limited prospects for increasing its health budget to meet the national health targets.[640] Though, in

[626] Zambia 2022 Census of Population and Housing Preliminary Report
[627] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ZM
[628] World Bank. Macro Poverty Outlook for Republic of Zambia: October 2022 (English). Macro Poverty Outlook (MPO) Washington, D.C.: World Bank Group.
[629] Zambia Joint World Bank-IMF Debt Sustainability Analysis, August 2019
[630] https://www.theigc.org/blogs/taxing-effectively/zambias-debt-crisis-affecting-its-ability-collect-tax
[631] UN ZAMBIA Socio-Economic Response and Recovery Plan – July 2020
[632] https://data.theglobalfund.org/location/ZMB/overview
[633] Zambia Population-based HIV Impact Assessment (ZAMPHIA 2021)
[634] Global Fund Funding Request and internal documents (confidential), 2020
[635] MOH TB Annual Report 2021
[636] Global Fund DnA - Country Factbook Zambia, 2023
[637] Global Fund DnA - Country Factbook Zambia, 2023
[638] National Health Strategic Plan for Zambia 2022 to 2026 revised February 2023
[639] Zambia National Health Strategic Plan 2022-2026
[640] UNICEF (2023). Zambia Health Budget Brief for Sustainable Financing of Healthcare Delivery

2023, the government has managed to increase its budget for the health sector to 10.4%.[641] As part of the national efforts to increase DRM, the National Health Insurance Management Authority (NHIMA) was established in 2018 to mobilise extra resources for universal health coverage. The NHIMA was also expected to enhance financial risk protection to the population by reducing out-of-pocket expenditure on health and increasing pooled funding through greater access and usage of health insurance products by prepaid members. However, OOP spending, remains a significant part of total health expenditure in Zambia, in part due to the fact that the National Health Insurance Scheme has struggled to reach rural communities or cover the large informal sector in the country. [642,643]

There is a complex interplay between cultural, religious (majority Christian), and biomedical factors in the country, which significantly influences health programming and care-seeking behaviours.[644] Religious beliefs and cultural norms have been contributing to stigmatisation and discrimination regarding HIV/AIDS, hindering efforts to reduce the spread of the disease. These factors are further compounded by gender norms, creating additional challenges for care-seeking behaviours and access to services across the population, especially for AGYW.

14.1.2. Summary of Global Fund support

Zambia is part of the Global Fund "High Impact" portfolio and has been eligible for funding since 2003 due to the country's income classification and disease burden for HIV, tuberculosis, and malaria.[645] Global Fund's allocation to Zambia has increased steadily over the last funding cycles, by 38% from Grant Cycle (GC) 4 (US$ $224M) to GC5 (US$309M), and by 42% in GC6 (US$438M). A larger proportion of the budgets were allocated to HIV/TB, followed closely by Malaria.[646] The main focus of investments within HIV/TB are Treatment, Care and Support (36% of HIV/TB allocation); Covid-19 (29% of HIV/TB allocation); RSSH (10% of the HIV/TB allocations) in GC6 (Figure 1). For Malaria, the GC6 grant focused on vector control, primarily LLIN mass campaigns (39% of Malaria allocation); and case management (40% of the allocation).

The Global Fund currently has four core grants active in Zambia, implemented by two PRs, the MOH which manages around 70% of the signed grant amounts and CHAZ, which manages around 30% of the total grant budget. CHAZ manages about 8% of the health facilities in Zambia, with more prominence in rural areas as well as an extensive network of Church Health Institutions (CHI) that work as SRs. [647] The CHIs have been integrated into the public health system and are supported by government health workers, operational grants, and drugs and medical supplies from the MOH. The MOH works through the Provincial and District Health Offices as SRs and SSRs.

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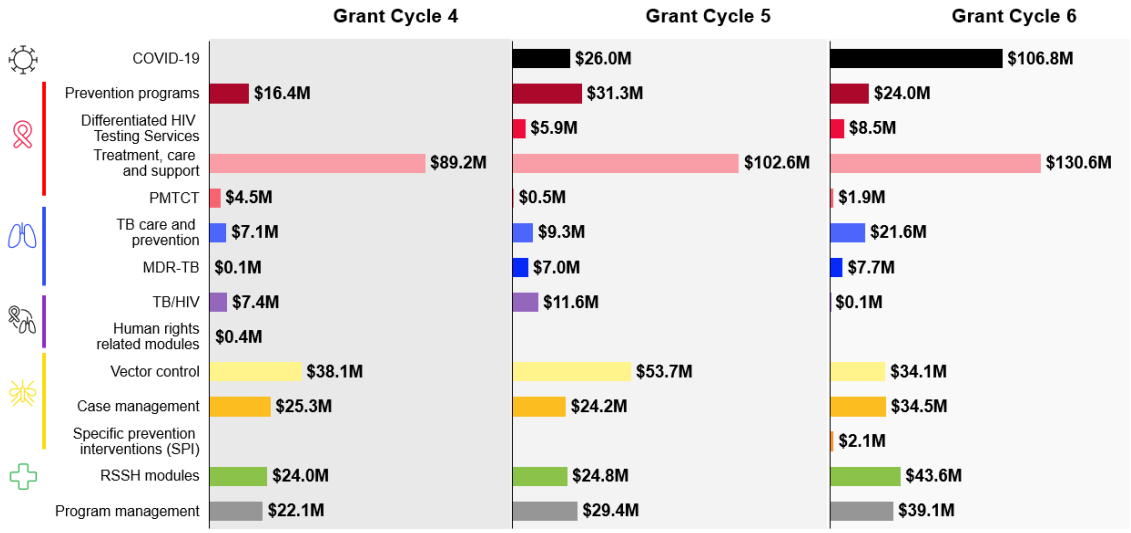
[641] UNICEF (2023). Zambia Health Budget Brief for Sustainable Financing of Healthcare Delivery
[642] Masiye F, and Kaonga O. (2016). Determinants of health care utilisation and out-of-pockets payments in the context of free public primary healthcare in Zambia. International Journal Policy Management.
[643] UNICEF (2023). Zambia Health Budget Brief Sustainable Financing of Healthcare Delivery
[644] Anderson, M. (2020). Disillusionment and Fear: The Impact of Zambia's Religion-Political Climate on Sexual and Reproductive Health Organisations
[645] https://data.theglobalfund.org/viz/eligibility/table?locations=ZMB
[646] Global Fund (2023). DNA Country Factbook/Zambia
[647] https://www.chaz.org.zm/index.php/about-chaz/

Figure 1: Zambia Global Fund budget breakdown by module by Grant Cycle[648]



Global Fund investments aim to support the country in sustaining the progress made in the fight against HIV and TB, countering the recent worsening trend for malaria, and protecting gains against the three diseases.[649] The country also benefited from several catalytic investments during the review period. There were two Matching Funds (MFs) in GC5 worth $US7million, one focused on HIV and AGYW, and the other on RSSH HR. The HIV and AGYW MF continued in GC6. There were three MFs funded in GC6 worth $US12.3million: One for HIV and AGYW, another for HIV Condom Programming, and the third for TB Missing People. Zambia was also included in three Multi-Country Grants (MCGs): (i) The Multi-country Africa ECSA-HC TB grant worth $US 4million, to support strengthening of National TB Reference Laboratories networks and improving quality Lab service provision in 18 countries; (ii) the Multicounty Southern Africa TIMS - TB worth $US10.5million, to improve access to quality TB prevention and treatment services for key mining-related populations; and (iii) the Multi-country Southern Africa E8 - Malaria worth $US14million to accelerate zero local malaria transmission, through the provision of a mechanism for collaboration and joint strategic programming across focus countries. Zambia also had access to several SIs in GC6 to which it was eligible including: Condom Programming, Differentiated HIV Service Delivery, TB Preventative Treatment for PLHIV, AGYW, TB Finding Missing People Cases, Data, CRG, STE, PSM Transformation, and CCM Evolution.

14.2. KEY FINDINGS

14.2.1. Relevance of Global Fund investments

There has been a gradual increase in national health allocation over time, rising from 8%[650] in 2020 to 11.9%[651] in 2024, however the funds allocated are inadequate to address the disease burden with 80% of the health response underfunded.[652] Zambia's healthcare landscape is regarded as “far from self-sufficient”, relying heavily on donor funding. Stakeholders report that approximately 80% of the resources needed to sustain the country's health initiatives are unfunded,[653] with donors such as Global Fund providing financial and technical assistance to fill this gap. Global Fund's investments, alongside other donors, have bolstered the health system, providing services across the three diseases (HIV, TB and Malaria) as well as channelling resources into strengthening health systems including capacity strengthening of key actors and processes, HRH recruitments to fill the significant gap in health workforce,[654] as well as Global Fund's commitment to commodity security which has ensured a steady supply of HTM commodities.

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[648] Global Fund (2023). DnA Factbook Zambia June 2023
[649] https://data.theglobalfund.org/location/ZMB/overview
[650] UNICEF (2023). Zambia Health Budget Brief Sustainable Financing of Healthcare Delivery
[651] 2024 Budget Address by Honourable Dr. Situmbeko Musokotwane, MP, Minister of Finance and National Planning, Delivered to the National Assembly
[652] UNICEF (2023). Zambia Health Budget Brief Sustainable Financing of Healthcare Delivery
[653] Health Financing Strategy: 2017 – 2027 Towards Universal Health Coverage for Zambia
[654] Zambia National Human Resources for Health Strategic Plan (2018 – 2022)

Global Funds' investments in Zambia are described as highly relevant by stakeholders, especially in light of current fiscal constraints in the country. The Global Fund is seen as an important partner in Zambia and stakeholders unanimously regard Global Fund's investments as highly relevant, especially considering the fiscal constraints in-country. The Global Fund is the largest donor for TB and Malaria in the country, and second largest for HIV. For HIV, Global Fund investments strategically cover provinces that are unsupported by PEPFAR under the National HIV program. The TB grant covers drug costs and operational costs, with matching funds allocated annually to ensure sufficient funding for TB programming. As for Malaria, the Global Fund further sustains universal coverage of malaria treatment in Zambia and is the primary funder of ITNs for mass campaigns.

Global Funds' support for HTM commodities is said to be the most crucial component, alongside the use of "Wambo" for procurement which increases value for money. Global Fund's interventions to improve sample transportation networks and strengthen laboratory systems are also reported as highly relevant investments. Stakeholders report that the use of Wambo has produced significant savings (estimated to be up to 9 million dollars in a year by stakeholders)[655] that are reinvested to support other program activities. The country is heavily reliant on Global Fund for HTM commodities with TB medicines 100% funded by the Global Fund as well as a large proportion of malaria prevention items especially ITN procurement. There were some challenges with commodity availability over the last funding cycles, largely due to Covid-19 related restrictions. Global Fund also supported Zambia to establish its hub-and-spoke sample transportation system, mainly used is for HIV, TB and Covid-19, to improve the timeliness and efficiency of testing services. This system comprises central hub laboratories, linked to a network of spoke locations (satellite locations), that collect, transport and run tests on samples from spoke facilities lacking the infrastructure and equipment to do so. This system was very important in the Zambia context where very few hubs were available with adequate testing capacity and patients previously had to travel very long distances to get their tests done.

The funding request adequately considers contextual factors (HTM epidemiological profile, socio-economic context etc.), within the confines of available funding and final stripping process. The funding request for health interventions is said to be well aligned with national strategies for HIV, TB, and Malaria, considering the country's specific context and needs. While healthcare systems are in place for TB prevention and treatment among those with HIV, there are persistent gaps in diagnosing HIV and TB co-infections, with drug-resistant TB posing a significant threat in Zambia. The country ranks among the top 30 countries worldwide burdened by TB and HIV, with TB accounting for over 40% of deaths among people living with HIV.[656] Despite a decrease in HIV incidence, Zambia still reports a high number of new cases (approximately 28,000 annually), particularly among females and young people as noted above.[657] Key populations are also at heightened risk and often experience stigma, discrimination, violence, and limited access to healthcare services. Malaria remains a persistent challenge in Zambia, with the entire population at risk of contracting the disease, especially in rural and economically disadvantaged provinces. While significant progress has been made in malaria control, 2020 saw a worsening of epidemiological trends.[658] Stakeholders highlighted the above gaps across the three disease programs and felt strongly about Global Fund's investment being strategically focused, aligning with the three disease's strategic plans and informed by local evidence. However, the final scope of interventions is constrained by the available funding envelope, emphasising the need to balance ambitious targets with financial constraints. Some stakeholders also highlighted a lack of clarity on the final stripping process during which grants components are allocated between PRs, with no clear rational for the allocation split between the MOH and CHAZ, instead of evidence/activity-based funding, which may impact the efficiency of the allocation process.

Global Fund investments are responsive to emerging country needs and disease priorities with flexibility to introduce WHO recommended innovations and adapt implementation strategies during and across grant cycles as needed. Stakeholders shared that Global Fund investments in Zambia were highly responsive to the country's evolving disease priorities and healthcare system requirements. This responsiveness is evident across HTM

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[655] Technical Evaluation Reference Group: Thematic Evaluation of the wambo.org pilot for non-Global Fund financed orders, December 2022
[656] https://data.theglobalfund.org/location/ZMB/overview
[657] Zambia Population-based HIV Impact Assessment (ZAMPHIA 2021)
[658] https://data.theglobalfund.org/location/ZMB/overview

and the broader healthcare infrastructure. Global Fund's support for TB has been instrumental to fight the disease, leading to remarkable successes, especially in finding missing cases for both Drug Sensitive and Drug Resistant TB with additional funds through catalytic investments to address funding gaps. The TB Matching funds have intensified community case finding efforts alongside innovative diagnostic methods to boost TB notifications. The increasing frequency of TB surveillance and situation room reviews from monthly to weekly, the introduction of more sensitive GeneXpert machines, particularly for children and the innovative use of mobile trucks equipped with diagnostic equipment to reach rural areas and underserved communities with TB testing are examples of responsiveness and flexibility of Global Fund's investments. Another example of responsiveness is the recent change in utilisation of vector control methods by the Malaria program to curb the rising number of cases due to climate change, Covid-19 and poor use of ITNs. Stakeholders describe the change in strategy of the malaria program from a near-universal indoor residual spraying (IRS) in 2022, to scaling back indoor residual spraying (IRS) to malaria hot spots, and utilising ITNs as the primary vector control intervention in 2023. In addition, the Global Fund invested to strengthen the courier network for sample transportation as part of the HIV program, enabling samples to get carried to facilities with more testing capacity to increase HIV testing and respond to ongoing challenges due to the limited number of laboratories. Stakeholders however report the missed opportunity to support scaling up the Mass Drug Administration[659] in the Malaria program, an evidence-based intervention being rolled out by the Government. The decision not to fund this intervention was taken due to variations in the country's approach compared to WHO guidelines which recommends this intervention for low prevalence settings rather than high prevalence settings.[660,661]

14.2.2. Progress and results achieved

HIV Progress

Zambia's progress towards the UNAIDS 95-95-95 targets stands at 89%, 98%, and 96% among adults (15+) living with HIV.[662]ART coverage has increased significantly, but HIV prevalence continues to be higher among KPs and AYP, with poor performance in programming/models supporting these groups. Unmet needs exist particularly around AYP and women, only 73% of young people aged 15-24 were aware of their HIV status.[663] Support through the Global Fund has made significant progress in tackling the epidemic among adults, with new HIV infections reduced by half between 2016 and 2021.[664] The country has rolled-out multiple innovative treatment strategies such as enhanced adherence counselling, ART multi-month dispensing and ART home deliveries. Despite the significant progress in tackling HIV treatment for adults, there is a resurgence of new HIV cases among adolescent and young people (AYP) and key populations (KP) which threaten to stall or potentially reverse the programmatic gains made so far.[665] Stakeholders link the rise in new infections to a number of reasons including the cultural beliefs related stigma and discrimination that hinder young people's access to prevention services. The focus on biomedical interventions/facility-based service delivery to the detriment of structural interventions at community level is an additional factor hindering access to hard-to-reach groups. Furthermore, there has been slow progress in the roll-out of comprehensive sexual education (CSE) in schools where AYP can be specifically targeted. For key populations, HIV programs are constrained by legal and religious/societal barriers which limit the implementation of KP-responsive programs in Zambia.

Some interventions of the HIV program have been challenging to deliver, including Paediatric ART services, PMTCT and VMMC, which have stalled or declined in coverage as a result. Despite a slight increase, paediatric ART coverage remains low (31% in 2021 from 28% in 2018). PMTCT ARV coverage has declined from 41% in 2018 to 25% in 2022; and Early Infant Diagnosis (EID) yields only 28% of infected infants at two months.[666] Stakeholders

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[659] This is currently directly supported by the government, who are unable to fund scale up due to limited funding. Stakeholders have shared that the Global Fund was unable to approve funding for this intervention as it was not pre-qualified by WHO.
[660] WHO (2023). WHO recommendations on malaria elimination. https://www.who.int/teams/global-malaria-programme/elimination/recommendations-on-malaria-elimination
[661] National Malaria Elimination Strategic Plan 2022-2026
[662] Zambia Population-based HIV Impact Assessment (ZAMPHIA 2021)
[663] Zambia Population-based HIV Impact Assessment (ZAMPHIA 2021)
[664]https://zm.usembassy.gov/zambia-surpasses-unaids-hiv-treatment-and-viral-suppression-targets-and-on-track-to-surpass-hiv-status-awareness/
[665] Audit Report for Global Fund grant to the Republic of Zambia (2022)
[666] Global Fund Nigeria Portfolio analysis 2022

describe challenges in ensuring timely and secure delivery of HIV test samples for EID, as couriers struggle to maintain sample integrity during transit and ensure safe transport and delivery of samples. EID couriers play a critical role in the timely diagnosis of HIV in infants, and addressing these difficulties is essential for the effectiveness of EID programs and ensuring that infants receive the necessary medical attention. Women in rural areas are also often unable to attend ANC services due to competing priorities (e.g., having to prioritise their livelihoods such as farming over ANC attendance), limiting their uptake of HIV testing and treatment services. It was also reported that fear of stigma and discrimination (including from healthcare providers and communities) often deters pregnant women from seeking PMTCT services, further limited their access to HIV services. Voluntary medical male circumcision (VMMC) coverage also seems to have stalled as the number of males circumcised is reported to be reducing. The reduced focus on community outreach services, coupled with poor health seeking behaviour among men, who are now required to seek services at the health facility, have been contributing factors to the reduced uptake of VMMC. Though some shared that the VMMC program could have simply reached a saturation point in Zambia. Additionally, there are systems-related challenges such as uneven distribution of high quality technical support to health facilities depending on levels of external donor support. This reinforces the need to strengthen harmonisation of standards across sites to address issues in varying standards of service delivery affecting all services.

TB Progress

Zambia reports a significant increase in TB case notification for both DS-TB and DR-TB, including growth during Covid-19 years. The number of DS-TB cases notified increased from 35,000 in 2018 to over 50,000 in 2021, and DR-TB notifications increasing from 20 to 600 annually. There has been continued progress across a number of interventions in the TB cascade of care which have contributed to reducing TB incidence in Zambia from 376/100,000 to 319/100,000 population.[667] There has been strong collaboration between the TB and HIV programs leading to positive programmatic results with 93% of TB patients knowing their HIV status and 98% of HIV+TB patients on ART in 2020.[668] Stakeholders attribute these successes to increased community testing, improved diagnostic capacity through scale up of GeneXpert machines by Global Fund and other actors (from below 100 to up to over 300 across the country), capacity building of healthcare workers in intensified case finding and supporting facilities to do active case findings at every entry point. The introduction of sputum testing for children, has also contributed to increasing notification among children. The mobile trucks with GeneXpert and Chest X Ray facilities in Lusaka (the epicentre of TB) and Copperbelt increased access to TB testing in underserved areas. In addition, the roll-out and scale-up of TB preventive treatment (TPT) has contributed to lowering TB-HIV co-infection rate, from 46% (2019) to 39% (2020).[669] The 2013/2014 DS-TB prevalence survey and the 2019 drug resistance survey[670] was also reported to have helped recalibrate targets and inform current strategies.[671]

TB treatment success rate has increased significantly, reaching over 90% for DS-TB, and increasing from 33% in 2015 to 79% in 2022 for MDR-TB.[672] Stakeholders shared that the success of TB treatment interventions have highly contributed to the decline in TB incidence. The high treatment success rates reported are linked to the training of health workers especially community volunteers by Global Fund and nutrition support programs provided to vulnerable populations through a complementary World Bank project. The decentralisation of treatment centres has also been a critical contributor to improving DR TB treatment success rates as it provides more accessible treatment sites for patients across the country. Previously there were only two treatment centres for DR-TB (Ndola Central Hospital and The University Teaching Hospital-UTH), but these services are now available in all provincial hospitals and over 100 sites in the country through Global Fund's support.

Malaria Progress

Malaria mortality has reduced as a result of increased access to prompt diagnosis and treatment, following the expansion of community health workers in the country. However, the disease burden has recently been

[667] MOH TB Annual Report 2021
[668] Audit Report for Global Fund grant to the Republic of Zambia (2022)
[669] MoH 2022-2026 Strategic Plan
[670] 2019-2020 Tuberculosis Drug Resistance survey
[671] Zambia 2021 NTLP Annual Report Ministry of Health
[672] Zambia National Strategic Plan for Tuberculosis And Leprosy Prevention, Care, And Control 2022-2026

increasing, due to Covid-19, climate change and associated changes in vector control strategies. Between 2016 and 2021, mortality rates decreased from 48.3 per 100,000 population to 45.2 per 100,000 respectively.[673]Stakeholders reported significant progress in increasing access to early treatment, thereby reducing severe malaria cases and subsequently preventing mortality. This was achieved through an increase in CHWs deployed across the country, funded by the Global Fund and partners such as PEPFAR, Rotarians and PATH. An estimated 25% of all malaria cases are now seen at community level by CHWs, up to 50% of cases seen in the Eastern Province.[674] Global Fund has also played a major role in ensuring the availability of vector control, diagnosis and case management commodities. These successes have inspired a shift in focus with the country establishing ambitious goals for reducing malaria burden in high transmission settings and eliminating it in lower transmission locations.

Despite this progress and the subsequent reduction in malaria mortality, Zambia has been experiencing an increase in malaria cases, in both relative and absolute terms since 2018.[675] Stakeholders suggested that the increase in malaria related morbidity is driven by operational challenges in implementing and adapting program activities in the context of a changing environment. In particular, the climate change conundrum has resulted in increasing rainfall that has necessitated a change in vector control strategy. Stakeholders reported that the country adopted a mosaic approach to allocating Insecticide Treated Nets (ITNs) and IRS that was not effective, with malaria cases only dropping in places where ITNs are distributed. This is also linked to a safer new IRS product introduced that was ineffective, compared to the harsher though non-environmentally friendly product previously deployed. In addition, Covid-19 related disruptions in international supply chains caused significant delays in the arrival of ITNs and subsequently delayed the implementation of the 2020 LLIN mass campaign by three months.

There has been consistently low IPTp coverage with most women receiving only one or two doses instead of 3. IPTp coverage is consistently low with only 61% to 67% of women who received three or more doses of IPTp in 2018.[676] Stakeholders reported that the gaps in IPTp coverage are potentially due to the quality of Antenatal Care Services and underlying health systems gaps such as access challenges (geographical and financial), shortage of healthcare workers and inadequate sensitization and awareness raising efforts on the importance of IPTp. Women in remote or rural areas often prioritise their livelihoods over these services, as they are often engaged in farming during the rainy season (harvest and planting). In addition, the long distances, inadequate transportation facilities, and associated costs deter them from seeking antenatal care or completing the required number of visits to received iPTp.

RSSH Progress

Global Fund extensive investments in commodities for the three diseases, coupled with the expansion of Zambia Medicines and Medical Supplies Agency (ZAMMSA) Warehouses has led to increased commodity security for the three diseases through more procurements, and decentralised storage and management at subnational level. Global Fund procurement and supply chain management (PSM) interventions are well aligned with Zambia's Health Sector Supply Chain Strategy and Implementation Plan, enabling coordinated PSM improvements efforts across the three diseases. These include investments towards the setup of two new distribution hubs, and the planned recruitment of a procurement coordinator. The ongoing scale up warehouse management systems is expected to further improve order processing and boost responsiveness to the needs of health facilities. There has however been reports of recent challenges with anti-malaria stocks linked to currency (Kwacha) depreciation and Covid-19 supply chain disruptions, delaying procurement processes.

The laboratory systems strengthening initiatives have contributed to scaling up services including through the procurement and distribution of equipment and support for strengthening oxygen systems during Covid-19. Global Fund investments for laboratory systems strengthening have resulted in better equipped laboratories in more locations across the country, and contributed to reducing turnaround times for delivering test results and facilitating quality of care. Servicing and maintenance contracts have also been established in light of previous

[673] WHO World Malaria Report 2022
[674] Zambia National Malaria Indicator Survey 2018
[675] World Health Organisation (2019). World Malaria Report 2020.
[676] USAID President's Malaria Initiative FY 2022 Zambia Malaria Operational Plan

challenges with breakdowns and long periods of equipment downtime due to the absence of these maintenance agreements, to ensure the longevity of medical equipment and sustainable laboratory capacity.

There have also been significant numbers of HRH recruited including nurses and CHWs through Global Funds investments, with a clear transition plan to the government payroll. The health workforce shortage has been a recurrent issue in Zambia. With the support of Global Fund's investments, the MOH was able to recruit additional health workers, especially nurses and CHWs to support the delivery of health services. To ensure the sustainability of these investments, a transition plan to the government pay roll in the final year of the grant cycle was developed, although this transition was not achieved in GC6, and there is currently a lack of visibility on when it will happen.

14.2.3. Funding model and business processes

Funding model

The funding request process is said to be a robust bottom up process, enabling adequate technical support for grant writing from TA partners and meaningful consultations with key stakeholders, although there is room to improve the efficiency and coordination of the process. Also, due to limited visibility of other donor and partner program portfolios across the country there is some overlap and duplication in implementation areas. Stakeholders (CCM, PRs, MOH) find the consultants hired by TA partners to support writing of funding applications have been helpful to facilitate high quality applications within the required tight timelines. These consultants work hand in hand with in-country experts from the MOH, PEPFAR, PMI, and UN agencies and other stakeholders. Though, some stakeholders highlighted the growing capacity within MOH personnel to support funding request development and indicated they could start taking a more active role in the writing process. The broad range of consultations (including community engagements led by CSO partners at subnational level) prior to and during the application process are reported to be productive to facilitate inclusive participation and contributions across stakeholders. However, stakeholders reported a number of challenges in coordinating these meetings including changing timelines, inconsistency in availability of some technical leads for writing sessions, as well as challenges in consensus-building among CSOs. Due to the diversity of the CSO constituency, representatives sometimes have divergent views and interests, occasionally leading to disruptions during larger preparatory meetings. In addition, the grant writing process is affected by the limited visibility of available resources across partners and diseases programs, which have led to some duplications in HTM interventions (e.g., reported overlaps between Global Fund and PEPFAR activities). A mapping of interventions is spearheaded by the MoH to try to limit these duplications, though with limited effectiveness due to poor planning and coordination of the process.

The CCM has been restructured to optimise its effectiveness, however there are still some issues including an inadequate representation of some constituencies, lack of malaria focused representatives, and high turnover of Government representatives. There is a perception among stakeholders that the CCM is effectively playing its oversight role, and facilitating country ownership of Global Funds investments. It recently underwent a restructuring process to optimise its efficiency and effectiveness, with its membership reduced from 29 to 17 members (including CSOs representatives). However, some persisting gaps have been highlighted including the inadequate representation of malaria stakeholders at the time of this review. There were also mixed views on the adequacy of MOH representation, with some stakeholders indicating a need to have different government officials representing HIV/TB, Malaria and HSS, and others indicating that the representation through a single official (Permanent Secretary/Public Health Director) is sufficient. Stakeholders also reported frequent changes in government representation on the CCM, due to turn over at the government level, resulting to a need for ongoing orientation of CCM members.

Key Stakeholders, including the government, international partners and civil society, are all represented within the CCM which allows for adequate engagement across HTM actors. However, stakeholders reported some unbalance of voice and decision making influence in favour of civil society representatives compared to other stakeholders. The CCM is well respected by high level government officials and is said to have the ear of the government. Stakeholders perceived that there is strong relationship between the CCM and the government that has been beneficial to strengthen HTM interventions in the country including for supporting lobbying and advocacy to the Ministry of Finance for additional budget allocation. Civil society representatives are the majority members in the CCM compared to other constituents. They actively participate in CCM processes, and play a critical role for holding implementers accountable. However, some stakeholders report that CSOs have sometimes benefited from

this majority to delay decision-making on areas divergent to their interests, or opposing evidence-based proposals from partners and Global Fund's CT. According to these stakeholders, the voices of bilateral and multilateral partners are not as prominent in the Zambia CCM with limited influence over decision making, however, they reported that the CCM Secretariat was working to foster better consensus among stakeholders and CCM members.

The CCM is heavily involved in program management beyond the traditional oversight role due to historical challenges with past PRs accountability and transparency. This has resulted in lower PR autonomy and an overstretched Secretariat. The 2009 OIG [677] review identified resource misuse amongst PRs in Zambia. This led to several recommendations which were implemented over time with lingering effects including a more involved CCM playing an expanded role. The expanded role involves reviewing and approving reprogramming decisions and in some instances, following up on audit report corrective actions. As a result, the CCM is involved in a lot of decision making, attending multiple ad-hoc meetings, which affects regular attendance of some CCM members. Stakeholders report that the secretariat is a well-established team with strong administrators, but is stretched thin with a large funding portfolio to manage considering the size of the team. The CCM is also said to not leverage technical experts sufficiently to address its personnel gaps.

The good coordination across national implementing entities, in particular the coordination between disease programs and the PMU and between PRs, has also been cited as a key enabling factor that facilitates the implementation of programs. Technical implementation of programs is currently led by the disease programs, whilst the Program Management Unit (PMU), largely integrated into the MOH, focuses primarily on grant management. To strengthen coordination and oversight across these entities the PMU at MOH is currently being restructured to embed its technical officers within the disease program offices and embed other grant management roles in the policy and budgeting directorate. Stakeholders also highlighted the need for disease programs to have a better budget visibility during implementation to strengthen implementation. Regarding the relationship between PRs, Zambia has had two Principal Recipients (PRs) for Global Fund grants in the past 8 years:[678] the Ministry of Health (MoH) and the Church Association of Zambia (CHAZ). These two institutions have had a strong working relationship prior to Global Fund investments and continue to coordinate very effectively together with support from the CCM. Stakeholders have also highlighted the good working relationship between PRs and their SRs which contributes to strengthening interventions implementation. The MOH works with its Provincial and District Health Offices as SRs and SSRs, mimicking their traditional arrangements within the Government. However, a challenge highlighted by stakeholders was a lack of understanding of Global Fund procedures and process by SRs which had sometimes led to grievances between PRs and some SRs. Better communication on Global Fund processes across actors could help prevent such incidents in the future.

Sustainability

The Government of the Republic of Zambia (GRZ) has demonstrated significant ownership and leadership in relation to Global Fund's investments, and has consistently met Global Fund's co-financing requirements, in addition to its contribution through HRH and the vast health care infrastructure throughout the country. Stakeholders report that Global Funds investments are already effectively implemented through the country's health system, a critical integration that promotes better sustainability of interventions. The country has also consistently met the co-financing requirement, as stakeholders report that government contribution often slightly exceed 15% (through a direct cash injection). Stakeholders estimate that this contribution increases up to 40% when including government investments in personnel and infrastructure for hospitals. Maintaining and potentially increasing this co-financing requirement is strongly recommended by many stakeholders, who recognize its role in the journey towards sustainability.

Whilst the government has been very supportive of increasing domestic financing for health, stakeholders flagged the lack of advocacy and leadership to drive these efforts, including the lack of a clear transition plan of Global Fund's interventions to the government. Stakeholders highlighted the absence of a clear transition plan by the CCM and PRs to guide gradual efforts for transitioning Global Fund's interventions to the government, although the CCM was reported to be in the process of creating one at the time of this review. In the meantime, the default

[677] OIG Country Audit of Global Fund Grants to Zambia 2009
[678] Key donors to reinstate health funding to Zambia

process is for the government to fund components not taken on by Global Fund and other donors, as there is no drive or requirement to gradually absorb some of Global Fund's portfolio. Beyond direct government allocation, there are several emerging opportunities through government led initiatives that can be leveraged or supported by the Global Fund to increase domestic financing for health including:

- The Constituency Development Fund to be harnessed for health at local government level.
- The National Health Insurance Scheme (NHIMA) through increased informal sector coverage.
- The National Health Financing Strategy by NHIMA is also introducing taxation earmarked for health e.g. from cigarettes and alcohol consumption, mobile money.
- Private sector CSR of large private companies e.g. the mining sector
- The end malaria council and an end malaria fund, set up by the head of state to garner domestic resources for the private sector and advocacy to the treasury to increase financing for malaria.
- Social Contracting between Government and private sectors to improve access, quality, and efficiency of healthcare services and leveraging the expertise and resources of both the public and private sector.

Risk Management

Global Fund appropriately manages risks for its funding, with contextually appropriate risk management processes in place and implemented accordingly. Stakeholders reported that Global Fund risk management systems are robust and effectively implemented, enabling effective risk management in Zambia. These processes include for instance annual trainings on risk management hosted by the Global Fund; the use of risk registers and compliance personnel by PRs to enhance risk management; and improved financial management systems using software (e.g., Navision, Sun Accounting System and QuickBooks) for better accuracy and credibility of financial reports on grants. The Local Fund Agent (LFA), internal auditors within the PRs, the national auditor general and CCM leadership also play critical roles to implement a comprehensive risk management approach and ensure an effective and accountable use of Global Funds investments.

The risk management systems and initiatives do not preclude the selection and implementation of the most impactful or needed programs in Zambia, as the CCM effectively coordinates the design implementation and monitoring of investments through its expanded oversight role. Stakeholders described the in-country consultative processes led by CCM during the funding request/ application process as very effective which results in agreed priorities across a wide range of stakeholders and achieves a good balance between funding risk and program suitability. They also described the oversight of CCM during implementation as contributing to enhance risk management during program implementation. Examples include: approving PRs reprogramming decisions before communication with Global Funds Country Team and working closely to address proposed audit related management actions.

Stakeholders view Global Fund's focus on commodities as a necessary measure to ensure critical availability of medicines and health products for HTM programs. The Global Fund remains the main source for HTM commodities in the country. The ring fencing of funds for commodities during funding request processes is not viewed as a risk, but rather as a critical measure to deliver HTM programs effectively, especially with the large HIV burden in the country. Beyond the originally earmarked funds, stakeholder report that savings during the first 2 years of the funding cycle are ploughed back to fill any commodity gaps in the third year of the grant cycle.

M&E

Global Fund investments are implemented through the country's health system and as such utilises the national M&E system, except in a few cases where the national system does not collect the required indicators. Stakeholders report a good integration of data collection and monitoring processes overall with limited parallel systems except for specific interventions that are only supported by the Global Fund and for which integration may be constrained (e.g., because of a lack of appropriate existing systems). Most data is manually integrated back into the main system except KP reporting data. Data collected around KP service delivery is done through PEPFAR and uses a parallel National HIV/AIDS, STI and TB Council (NAC) database without being integrated into the main national system due to legal framework constraints.

Key PRs personnel are familiar with the Global Fund Performance framework and describe a robust target setting process, sometimes limited by inadequate disease burden or population size estimates for new programs and populations of interest. Global Fund investments contribute to progress across the diseases to reach national targets, by strongly aligning with the programmatic gap tables which showcase existing gaps to prioritise across the three disease areas. However, the challenge faced in the target setting process is inadequate evidence on population/disease burden estimates especially for new populations of focus such as KPs and newer interventions e.g. PrEP. Stakeholders have raised concerns about potential underreporting, hindering the reliability of current estimates and particularly impacting baseline benchmarking, though the size and extent of the discrepancy is hard to evaluate due to insufficient data.

The Global Fund has supported M&E innovations, especially digitization efforts which are expected to be cost effective. However stakeholders have reported some gaps in operationalizing several digitization interventions due to suboptimal resources management during the implementation of these interventions. Global Fund support to enhance M&E systems is viewed as key to drive innovation and digitization efforts. This include the main digitalization success supported by the Global Fund, the migration the DHIS to DHIS2 web-based, which happened prior to this review strategy period. The TB reporting system has also been integrated into DHIS2 with Global Fund support. However, stakeholders highlight the opportunity to learn from previous initiatives that have not delivered the intended results to better contextualise these interventions. One such learning is the need for a thorough assessment on required capacity and supportive systems ahead of implementing these innovations, to ensure they are effective and adapted in the context of Zambia. This is illustrated in the following reported innovations:

- SmartCare (an electronic medical records system) was supported but required extensive IT expertise for its management which was not readily available within the MOH, and required external technical assistance. There is a new version called SmartCare plus (a web based version) currently being rolled out which shows some promise.
- Smart paper technology, introduced to scan paper-based records into electronic records, which was ineffective because there was no technical resource in-country to troubleshoot the errors experienced.
- Community volunteers provided with mobile phones, without a maintenance or insurance policy, or training when required. As a result, CHWs often had to reverts to paper based processes once the phones broke down or were stolen. Some CHWs were also not digitally literate and were not able to be trained due to low capacity.

Global Fund has improved its flexibility for reporting processes with timelines for reporting moved from quarterly to 6 monthly to reduce reporting burden at national level, although stakeholders report there is room for streamlining the process. Although the Global Fund has improved its flexibility for reporting processes, stakeholders shared that reporting could still be improved. They shared that reporting could be made easier through better linkages between the national HMIS and Global Fund's processes, although this is not currently feasible due to in-country legal restrictions on data sharing. There is also an increasing demand for more disaggregated data by age, sex, methods which allows for better data monitoring but requires additional time and capacity to be factored into reporting processes. Furthermore, Stakeholders report frequent changes in guidance and of templates without commensurate frequency or reorientation and training which adds inefficiencies in the process.

14.2.4. C19RM

Global Fund's C19RM processes were well suited to the country context and contributed to respond to the pandemic emergency in Zambia. Funding implementation was also responsive to the evolving situation with a gradual shift towards health system's needs, including improving laboratory and warehousing systems. Stakeholders have confirmed that C19RM funded interventions were much needed and relevant to enable an effective response to the COVID-19 emergency and ensure the continuation of essential services and HMT programs during the pandemic. C19RM investments were used to supplement ongoing national efforts for the pandemic response including the provision of PPE for service delivery and oxygen in health facilities, especially in the early days of the response. With the evolving situation, stakeholders stated that C19RM funds became largely directed towards health systems strengthening efforts and other related health service needs. These range from training of community health workers and equipping them with necessary resources to deliver community-based services and home visits;

establishment of a hub and spoke transportation network for sample transportation (also used for Covid-19 testing); improving health facility infrastructure and warehousing facilities; support for additional HRH; procurement of IT equipment; and support for TB surveillance and situation room activities. Stakeholders reported they did not face any major challenges in accessing Wave 1 funding, however highlighted that Zambia initially struggled with the original redirection of existing funding from HTM to Covid-19, with delayed reprogramming processes and inadequate funds from other sources to address the pandemic.

The Covid-19 pandemic significantly affected health service delivery (including HTM services and outcomes), however the C19RM funds, including the initial budget flexibilities and the Wave 1 funding, largely mitigated the impact of Covid-19 across the 3 diseases. The shift of health systems resources towards controlling the spread of Covid-19 virus in Zambia negatively impacted the provisions of health services including HTM services. The country's health system was already stretched with limited HRH capacity, infrastructure and budgets and a high burden of all 3 diseases. The initial budget flexibilities as well as the Wave 1 funding were utilised to address some of the key disruptions in service delivery. For instance, laboratory improvements and sample transport network strengthening addressed the competing demand for the VL testing platforms (used for both Covid-19 testing and viral load/HIVDR testing). Challenges with access to health services were addressed by community service delivery and multi-month dispensation. Additional health workforce hired cushioned the pressure on strained health facility staff who were providing Covid-19 related support in addition to routine health services. Also, supply chain disruptions were addressed by renovations and expansion of warehouses and associated hubs. This allowed for further storage capacity but did not address the delays due to supply chain and manufacturer constraints. For instance Covid-19 related global disruptions in international supply chains resulted in delayed arrival of ITNs, delaying implementation of the campaign by three months in 2020.

14.2.5. Catalytic investments

Majority of stakeholders struggled to articulate the purpose of catalytic funding, but those with more knowledge reported that they were beneficial in some regards (e.g., harnessing additional domestic investment for health) though with limited catalytic effect. Majority of stakeholders struggled to articulate the purpose of catalytic funding or how they have been effective. Most respondents however report matching funds to be the most catalytic investment as they enabled an increase in government funding to scale up supported interventions. The multi-country grants are said to fill a unique niche as they provide access to services for populations that may otherwise not have been served and opportunities for cross-learning between the different countries involved. Strategic Initiatives (SIs), especially the DATA SI, seemed to be welcomed as a unique opportunity to strengthen data systems capacity, although stakeholders reported numerous failed digitization projects as illustrated previously. TA providers were also reported to have not met local stakeholder needs as there were no tangible outcomes after years of support as part of the initiatives. As such, these M&E SIs are deemed to not be catalytic or overall impactful. There are however references to successes from before this review period.

Whilst TB Matching Funds have been reported as instrumental to catalyse progress on TB outcomes, Matching Funds on AGYW and condom programming have had more mitigated results. TB Matching Funds intensified case finding through scaling up coverage to locations that would ordinarily not have been prioritised and increasing investments in services historically been underfunded. Stakeholders reported that the impact of the TB matching funds was visible, as it catalysed coverage of case finding efforts, enhancing progress on already high treatment completion rates. The marked improvement in TB outcomes are said to be linked to these investments.

The Matching Funds on AGYW and condom programming on the other hand have not been as impactful, hampered by existing inherent challenges in implementation and with implementing partners. Stakeholders reported poor progress with reaching Adolescents and Young People (AYP) in general as well as inadequate condom programming. The gap in services were mostly related to HIV prevention as the current PRs primarily focus on treatment service delivery. Also being a faith-based institution and a government institution, in a country with very strong cultural and religious inhibitions, there are limits to service type and reach. In addition the supply chain management processes for condom distribution are inadequate with condoms only available at health facilities. Stakeholders reported that these funds may have been impactful if they had been directed towards community services and implemented by a CSO close to communities. There was however success in generating additional funding from the government as matching funds with about 1m out of 6.2m USD for reproductive health allocated to condom programming in 2022.

This was the first-time funds were allocated to Condom programming in the country, although these funds are reported to have poor absorption due to a lack of appropriate and effective delivery systems.

14.2.6. Partnerships

There is an effective collaboration between the Global Fund and other international TA partners such as UN agencies during the development of funding requests and programs implementation, though stakeholders reported minor gaps in coordination. Stakeholders describe significant engagement and involvement of TA partners in Global Fund interventions. Their support ranges from providing normative guidance to enhance national strategies, evidence generation for strategy development and funding request applications, direct support during grant writing process through consultations and drafting by writing consultants etc. However, stakeholders reported that the coordination across partners and stakeholders during the funding request process could be better, mainly due to a lack of clarity on the process and its requirements, as well as frequent changes in committee meeting dates or absenteeism of writing team leaders.

There has also been a largely effective relationship between PEPFAR and the Global Fund with extensive involvement in each other planning processes and some level of alignment with room for improvement. Global Fund actors as well as the MOH participate actively in PEPFAR's COP design process, where they define national priorities to be supported in PEPFAR HIV programming. The inverse also happens with PEPFAR sitting on the CCM and actively participating in the Global Fund application process. This enables better alignment across the two major HIV and TB donors and better delineation in what each donor supports in alignment with the MOH. However, stakeholders have flagged there is some room for improvement in this process as mapping exercises are sometimes done without proper planning and coordination, leading stakeholders to miss some of these important meetings.

Despite ongoing coordination and collaboration efforts, some duplications remain due to a suboptimal visibility across health sector partners, mainly in HIV and less so for TB and malaria which operate in a more harmonised system. Stakeholders reported suboptimal visibility across the healthcare ecosystem, with inadequate mapping of funding and partner portfolios. There are reports of duplicated and overlapping activities that a deliberate mapping exercise can help reveal to optimise available funding. Some examples include duplication around PEPFAR's DREAMS and other AGYW interventions. There is also the potential for CLM efforts and KP interventions to overlap in the upcoming grant cycle. Duplication seems to be unlikely in the TB program with very few partners. The TB situation room has also served as an avenue for enhanced collaboration among TB partners including technical partners and PEPFAR. In the Malaria program, the National Malaria Elimination Centre (NMEC) utilises several initiatives which have been reported as effective including: a digital work planning tool, monthly partnership directorate meetings and annual harmonisation exercises to map its partners contributions.

The Global Fund is also recognized for strengthening national institutions and CSO actors through its country ownership principles. Notable results have been observed in strengthening CSO visibility and voice especially through the CCM. In regard to health systems strengthening, a Community Health Assistants cadre have been trained and deployed to health facilities. Furthermore, government structures and local organisations (MOH, NAC and CHAZ) who lead implementation of investments have been capacitated through their interaction with Global Fund's model.

14.2.7. Gender, human rights, equity & communities

The design of Global Fund applications include clear considerations and interventions to reduce human rights barriers, advance gender equality and enhance equity, but these are rarely implemented due to inadequate legal frameworks (especially for KPs). There are also gaps in PWD needs. Stakeholders report that human rights, gender equality and equity related interventions are well spelled out in Global Fund applications, with corresponding allocated budgets. The only area that was reported as a consistent gap was interventions to address barriers to service delivery for PWD. There are, however, conversations on including this in GC7. Stakeholders also report inadequacies in implementation due to legal and religious limitations and high levels of stigma. Many cases are withdrawn from courts due to stigmatisation, leaving available budgets for legal representation barely utilised. The country has also not conducted any CRG assessments to determine levels of stigma though there is a perception that stigma is very high and linked to strong religious and cultural inclinations. CRG assessments are said to be planned in GC7.

The needs of several vulnerable and key populations are not being effectively met during implementation due to inadequacies in the national legal framework, as well as limited providers, interventions and service delivery options. The lack of CSO led activities is reported as a missed opportunity to reach more KPs. A number of interventions to reach vulnerable and key populations are being funded by the Global Fund but remain challenging to implemented with limited effectiveness due to contextual barriers and related constraints. These include the following examples:

- The CHAZ AGAPE program focusing on keeping girls in school and an MOH dedicated for the AYP program, but these operate under religious and legal restrictions/inhibitions on program types and populations served.
- PWD needs are not being adequately considered in funding requests, although there are reported to be included in the ongoing GC7 FRs
- Some KP groups received limited dedicated support specific to their needs outside of general service delivery (e.g., MSM, Lesbians, Trans).
- Young people have not been effectively reached (increasing new infections mostly among young people) as current interventions strategies and messaging have not worked.
- Condom programming is done primarily through health facilities, with limited CBOs involved in implementation.
- TB program is hampered by stigma as well as wider contextual issues such as travel distance to health facilities and the cost of some services such as X-rays (when all TB services are supposed to be free), further limiting access to TB services to KP and other vulnerable populations.
- There are reports of self-stigmatisation among KP and other vulnerable populations which hinders their ability to fight for their rights or access available services. Stakeholders shared there has not been sufficient work to address this.

Stakeholders highlighted that, because of the limited technical and fiduciary capacity of CSOs, they are often unable to receive funding and run interventions, which is a missed opportunity to bring services closer to communities and better contextualise them for KPs and other vulnerable populations. A few CSOs serve as SRs under the private sector PR, but there is an urgent need to use more CSOs to support community engagement and Social and Behaviour Change Communication (SBCC) activities, especially towards reaching young people. The capacity gaps highlighted include organisational policies, financial management and accounting systems, governance, M&E, and HR. Stakeholders also reported largely weak coordination among CSOs, with many unaware of funding opportunities. There were initial conversations to include a third PR in GC7 but this was not agreed as stakeholders felt there was no CSO sufficiently capacitated to play the role.

Interventions are often focused on treatment and service delivery (for both the general population and KPs) with limited attention to equity issues and advocacy to address legal restrictions. The KP consortium set up to coordinate KPs is also constrained by the current legal framework, with little to no political will to change this. All health facilities are open to all including KPs, however high levels of stigma and discrimination make this model less suboptimal for encourage and enable KPs access to services. There are also One Stop Centres (OSCs) and community delivery services which are open to vulnerable groups, mostly targeting GBV survivors to completed facility service delivery. CHAZ is working in 48 OSCs, alongside other partners e.g., EU, SIDA. Under Global Fund's investments, KP service delivery programs include only two health facilities in the country which directly target KPs. Stakeholders indicate that PEPFAR has been more successful with implementing KP programs being non-religious and non-governmental. Lastly, KPs are not actively involved in delivering KP programs and do not feel that the efforts of the current PRs and SRs make any real difference for their communities on the ground. KP service delivery programs are still a contentious issue in the country, as illustrated by a recent MOH circular (released a few weeks prior to this case study) asking for the sexual rights terminology not to be used anymore in SRHR as they also promotes LGBTQI rights. Instead all related programs are now to be labelled Reproductive Health. There continues to be little or no focus on advocacy to change the legal framework, beyond a few actors such as STOP TB and PEPFAR working to address this issue, with limited results.

14.3. CONCLUSIONS AND SUGGESTED AREAS FOR STRENGTHENING

Global Fund investments are very relevant and designed to meet the country's needs. Investment in HTM commodities and the cost savings facilitated through the use of Wambo procurement mechanism are cited as especially helpful. The funding application process adequately considers contextual factors including disease burden, program gaps and socio-economic context, with a broad range of meaningful consultations across stakeholders. However, the finalisation process is hinged on streamlining the proposal to the funding envelope and the politics around consensus building, with some important interventions cut in the end.

Global Fund's model is seen as a flexible funding model with opportunities to introduce WHO approved evidence-based innovations and reprogram budget as needed. The CCM engages well with key country stakeholders but is somewhat more involved in program management than its typical oversight role would be, potentially reducing PRs autonomy in the process. The CCM is also perceived to be heavily CSO driven, however the CSO constituency struggles to achieve consensus due to its diversity. The Global Fund business model is seen as promoting sustainability through its country ownership focused approach and national leadership during implementation. The country has also been meeting its co-financing requirements, a core element of the STC policy, and the Government have been largely supportive of increasing domestic contributions. However, the lack of a clear transition plans to guide efforts in domestic resource mobilisation and gradually reduce Global Fund investments has been highlighted as a key gap.

Catalytic investments, especially matching funds have enabled increased domestic funding and should be harnessed more with high impact interventions that are effectively delivered. Investments in digital innovations through CIs have had limited success and further assessment on appropriateness in the country's context is needed before introducing similar interventions. The limited visibility across health sector partner's investments results in duplications, leaving opportunities to better optimise available resources. Lastly, in a country with strong religious and cultural values that inhibit the delivery of certain services, advocacy for changes in the legal framework is essential to implementing HRG and related interventions as well as a reconsideration for the appropriateness of the current implementers who may not be best positioned to deliver community-based services for vulnerable and key populations. Currently CSOs are perceived to have lower capacity than is required to serve as PRs, whilst there is an urgent need for community-based delivery and community-led interventions.

The review proposed the following suggested areas for strengthening towards improving the relevance, coherence, impact and sustainability of Global Fund's investments in Zambia:

1. Strengthen the capacity of civil society to lead community-based elements of prevention programming and HRG interventions, with a CSO positioned to become a PR in grant cycle 8. This is critical to moving the needle on AYP and KP service delivery outcomes.
2. Review the extended role of CCM vis-à-vis the historical accountability of current PRs with a goal to increase PRs autonomy and reduce CCM responsibilities and workload.
3. Invest in advocacy towards changing the country's legal framework around service delivery to key populations, including research to generate evidence and baseline data for new programs such as adolescent surveys on HIV and KP size estimates..
4. Facilitate the development of a transition plan (with clear advocacy activities) that promotes increased domestic investment and gradually reduces Global Fund's envelope.

A.28. REFERENCES

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A.29. INTERVIEW LIST

The case study was informed through consultations and focus group discussions with 32 stakeholders from the following entities:

Stakeholder category	Entities
CCM	CCM (including PAOGZ and AFRYan)
Government	MOFNP
	MOH-PMU (PR)
	MOH
	MCDSS
	GENDER DIVISION
	NAC
PR (non-state)	CHAZ
Donors and technical partners	UNAIDS
	WHO
	PEPFAR
CSOs and community-based organisations	FLEM
	Christian Woman Rock
	Decisive Minds
	Zambia Federation of the Blind
	Youths Platforms
	C-SAG
	CSOs

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